**EPISODE 204: Finding A New Path and Happiness When You Slow Down And Plan For Retirement**

**With guest Dr. Dike Drummond**

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DD: “Doctors are used to working really hard. They're used to being very busy. What you're doing is shedding an identity when they think about retirement. You're releasing something that you've become and some of them have money programming that keeps them from feeling comfortable even when they have a significant net worth.”

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hey there, and welcome back to the Doctor's Crossing Carpe Diem podcast. I'm your host, Heather Fork, and you're listening to episode number 204. We've been diving deep into the important topic of aging and retirement. And today I'm thrilled to bring you the third episode in our four part series, exploring this crucial phase of life.

I have a very special guest joining us today, Dr. Dike Drummond, who will guide us through both the psychological aspects of approaching retirement and some logistical considerations that can help ensure that this next chapter unfolds in alignment with your hopes and visions.

Dr. Drummond is a male trained family physician, professional coach, author, podcaster and speaker, as well as CEO of The Happy MD, a platform devoted to helping physicians prevent and recover from burnout. With over 3,000 hours of one-on-one coaching experience and having trained more than 40,000 physicians across 175 corporate clients, Dr. Drummond brings a wealth of insight into navigating the transitions we face in our careers and beyond.

I'm excited to have Dike here to help us consider a range of important topics, including our physician identity, purpose, legacy and health considerations so each of us can determine what truly matters in this next phase of life. Dr. Drummond will guide us through these areas, helping us reflect on what a fulfilling and meaningful retirement might look like based on our individual values and priorities.

Before I dive in, I just want to mention and in the show notes, you will find links for the other two podcasts, 195 on ageism and hiring, and 202, part-time jobs for the peri-retirement period. And that there will be an episode on the financial aspects of retirement coming soon. Without further ado, it is my distinct honor and pleasure to welcome Dr. Dike Drummond to the podcast. Hi Dike, how are you?

DD: Good morning, Dr. Fork.

HF: Good morning, Dr. Drummond.

DD: That's a lovely introduction, thank you very much. In full disclosure, what I want to do is just let everybody know I'm 66 years old and last December 6th, I had a stroke. And so if you've not had any health concerns and you're my age, you may not be familiar with what it feels like to have the Grim Reaper fire a cannon shot across the valley of your boat. But my medical history also includes that I've had three atrial ablations for intermittent atrial fibrillation, sick sinus syndrome and I now sport a lovely two chamber pacemaker. I used to be an athlete in my younger days. And as a coach, I've helped a lot of people retire. And in my case, after being a physician for 10 years, full service rural family doc, delivered 500 babies in all, I was then a small business owner for 10 years and now for the last 14 years, I've been 100% devoted to helping doctors recognize and prevent burnout in themselves and others.

Through TheHappyMD.com as my website, I am not the happy MD. Most times I'm pretty cranky. This is a place where you can go to get the tools so you can be the happy MD.

There's things in your life that you have control over and things that you don't. For instance, when you were born, you didn't have any choice over the family of origin that you were born into. And you may not have had a whole lot of choice or felt like you had a whole lot of choice in the career that you chose. It could have been dreamt up for you by your family. But now, assuming that you've gotten to a stage in your career where you're contemplating retirement, you have choices on how you would do that. You actually have a choice on how you're going to die in some cases, depending on the illness that takes you out.

And what I find is that doctors are used to working really hard. They're used to being very busy. Some of them have money programming that keeps them from feeling comfortable even when they have a significant net worth. And I find that in the stages of quitting smoking, there was pre-contemplation, contemplation, planning, and active quitting, that kind of stuff. Doctors have the same kind of stages when they think about retirement.

I don't think about retirement. I'm thinking about it, but I'm not doing anything. I'm actually planning, now I'm going to do it. The four stages are there. But in the middle of all of that, and I've actually mapped this out before, in the middle of those stages is all of Kübler-Ross’ stages of grief. All of Kübler-Ross' stages of grief. Because what you're doing is potentially, some people never do this, and we'll talk about dying in the saddle in a second, but what you're doing is shedding an identity. You're releasing something that you've become. It's almost like an actor who has a role that makes them famous that they can't let go of. Jack Nicholson is always Jack Nicholson. He's just got different names for the character.

There's all this grief and sadness and feeling lost, and “What'll I do if I'm not seeing patients every day?” A lot of times when I meet people, let me just give you a for instance, and this is a true story. This is actually a case study. A woman came to me who was 68 years old. She was a neurologist and had lost a couple of her partners, and then they had tripled her workload, and she was working her face off and was concerned about being burned out and wondering how she was going to continue to go like this.

And in the course of a first call, when I do a discovery call with somebody, I ask a couple of quick questions that tell me a lot about the dynamics in the background. I said, “Are you married?” She said, “Yeah, my husband's 74. He's had a stroke. He has to walk with a cane.” Okay, she's 68. He's 74, already had a stroke. I said, “What's your net worth? - $7 million.” Wait a second. No, what's happening is her being so busy in her practice and so present and working so hard to fulfill the conditions of her job description, she's able to block out the acknowledgement of where she is in the cycle of her life, and she's able to actively deny her humanity and her husband's humanity.

I said, “If you guys weren't working, what would your husband be doing? - Oh, gosh, we'd love to travel. We would love to travel.” And I said, “Do you want to die in the saddle?” That's always my question. Do you want to die in the saddle? Imagine it's next Thursday, 03:00 in the afternoon, you're between patients and you drop dead in the office. Is that how you want this to go? This is what the answer I get. Every time I ask that question, what do they say? Have you ever asked this question?

HF: I hadn't thought of this, I hadn't thought of that.

DD: No, they usually sound like Will Smith. They go, “Oh, hell no. I don't want to do that.” But check this out. This has been constant since I got my MD in 1984. Look at the doctors who win awards from their specialty society. Specifically, look at the family doctor of the year in the state of Minnesota, or Indiana, or Nebraska, and look at the person they hold up as the paradigm of what it means to be a great family doctor. He's 78-year-old and still sees patients full-time. It's like, “Hang on a second. Dying in the saddle isn't mandatory.”

However, what we had to do is work on, look, I know your boss wants you to work like a dog. The more you see without two partners' salaries in the mix, the more money they make. And I know they're going to play dirty and say, “What's wrong? What about the patients?” They're going to doubt your ethics, they're going to doubt your work ethic. I know that pressure's going to be there, but you're the boss. $7 million by anybody's measure, and she didn't spend anything in a month, and their house was paid for. $7 million by anybody's measure, you are financially free. You can do anything you want. Then this woman, over the course of about a half a dozen visits, had quit and was leaving on a European vacation with her husband, and was quite happy about it.

HF: Well, that's a great intervention, Dike. And I also appreciate you sharing sort of where you are at in terms of your age and what you've experienced. And just looking at you from here, it's not obvious that you had a stroke or have any physical issues at all. You look like you're in great health, but different things can happen to us at any stage.

Now, not everybody has $7 million. In that way, it can sometimes be an easier decision when it's like very clear-cut. A lot of physicians have had different things happen and may have $2 million, or they may have $1 million, or they may even have less, or they may have had some bad divorces and have less money. So, it gets a lot complicated. We have the financial piece, which we'll be looking at in an upcoming podcast, but that is part of the picture.

I do want to definitely address these stages. I think they're important that you bring that up and also understanding too, that there might be some people who don't necessarily go through anger and grief, and they may actually be very happy and ready to retire. So, how do you suggest physicians start looking at their unique situation?

DD: Well, the first thing is money. And I mentioned that she had a net worth of $7 million. That's because I asked. And she knew, which is rare. In my experience, I always ask “What's your net worth?” because money drives your behavior. Even if you have a lot of money, if you feel that money is scarce, if you have a lot of fear programming around money, it will affect the quality of the decisions that you make.

If you're thinking about retirement, normally for most people, a significant piece of that is a financial decision. Do I still have to work to earn money to feed my monthly expenditures? If the answer is yes, the question is “What do you want to do for that?” And for most people who are doctors, especially seasoned doctors, mature doctors, the fastest path to cash, the most money you can make for the least amount of time away from your home is going to be seeing patients in some fashion.

So, adjusting yourself to a step down perhaps in your practice, but still earning money because you need it is an important thing to consider. You have to get the gears all coordinated in the same direction. But I rarely find that somebody in their 60s does not have a significant net worth as a doctor.

HF: I see quite a range. And I think a lot of doctors do have enough money, but I definitely see physicians who don't and feel like they need to keep working. I think that's a great place to start because it does inform the kinds of decisions that you make next about how you want to spend your time. So, let's say they look at the financial piece and then that helps give them some guidance. And then even when we have these concrete steps like looking at your money, these other things such as the psychological factors come in and I want to share a quote to see how they can catch us up sometimes.

This is from a physician who said I could share this. He is an internist and he said, “Even after 39 years of clinical practice, there was a sense of guilt. Do I deserve to retire? I'm a doctor and that makes me different than other baby boomers who are retiring every day. Shouldn't I stay on for the patients even though I'm burnt out?”

DD: Classic, classic. Our programming that we absorb, and that was a doctor, let's just acknowledge, that was trained under no work hour restrictions. That's an old school doc that was working 120 hour weeks just like I did and I think just like you did. Did you have work hour restrictions?

HF: No.

DD: Okay. We worked 120 hour weeks. We got trained in a different way and it was drilled in deep. The two prime directives were drilled in deep. The first is the “Patient comes first.” Everybody knows that. It's conscious. Everybody expects that. Let me just say real quick, can the patient come first 24/7 365 and you have any hope of being a normal human being? The answer of course is no. “The patient come first” has to have an off switch on it and that's one of the key things that we teach as a burnout prevention technique is the off switch on your programming. When you come home, you can shut it off.

The second one, the second prime directive is rarely mentioned out loud but it's way deeper and way stronger and it goes like this, “Never show weakness. Never do anything to make anybody think you haven't got what it takes.” And what that does is those two things discombobulate our ability to create healthy boundaries.

 And so, in a well-programmed doctor, if they're contemplating a healthy boundary, if they're contemplating a healthy boundary, they will immediately feel shame and guilt and the phrases that will come into their head are “What about my team? What about my colleagues? What about my people? And what about my patients?”

That's how you know you're contemplating a healthy boundary and that you're a good doctor, is the first thing you think is “What about them? I can't abandon them.” That's a healthy and normal reaction. This is contemplation. We said precontemplation. This is contemplation of what it would be like to retire.

And then my comeback, and it's a tough love comeback is “Do you want to die in the saddle?” And then I usually get, “Oh, hell no.” Okay, we got a space in here between where you are and what you want to avoid that we need to talk about.

HF: Absolutely, and I love that you put it in this frame of how we get programmed and it is programming. It's as if sometimes you've been in a cult and then you have to go through deprogramming. We have to change that software. And it's interesting because when I was emailing with this position back and forth a bit, I said, “Are you still feeling guilty?” Because that was a little bit ago and he actually worked through this thought process. “Yes, there are other doctors who can take care of these patients. I've done this a very long time. It's time for me now.” And he also wanted to be available to be with his family and his grandkids and to travel and to do other things. So we can make that shift but we sometimes need some help through that thought process.

DD: And what I would say is that there's the reality of this question which is what I always ask, “Whose responsibility is it to take your patient's insurance money and provide care? Is it your personal responsibility to do that?” The answer is no. Whose responsibility is it? It's your employer.

For instance, if you broke your pelvis in a car wreck on the way to work today and couldn't work for three months, whose responsibility is it to make sure there's a doctor there to take care of your patients? Your employer. What we're talking about is giving reasonable notice and getting the heck out of there. That's number one.

And secondly, you also have to acknowledge that there's a part of this programming that is responsible for our success because shame and guilt are powerful drivers of performance. Shame and guilt is what didn't let you walk out when you were asked to stay up for 36 hours on your hospital shift. Shame and guilt and never show weakness programming. And yes, we were definitely brainwashed. And one of the reasons that burnout is so prevalent as doctors is that we're trained to burnout. We're trained to burnout because our residency education produces a good resident. A good resident, somebody who does what they're told, even if it's an obnoxious request, colors inside the lines, always says yes. We're trained to be good residents, not trained to have a healthy practice and life balance when we get out and start seeing patients for real.

One of the big challenges right now is that you and I, when we were in residency, worked harder than we ever worked in our life. Our job after residency was a cakewalk. The challenge for the generation now that's coming out is they've never worked as hard as their first week of their new job working with a bunch of boomer doctors because they were never prepared by the work that they did in their residency education. And that's a big shock to them. And that's why we're seeing younger doctors abandoning the profession in huge numbers.

HF: Okay, if we start reframing our mindset to be able to prioritize more our own needs and wants, I want to start talking a little bit about thinking about how you want to create this new chapter in your life. And I wanted to share something interesting that another client I was talking to the other day said I could say on the podcast. And she is a family practice physician. She's had her own practice for over several decades and she's in the process of selling it. She is 60 years old.

She said, “The job I am interviewing for now is retirement.” I love how she framed that up. I'm going to interview for this job. And I said, “Well, what's the job description?” And she said, “I'm going to try to relax and sleep in to 06:30 instead of 05:00 to 05:30. I will exercise more. I will continue to do my meditation ritual. I will go to a dance class in the middle of the day which I can never do. And then we're going to be traveling in the spring and summer.” And she also said, “I'm going to try not to drive my family crazy because I tend to be a busybody and have a lot of energy.”

And she also said, “I need to have a backup plan so I don't go nuts.” And I said, “What do you mean by that? What would going nuts look like?” And she replied, “Getting depressed because I don't have enough interaction with people.” She said, “Full-time family practice, that was too much. But just kicking around at home and doing these other things, that's not enough either.” So she's trying to figure out how she wants to fill the space. And so, how would you help physicians sort of figure out this next chapter?

DD: Well, first of all, you have to acknowledge your mortality which is something most doctors, even though we're exposed to patients who die and some of us are hospice doctors even, the first person acknowledgement of mortality is actually quite rare in doctors, in my experience.

Example, for me, one of the things that I've done is I belonged to a rugby team when I was in college. I was the captain of the team. We have reunions every year. We're going to have another one here coming up in October. And there've been three members of my rugby team in college who died. And so, what I did was I got a challenge coin. I have one of those heavy metal challenge coins that says on it, Memento Mori, Remember the Dead, Tempust Fugit, Carpe Diem. And I carry it in my pocket and it's heavy enough that I can feel it. And multiple times a day, I'll grab it and I'll fiddle around with it in my fingers to remind me of my mortality.

I also picked up a book called Four Thousand Weeks: Time Management for Mortals. It's a book that says, look, you only got 4,000 weeks, your time is coming. The key is not to try and do everything because nobody could ever do anything. It's never been true that you can do everything. But the question is, in the time that you have, what do you want to do? And when you acknowledge your mortality and realize that you only have so much time left, the other thing to understand is the structure of a human life transition. And my instructor for this is a guy named William Bridges. His book is called Transitions and I highly recommend it.

I have given a signed copy of the book Transitions to every coaching client I've ever had. Because everybody that's come to me, burnout is the sign of an impending life transition. And the most important thing to understand is the order in which transitions occur. And Bridges does a lovely job of teaching this.

All transitions begin with an ending. All transitions begin with an ending. All transitions end with a beginning. And in the middle of those two things, he calls it the neutral zone. And he says that most people are uncomfortable in a transition when something's ended that you're familiar with and the next thing hasn't begun yet. This neutral zone is uncomfortable. He says most people treat it like crossing a busy street. You just try to get through it as fast as possible.

And one of the things I know for sure, and you know this as well, Heather, is anytime any doctor makes a significant change in their relationship with their career, there's a significant decompression period. You can plan what you would do if you weren't seeing patients. But the dominant thing that will happen for the first several weeks to months to years of you not seeing patients is simply decompression, is simply getting your energy back, getting enough sleep, being able to go to the class, being able to do your exercise, and becoming a human again. Because being a physician is at least part a dehumanizing experience.

And I've seen people who are really burned out, not people who quit really burned out, but they got into a healthier work setting. And they say to me at 18 months, they say, “Oh my God, I'm only just feeling like I'm coming back up to the surface. I didn't realize how far down I was.” And I see that and I'm sure that you do all the time.

At some point in time, you don't know what's going to happen next, but the thing you have to do is trigger the transition by triggering the ending and then being very patient with what happens next.

HF: That is brilliant, Dike. I love that book, Transitions. I will link to it in the show notes. And I also really like how you describe this interval period where there's an ending, but we haven't really started the new chapter yet. And I hear doctors describe this as, “I feel like I'm on this life raft and I floated away from the shore, but I can't see where I'm going.” So it was sort of this in-between state that we don't like uncertainty. We like having a plan. So it goes against the fiber of our being. So it's often very uncomfortable. And like I said, we want to stay busy. We want to get to that next thing very quickly, but we often need this period, like you said, to become human again. And we have to return to ourself because we often lose who we really are in service of serving.

Now, I want to bring up another point that this physician who's selling a practice, a family physician mentioned, which I think is really interesting about thinking about this phase too, is she said, “I want to be able to try things and fail, which really means not having to be perfect or right. We're used to having to be perfect and not make mistakes and we get punished when we do.” And she said, “I just want to really be able to try things that I may not even be good at and feel that freedom of being more human.”

DD: I'm reminded of a cartoon show my kids used to watch when they were little called The Magic School Bus. And The Magic School Bus was driven by Ms. Frizzle. And Ms. Frizzle used to say, “Hey kids, get messy, make mistakes.” One of the things that is part of the decompression of letting go of being a doctor is not needing to be right, is not needing to follow a schedule, is not needing to follow protocols and algorithms, not needing to worry about liability and all that kind of stuff. And what you can do is you can begin to conduct your life based upon whim. And what I encourage you to do now that you're free, if something sounds like it might be interesting, go experience it.

This is the same advice that I give people who are looking at a career change. Let's say in your semi-retirement, you say, “Gosh, wouldn't it be cool? I've always made really good pizzas. Everybody says my pizzas are awesome. Wouldn't it be cool to have a pizza restaurant?” I say, wait a minute, if that's what you think, you need to go shadow a person who owns a pizza restaurant and see when you're living it, you still like it. But you can live on whim. That sounds interesting, go do it. What's stopping you? Is it going to be fun? I have no idea.

And what's interesting too is the word fail. Let's get rid of fail, because fail is inaccurate. Fail is bull. Let's just talk about the setup that most people will call failure, because I know for a fact that it's an inaccurate word to use in this situation. So you're going to do something you've never done before. That's called an experiment. And you think it's going to turn out some way. That's called a hypothesis. Well, you run the experiment to test the hypothesis, and you may or may not be right. So you say, “I've never painted porcelain, and there's a new paint porcelain art shop on Main Street, and I'm going to paint this beautiful coffee cup.”

And you paint it up, and you paint it up, and it doesn't turn out the way you want. And you might say, “Oh, I failed.” No, you had an experience of painting porcelain. You learned something, but it's not a failure. There's no way to fail. The only way to fail is to have the impulse to paint porcelain and then not do it. That's how you fail.

HF: Exactly, I'm so glad you brought that up, because the word has so much charge around it. We just changed the word. I love this quote by Edison, and he said, “I didn't fail 10,000 times. I found 10,000 things that didn't work.” And failing to try, like you said, I love that, is just failing not to do something. That's the only kind of failure there is.

DD: Have an urge and don't experience it. Because again, your clock is ticking. Your clock is ticking. If you don't go do that painting porcelain this week, you may never do it. You miss 100% of the shots you never take.

HF: Exactly. So we're getting close to the end of the podcast, but I'd still like to talk a little bit more on this topic. We started with money. First, look at your money. And then recognize your mortality. We don't have forever left. And then allow yourself to go through a transition phase, decompress, find your humanity again, and allow yourself to prioritize what you want to do. And don't put any framework around having it to be perfect or right, or look good in anyone else's opinion or justify it.

Let's say someone is still struggling with this identity issue. Maybe they were a very busy surgeon and they're used to being in the OR and having all these people around them. And then they retire, they go home. It's good for about a month. And their spouse says, “All right, honey, you got to do something.” But they still feel pretty lost. And they're like, “I don't even know what I want to do. This has been my whole life. I don't have passions. I don't have hobbies. I think maybe I need to go back to the OR or do something.”

DD: Well, if doctor is a role that you're having trouble shedding, there's all sorts of ways to be a doctor without working full-time at it. So, volunteer. I know a lot of people, especially ENT surgeons and folks like that, that go on mission trips where they might do 50 cleft palates in three days because that's what the mission is for. There's all sorts of foreign and domestic volunteer opportunities. And if you're a GP, a primary care doctor, there's all sorts of free health clinics and stuff that take volunteers to do it. You can work as much as you want as a volunteer without having to worry about the money and all that kind of stuff, the liability and all of that. That's fine.

DD: And the other concept that I want to bring in is the concept of legacy, because I feel the pressure of legacy, me personally. And when I say pressure, what I mean is over the course of my work, I've developed a body of knowledge and tools that are evergreen. They'll never be anything other than effective as long as humans are still seeing humans in a healthcare setting.

Now, when AI takes over, it won't work on AI, but I can tell you that I want to hand off the knowledge base that I have created in some way to a worthy representative to carry on this work. And doctors, because of the fact that we are smart, gifted, typically have means, we have money, you have the ability as a doctor typically to create a legacy for yourself, meaning something that lives on and is a positive force in the world after your death. And so, many people will find a cause and put themselves into a cause in a way that creates legacy. And I believe that legacy is something that's quite healthy, personally. And I certainly feel it pulling me all the time.

HF: I think that's a great way to put it and that there are things that endure after we're gone. And for some people, that's their family. I know I've talked to some physicians and I say, “Well, how do you feel about leaving a legacy?” And some will find that that's really important and something they want to prioritize. And other physicians will say, “That's really not something I need to do. I really want to be able to be with my family and have the time that I missed out on before.” And for them, their family is their legacy.

DD: Yeah. And what they're doing is catching up on recreational time and sharing hobbies and being with each other and all of those kinds of things. And there's all sorts of structures that you can put in place to support the interests of your family members. So, yeah, there's all sorts of ways to express that legacy in that way as well.

HF: Absolutely. We're about to wrap up here. But before we go, I just wanted to mention something that you can do that would be really helpful for the podcast, and that is to give it a rating.

Right now on Spotify, we have 30 “5 star” ratings, and I don't know exactly how many are on the Apple iTunes, but whatever podcast platform you listen on, I would be very grateful if you can just give us a rating. And if five stars comes to you, that would be fantastic. I'd love it if in one month we could have 100 ratings on Spotify.

If you're not familiar with Spotify, it's a great platform for listening to music, but you can also listen to podcasts on there when you have the premium selection, which I think is around $10 a month, there are also books that are available to you and it's a wonderful, easy to use. It takes you five seconds to rate the podcast. You don't have to write a review or anything like that. If you want to do a review on iTunes, that's great, but I'd really appreciate it. So let's try to get to 100 on Spotify. If you can help me out in one month, guys. Okay, thanks so much.

Now we're back here to wrap up with our podcast with the wonderful Dr. Dike Drummond. Oh, there is one thing I want to address, which is physicians who maybe are feeling bad about maybe a mistake that they've made or something in their career they didn't really achieve. And so, they're feeling bad about themselves and the sense of my time has run out and I can't rectify the situation.

DD: I suggest some coaching and that's not out of self-interest. I would hate to think that if you're out there, dear listener, and you're feeling a hole, a regret, a missed opportunity that will not come back, something that you feel that you cannot rectify or come to peace with, that you would get some help around that. That you would not simply sit in that because that's what a doctor would do in the middle of their career is to avoid it, avoid it, avoid it, avoid it, and push it away.

But there are things that can be forgiven that cannot be forgotten and that's work that you have to do for yourself. There are achievements that remain undone that you can accomplish that can help scratch the edge of the thing that you're thinking about that was undone from previous. And I'll quote from the movie Troy a line that I say every once in a while that always seems to be relevant. “The truth is we are mortal and you will never be lovelier than you are today and we will never be here again”. So if you want to do something, I suggest you do it now.” If you look at the list of regrets of people on their deathbed, and there are several of these that have been published, one of them is always, always that I didn't retire sooner. Just so you know.

And then I want to put a plug for a resource that I've run into that I think is very, very interesting and supportive. It's called the Modern Elder Academy. Modern Elder Academy. And what it is about is about the retirement experience of high achieving people. They have residential courses and retreats in Baja, Mexico and Santa Fe, New Mexico. And I have no financial interest with these people just so you know. I'm just saying I'm going to go to one of their courses and everything I read about and see about them is really cool for high achieving people like doctors when you're contemplating what to do in this phase of our older life.

HF: I think that's a great take and I will definitely link to that in the show notes. Where can listeners find you if they'd like to access your resources and your podcast?

DD: My website is thehappymd.com. There's a “the” on the front. If you just do HappyMD, you go to a porn site. So thehappymd.com, that's our big repository of burnout prevention tools. And then my podcast is called The Stop Physician Burnout podcast. Now that's a leadership podcast, because in my philosophy, much of the reason that we have a burnout epidemic is because of poor leadership, because the leaders are the ones who design the systems and the cultures. And this blog is to give you the leadership skills if you're a physician leader for influence in the C-suite and to help us lead the charge to wellness.

HF: All right, excellent. Well, thank you so much again for coming on the podcast to talk about this very important topic, Dike.

DD: Yeah, you're welcome. I think it is a very important topic because most of the time when the issue of retirement comes up, it is quickly quashed by busyness in the pre-contemplation phase.

HF: Well, if we're all lucky enough, we will get there.

DD: There you go.

HF: Youngsters out there, if there are any of them listening, I think a lot of this can be helpful when you think about these things early on.

All right, my dear listeners, thank you again for coming on the podcast. Please share this episode with at least one person today. Take time to rate the podcast if you haven't already. And don't forget to carpe that diem. I'll see you in the next episode. Bye for now.

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[00:38:04]

Podcast details

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