

The end of the line: Concluding your practice when facing serious illness

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Dear Dr. Mossman,
I have a possibly fatal disease. So far, my symptoms and treatment haven't kept me from my usual activities. But if my illness worsens, I'll have to quit practicing psychiatry. What should I be doing now to make sure I fulfill my ethical and legal obligations to my patients?

Submitted by "Dr. F"

"Remember, with great power comes great responsibility."

- Peter Parker, *Spider-Man* (2002)

Peter Parker's movie-ending statement applies to doctors as well as Spider-Man. Although we don't swing from building to building to save cities from heinous villains, practicing medicine is a privilege that society bestows only upon physicians who retain the knowledge, skills, and ability to treat patients competently.

Doctors retire from practice for many reasons, including when deteriorating physical health or cognitive capacity prevents them from performing clinical duties properly. Dr. F's situation is not rare. As the physician population ages,^{1,2} a growing number of his colleagues will face similar circumstances,^{3,4} and with them, the responsibility and emotional turmoil of arranging to end their medical practices.

In many ways, concluding a psychiatric practice is similar to retiring from practice in other specialties. But because we care for patients' minds as well as their bodies, retirement affects psychiatrists in distinctive ways that reflect our patients' feelings toward us

and our feelings toward them. To answer Dr. F's question, this article considers having to stop practicing from 3 vantage points:

- the emotional impact on patients
- the emotional impact on the psychiatrist
- fulfilling one's legal obligations while attending to the emotions of patients as well as oneself.

Emotional impact on patients

A content analysis study suggests that the traits patients appreciate in family physicians include the availability to listen, caring and compassion, trusted medical judgment, conveying the patient's importance during encounters, feelings of connectedness, knowledge and understanding of the patient's family, and relationship longevity.⁵ The same factors likely apply to relationships between psychiatrists and their patients, particularly if treatment encounters have extended over years and have involved conversations beyond those needed merely to write prescriptions.

Psychoanalytic publications offer many descriptions of patients' reactions to the illness or death of their mental health professional. A 1978 study of 27 analysts whose physicians died during ongoing therapy reported reactions that ranged from a minimal impact to protracted mourning accom-

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panied by helplessness, intense crying, and recurrent dreams about the analyst.⁶ Although a few patients were relieved that death had ended a difficult treatment, many were angry at their doctor for not attending to self-care and for breaking their treatment agreement, or because they had missed out on hoped-for benefits.

A 2010 study described the pain and distress that patients may experience following the death of their analyst or psychotherapist. These accounts emphasized the emotional isolation of grieving patients, who do not have the social support that bereaved persons receive after losing a loved one.⁷ Successful psychotherapy provides a special relationship characterized by trust, intimacy, and safety. But if the therapist suddenly dies, this relationship “is transformed into a solitude like no other.”⁸

Because the sudden “rupture of an analytic process is bound to be traumatic and may cause iatrogenic injury to the patient,” Traesdal⁹ advocates that therapists in situations similar to Dr. F’s discuss their possible death “on the reality level at least once during any analysis or psychotherapy.... It is extremely helpful to a patient to have discussed ... how to handle the situation” if the therapist dies. This discussion also offers the patient an opportunity to confront a cultural taboo around death and to increase capacity to tolerate pain, illness, and aging.^{10,11}

Most psychiatric care today is *not* psychoanalysis; psychiatrists provide other forms of care that create less intense doctor–patient relationships. Yet knowledge of these kinds of reactions may help Dr. F stay attuned to his patients’ concerns and to contemplate what they may experience, to greater or lesser degrees, if his health declines.

Retirement’s emotional impact on the psychiatrist

Published guidance on concluding a psychiatric practice is sparse, considering that *all* psychiatrists are mortal and stop practicing

at some point.¹² *Not* thinking about or planning for retirement is a psychiatric tradition that started with Freud. He saw patients until shortly before his death and did not seem to have planned for ending his practice, despite suffering with jaw cancer for 16 years.¹³

Practicing medicine often is more than just a career; it is a core aspect of many physicians’ identity.¹⁴ Most of us spend a large fraction of our waking hours caring for patients and meeting other job requirements (eg, teaching, maintaining knowledge and skills), and many of us have scant time to pursue nonmedical interests. An intense prioritization of one’s “medical identity” makes retirement a blow to a doctor’s self-worth and sense of meaning in life.^{15,16}

Because their work is not physically demanding, most psychiatrists continue to practice beyond the age of 65 years.^{12,17} More important, perhaps, is that being a psychiatrist is uniquely rewarding. As Benjamin Rush observed in an 1810 letter to Pennsylvania Hospital, successfully treating any medical disease is gratifying, but “what is this pleasure compared with that of restoring a fellow creature from the anguish and folly of madness and of reviving in him the knowledge of himself, his family, his friends, and his God!”¹⁸

Physicians in any specialty that involves repeated contact with the same patients form emotional bonds with their patients that retirement breaks.¹⁴ Psychiatrists’ interest in how patients think, feel, and cope with problems creates special attachments¹⁷ that can make some terminations “emotionally excruciating.”¹²

Psychiatrists with serious illness

What guidance might Dr. F find regarding whether to broach the subject of his illness with patients, and if so, how? No one has conducted controlled trials to answer these questions. Rather, published discussion of psychiatrists’ serious illness is found mainly in the psychotherapy literature.

continued

Clinical Point

An intense prioritization of one’s ‘medical identity’ makes retirement a blow to a doctor’s self-worth and sense of meaning in life



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Inadvertent self-disclosure of an illness may do more harm than a planned statement

Table 1

Examples of state medical board recommendations for retiring

Notify the state medical board of your retirement status
Notify patients of your plan to retire and discuss any arrangements for their continued care
Discuss your plan to retire with office workers or employees and clarify your obligations regarding their benefits (eg, vacation, sick leave, health insurance)
Notify the U.S. Drug Enforcement Administration that you plan to retire
Arrange for the handling and proper retention of medical and business records
Contact your malpractice insurer and find out whether you should buy tail coverage
Find out whether your office lease allows you to sublet or has an “escape clause” that allows you to vacate the premises if you retire
Notify professional associations
Notify the post office and publications of the change in your mailing address
Source: References 24,28-31

What’s available consists of individual accounts and case series that lack scientific rigor and offer little clarity about what the therapist should say, when to say it, and how to initiate the discussion.^{19,20} Yet Dr. F may find some of these authors’ ideas and suggestions helpful, particularly if his psychiatric practice includes providing psychotherapy.

As a rule, psychiatrists avoid talking about themselves, but having a serious illness that could affect treatment often justifies deviating from this practice. Although Dr. F (like many psychiatrists) may be concerned that discussing his health will make patients anxious or “contaminate” what they are able or willing to say,²¹ not providing information or avoiding discussion (especially if a patient asks about your health) may quickly undermine a patient’s trust.^{21,22} Even in psychoanalytic treatment, it makes little sense to encourage patients “to speak freely on the

pretense that all is well, despite obvious evidence to the contrary.”¹⁹

Physicians often deny—or at least avoid thinking about—their own mortality.²³ But avoiding talking about something so important (and often so obvious) as one’s illness may risk supporting patients’ denial of crucial matters in their own lives.^{19,21} Moreover, Dr. F’s inadvertent self-disclosure (eg, by displaying obvious signs of illness) may do more harm to therapy than a planned statement in which Dr. F has prepared what he’ll say to answer his patients’ questions.²⁰

That Dr. F has continued working while suffering from a potentially fatal illness seems noble. Yet by doing so, he accepts not only the burdens of his illness but also the obligation to continue to serve his patients competently. This requires maintaining emotional steadiness and not using patients for emotional support, but instead obtaining and using the support of his friends, colleagues, family, consultants, and caregivers.²⁰

Legal obligations

Retirement does not end a physician’s professional legal obligations.²⁴ The legal rules and duties for psychiatrists who leave their practices are similar to those that apply to other physicians. Mishandling these aspects of retirement can result in various legal, licensure-related, or economic consequences, depending on your circumstances and employment arrangements.

Employment contracts in hospital or group practices often require notice of impending departures. If applicable to Dr. F’s situation, failure to comply with such conditions may lead to forfeiture of buyout payments, paying for malpractice tail coverage, or lawsuits claiming violation of contractual agreements.²⁵

Retirement also creates practical and legal responsibilities to patients that are separate from the interpersonal and emotional issues previously discussed. How will those who need ongoing care and

coverage be cared for? When withdrawing from a patient's care (because of retirement or other reasons), a physician should give the patient enough advance notice to set up satisfactory treatment arrangements elsewhere and should facilitate transfer of the patient's care, if appropriate.²⁶ Failure to meet this ethical obligation may lead to a malpractice action alleging *abandonment*, which is defined as "the unilateral severance of the professional relationship ... without reasonable notice at a time when there is still the necessity of continuing medical attention."²⁷

Further obligations come from medical licensing boards, which, in many states, have established time frames and specific procedures for informing patients and the public when a physician is leaving practice. *Table 1*^{24,28-31} (page 44) lists examples of these. If Dr. F works in a state where the board hasn't promulgated such regulations, *Table 1*^{24,28-31} may still help him think through how to discharge his ethical responsibilities to notify patients, colleagues, and business entities that he is ending his practice. References 28-30 and 32 discuss several of these matters, suggest timetables for various steps of a practice closure, and provide sample letters for notifying patients.

Physicians also must preserve their medical records for a certain period after they retire. States with rules on this matter require record preservation for 5 to 10 years or until 2 or 3 years after minor patients reach the age of majority.³³ The Health Insurance Portability and Accountability Act of 1996 requires covered entities, which include most psychiatrists, to retain records for 6 years,³⁴ and certain Medicare programs require retention for 10 years.³⁵

Depending on Dr. F's location and type of practice, his records should be preserved for the longest period that applies. If he is leaving a group practice that owns the records, arranging for this should be easy. If leaving an independent practice, he may

Table 2

Topics for a psychiatrist's 'professional will'

A principal designee (ie, the colleague who has agreed to undertake the clinical and administrative responsibilities of your practice)

Back-up designees if the first colleague is unavailable

Administrative details (eg, computer and voicemail passwords, where to pay office rent, location of records)

How to notify patients

Other parties to notify (eg, your attorney, hospitals where you have privileges, other colleagues, your malpractice carrier)

Events that trigger the professional will (eg, death, serious illnesses)

How the designee will know when to take charge of things for you

Source: References 36,39

need to ask another practice to perform this function.²⁵

A 'professional will'

Dr. F also might consider a measure that many psychotherapists recommend^{13,19,36} and that in some states is required by mental health licensing boards or professional codes^{37,38}: creating a "professional will" that contains instructions for handling practice matters in case of death or disability.³⁹

Table 2^{36,39} lists topics that a psychiatrist's professional will might cover. If Dr. F creates such a document, he should let office personnel and a close family member (eg, his spouse) know that it exists so they can see that it's implemented, if necessary. Dr. F also may wish to get one or more colleagues to agree to implement the document's provisions and let those colleagues know where to find the practice details they'll need—for example, where Dr. F has stored a sealed list that contains patients' names and contact information.^{19,36}

Clinical Point

Give your patients enough advance notice to set up satisfactory treatment arrangements elsewhere

continued

Clinical Point

Consider creating a 'professional will' that contains instructions for handling practice matters in case of death or disability

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Related Resources

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Bottom Line

Continuing to practice psychiatry while having a serious or terminal illness poses additional emotional, ethical, and legal challenges beyond those faced by healthy physicians. Psychiatrists whose physical conditions threaten their ability to continue working should think carefully about how they will prepare their patients, colleagues, office staff, and themselves for leaving practice.

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HIPAA and many states have regulations that require physicians to preserve medical records for certain periods after retiring