Termination and Transfer of Patients in Family Practice

Priscilla Day Boekelheide, MD
Chapel Hill, North Carolina

Once established, each physician-patient relationship faces termination. In this paper attention is given to various effects of that separation on both patient and family physician. Examples are given to show the importance of the management of termination in the ongoing care and health of the individual patient as well as for the emotional well-being of the family physician. This paper places its major focus upon the characteristics and coping behaviors of the patient and the physician. Suggestions are given to help reduce the transfer reaction and stress so that adjustment is more therapeutic.

Gradually, and with great emotional investment, a patient assigns a positive aura, in his/her own individual mind and for himself alone, to his family physician. The physician may be thought of as omnipotent and omniscient, as authority figure, confessor, healer, magician, father, mother.[1] For most patients—even for those who seldom call upon his services—that image also includes instant availability and permanence.[2] Loss of his physician and the consequent interruption in this support system, for whatever reason, delivers a forcible impact and requires adjustment in the patient's life. Holmes and Rahe[3] found that a cluster of social events was prominently associated with the time of onset of an illness. They list events involving loss, separation, and death as major areas of dynamic significance to adaptive or coping behavior.

Little has been written about how a change of practice influences the physician. However, one can look at the stresses the physician endures in his practice and readily conclude that these may be magnified by change, separation, or loss. Ross[4] and Bressler,[5] in discussing suicide among medical personnel, emphasize that very little is done to help such personnel to learn about and to accept their own emotional needs; and Ross and Bressler further point out the vulnerability of those in the medical profession to be all things to all people. The emotional conflict between an inner personal need to be given to and cared for and the impelling overt professional duty, which commonly leads to overwork due to expectations of persistent patients, produces a role strain which is described as one of the occupational hazards for physicians. The physician who has had previous experience in termination or transfer of patients has usually learned to cope with his own separation anxiety and will usually have less difficulty handling the termination.[6]

From the Department of Psychiatry, University of North Carolina School of Medicine, Chapel Hill, North Carolina. Requests for reprints should be addressed to Dr. Priscilla Day Boekelheide, Department of Psychiatry, University of North Carolina School of Medicine, Chapel Hill, NC 27514.

Types of Relationships

Positive

Positive feelings between patient and family physician enhance the therapeutic alliance, aid in establishing mutual faith and trust, and contribute to compliance and continuity of care.[7] There are progressive and regressive aspects for both parties in the relationship. In order to develop trust and loyalty in the physician, the patient must believe in his authority and must join the physician in the pursuit of good care. In some ways, especially when ill, the patient will behave towards the physician as a child toward its parents. If the physician's personality needs this dependency to feel secure, the physician will enjoy this traditional paternalistic role, and in his own regressive way he may inappropriately accept gifts. To encourage a progressive direction when the physician is terminating the physician-patient relationship, he should empathize with the patient concerning the grieving process and should share the reality of the loss. However, he should also encourage the patient in the problem solving process of adapting. Many patients will be able to express their feelings openly by telling the physician how much he will be missed by them. When the patient is not able to discuss his feelings overtly, the physician should look for signs of anxiety, sadness, and helplessness in the body language, and should bring his observations openly into the encounter. The fears and concerns, that the patient may never see the physician again, that the new physician won't understand or care as much, that the patient may die, should be thoroughly aired by helping the patient distinguish between his feelings toward the physician as parent, and the reality of the physician as a person who is only leaving.[8]

Ambivalent

Every relationship includes negative feelings along with the positive ones. Frequently, separation anxiety and guilt will be expressed in a hostile manner, the patient blaming the physician for his own angry feelings and even for his illness. Bitterness and rage may be projected in the form of a fear that the physician may die, or that he does not care, or that the physician is abandoning the patient. Old symptoms may reappear, new somatic complaints may be heard, or perhaps the patient will withdraw from the physician, becoming more regressed, silently pleading in this dependent manner for more care. His family may also add to the patient's difficulties in coping with the termination. Expressions of anger may be muted or displaced.[9] For example, a family practice resident nearing the end of a short-term counseling contract of "long interviews" was surprised to hear the patient remark in the next-to-last planned visit that the chair, the same chair the patient had sat in for several previous weeks, was hard. The physician was able to connect this immediately to the fact that termination was at hand, and help the patient openly express her feelings of anger and loss at no longer seeing him so frequently.

Leaving his practice or ending a patient relationship may stir up old feelings of guilt in the physician over abandoning the patient or of having himself been left, rejected, neglected. Not only must the physician be able to accept and deal with the patient's fears, anxieties, anger, and depression concerning the looming loss and separation, but he must face the same feelings within himself. The physician may be unaware of these feelings and may respond with offhand reassurance, may ignore or deny cues given by the patient, or may himself be so emotionally involved that he either says too much or too little. Sensing that his feelings of omnipotence and immortality are threatened, he may promise inappropriately to write or telephone or act eager to hear from each individual. Defensively, he may see the patient only as very sick, underestimating the patient's strengths and overestimating the degree of illness. On the other hand, he may avoid saying good-bye to those patients about whom he has had special feelings, whether positive or negative. He may rationalize that he was too busy or that the patient would not care anyway. If the physician's prejudices have been involved in the relationship, he may have a particularly difficult time in being empathic over the reality of the patient's grieving about the impending loss and separation. Lastly,

the physician's own family may resent the changes about to occur, and this may add to the physician's difficulty.

A neutral relationship may also exist. For all the profession's placing a high value on the personal nature of a one-to-one relationship, there are people whose personalities will not allow them to become emotionally close to the physician. A patient may choose to see a given physician intermittently, electing discontinuity of care by interspersing visits with other physicians. The physician must accept and respect the inhibitions and prohibitions involved.

Institutional

Some patients may find it easier to relate to an institution rather than to an individual physician. For some, the university hospital or government clinic may stand for the parental figure and may offer a less threatening target for anger than does the physician. This "transference to the institution" may protect them from the periodic changes in personnel or from the need to bare what the patients feel are "private" matters. Some patients may view the institution as a haven, experiencing a maternal sort of protection, perhaps taking on some of that power. Reider[10] describes the impersonal attitudes of such patients, their bland responses, their overcompliance, or their distant and unemotional involvement.

A recent graduating family practice resident* sent approximately 225 letters to his patients inviting them to attend his new practice 13 miles from the university Family Practice Center. Sixty-two letters were returned, undelivered; 52 patients indicated a choice, of which 13 chose to follow him into private practice. In examining these responses carefully the resident felt that most patients on his panel had never actually seen him, or had not seen him enough times to form a relationship with him; some were leaving the area; some continued to need attention from specialty clinics at the university hospital; some could not afford a private physician and used the university as a "discount" facility; a few considered his new office too far from their homes. It is clear that many of these responses (and nonresponses?) could fall into the "ambivalent" or "institutional" types of relationships.

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Effects of Termination

Separation can accelerate feelings within the relationship between physician and patient, and can bring closer to the surface certain character traits in both. For example, a patient may have his dependency feelings more exposed because of the impending separation and may become more clinging, demanding, and perhaps angry. His regressive demands may irritate the physician. Alert to these regressive phenomena and to the feelings they produce in himself, the physician may then be able to speak quite openly about this with the patient. The physician who ignores these external and internal cues may become annoyed and fail to interpret the immediate reactive distress. To the very dependent patient, reassurance may be seen as the physician's excusing himself for leaving, and anger, tearfulness, and resentment may ensue. The patient who has character traits of suspiciousness and uncertainty about being cared for may, with termination looming, have a flare-up of paranoid accusations of being deliberately abandoned or of the physician having hidden the full truth from him. If the patient has felt very close to the physician, for example, the motherly patient with the young male resident, she may express her feelings of sadness by offering a personal gift,

which the physician should be prepared to accept in a courteous and empathic way. As another example, a young, attractive, depressed woman wrote a farewell poem to her physician, but because her feelings of loss continued to increase, she was unable to recite or give it to him, or even to reveal its existence; her subsequent physician was the recipient of a sad recital. The patient who struggles to contain his feelings of close friendliness towards his physician may need to miss his final appointment or to neglect acknowledging transfer to the subsequent physician.

Support Systems

Emotional stress, life situation, and personality are three areas that Ireton and Cassata[11] evaluate in order to identify patient resources in coping with problems. Of the seven major adjustment areas which they list as those most people confront at some time in their lives, namely, work, marriage, recreation, religion, parenting, friendship, and health, the last three are intimately involved in terminating the physician-patient relationship. The family physician should look carefully at the current life situation of his patient, assess the strengths of the marriage and the relationship with the extended family, have a good understanding of the socioeconomic position of the family, and evaluate support systems such as religion and neighbors, and sublimations such as hobbies and recreation. Knowledge of past coping behavior in these latter areas can be used to encourage adaptation during the separation stress.

Having considered those factors which contribute to progressive and regressive reactions, the family doctor will then be able to identify those patients who will warrant special attention by virtue of their dependency needs. Those who are now labeled as Special Category include the chronically ill, the alcoholic, the pregnant patient, the depressed patient, and others with moderate to severe psychopathology, and children and aged from disorganized families. Seductive, aggressive, very anxious, and manipulative patients may also demand extra attention and care.

The Transfer

Timing

Thoughtful consideration given to the psychological diagnosis of the patient and to the physician-patient relationship at least two to three months before termination can aid in management and can produce many benefits for both patient and physician. This lead time allows for exploration of the physician's attitudes and feelings towards the patient and his/her family.[6] The family practice preceptor, the seminar leader, or the new physician to the practice, by openly inviting discussion of the patient, aids in bringing to conscious awareness the physician's feelings, and helps him to remove himself from any emotional involvement. This time interval can be used to reevaluate the patient's progress and can encourage a shift from the physician's preoccupation with the patient and the disease processes to integrative thoughts concerning the patient's own role in his support system as well as to his inherent capacities for handling difficult situations. This enhances the growth process in the patient by encouraging progression from the physician's role in answering questions to the patient's role in facing and solving problems.

To paraphrase the description by Keith[12] of the "transfer syndrome" of residents rotating through psychotherapy clinics, family physicians will recognize the anxiety and turmoil experienced by both patients and physicians when, for instance, the family practice residency ends or the family physician changes location or retires. In some settings periodic transfers are dictated by administrative rather than patient needs, a fact which feels "safer" for those patients who avoid closeness, but which provokes resentment in other types of patients. Encouraging positive feelings toward the clinic structure and toward permanent ancillary personnel makes the latter patients more comfortable.

In general, the longer and more intimate the physician contact, the more time the patient will need to prepare for the impending disruption. Patients who are relatively more healthy will usually require less time. Those patients who fit the Special Category should certainly be introduced to the incoming physician, preferably by the familiar physician; it may be appropriate for all three parties to meet several times, depending upon the

personality and illness diagnosis. In the case of a short-term medical illness in a patient with good mental health, one meeting will often suffice. If it is not possible for the patient to meet the new physician, the initial physician should take care to mention his successor's name several times.

The physician needs to regulate the timing and "dosage" of the termination procedure. For example, the physician can introduce the subject of leaving several weeks in advance of the final date, can repeat the information in subsequent visits, initially giving the name, later some identifying characteristics, or mentioning an interest common to both patient and new physician. By sequencing the information, the physician can gradually prepare the patient who has difficulty. He can modify his approach to the patient, give appropriate praise and feedback to the patient about his coping behavior, and model his own behavior as an important source of learning for the patient. By comparing how well the patient is coping with the impending separation with how the patient coped with similar occasions in the past, the physician can aid in anticipating and rehearsing the separation for smoother transition to the subsequent caretaker.

Manner

Aside from the individual physician's style, the manner of proposing the termination and transfer is of utmost importance. The resident who says, "I can't see you after October 1st because I am being sent to ——," or the physician who says, "I am closing my practice because I have to change locations for my wife's health," presents himself as a weak and passive person, much as the patient often feels himself to be.[6] This in effect negates the problem solving attitude which the physician wishes to foster. Presenting the facts in an active way enhances progression in the patient: "I am finishing my training July first and wish to discuss with you your future care here in the Family Practice Center," or "Our family is moving in November, and I want to talk with you about Dr. Jones, who is coming to continue my practice here." This active form implies the necessity for ending the relationship, acknowledges the physician's responsibility for this, and decreases the patient's resistance to accepting the next physician. By taking such an active stance, the physician will find it easier to cope with the patient's last-minute dependency resistances: requests for changes in medication, advice about a "crisis," cancellation of the final appointment. Further, acting firmly will help reduce the physician's denial of his own importance to the patient as well as limit some physicians' procedural defenses such as taking an earlier-than-planned vacation or leave, forgiving of fees, "forgetting" to say goodbye.

Matching Needs

In the Family Practice Center, educational needs must be balanced with patient needs. In the training of the resident, it is important to have a variety of experiences in problems both medical and emotional, including distributions of age, sex, race, family, and severity of illness. The patient may feel more comfortable with, and prefer, a younger or older physician, a male or a female. In a multiphysician setting, analysis of personality problems in both patient and physician allows matching for therapeutic satisfaction. For example, the physician who cannot desexualize his feelings in the medical process of examining a patient's genitals may need to transfer a seductive patient for the counseling process because of his inability to tolerate the patient's sexual behavior.[13]

Several young male residents had difficulty interacting with a sexually provocative, mentally retarded female who quickly learned to use an after-hours clinic. Teaching them effective methods of responding reduced their annoyance and anxiety, while transferring the patient to the overall care of an incoming female resident offered reeducative role modeling. After reaching an understanding of difficulties presented by another patient whose dependency needs had been enhanced by a motherly permissive physician, a match with a physician who could set firm limits was arranged. An anxious male homosexual pa-

tient felt more comfortable with a matter-of-fact older female physician than he did with a young male physician. The resident who is assigned to a hostile or nonchalant adolescent must be taught that this distant style of relating may reflect a defensive need and must therefore not be too energetically attacked because of the *resident's* need to feel close to the patient.

Final Visit

The planned last visit helps the patient face final mutual acceptance of the inevitable separation that allows physician and patient to correct any unventilated, unclear, or unfocused feelings or expectations. Once again the physician is given the opportunity to mention his successor's name. The departing physician must be careful not to align himself for or against his successor, but instead maintain an attitude of benign neutrality. A final handshake or brief touch can link the physician's nonverbal manner with the verbal, concrete reality of separation.

Procedure

Unfortunate consequences sometimes occur when the patient hears of the projected change through the community grapevine, from office personnel, or from a sudden formal announcement. Therefore, it is pertinent to discuss methods of informing the patient. If it is at all possible, the physician should inform the patient personally. Obviously, not all patients can be told in person, but surely those in the Special Category given earlier should be so informed.

Publicity in a newspaper announcement must be extended over an adequate time and should be specific with respect to time, place, and purpose.[14]

Letters should be worded carefully, supported with legal advice, if necessary. The language should be clear: the announcement should state briefly that the physician is leaving, has enjoyed working with the patient, has regret at leaving; it should give a minimal explanation for leaving. An offer to discuss choice of the future physician with the original physician should be included, as well as the office telephone number to encourage this discussion. Maintaining confidentiality of the records should be stressed. A request for the patient's signature on an enclosed release of information form should be made in the event the records are to be forwarded to another office or to a central location for future requests. Before forwarding records, the physician should ascertain that the receiving physician will accept the patient and should ask preference for full original records or off-service summaries. Finally, a specific statement can be added, with address given, concerning payment of bills. The overall message should be positive and brief and should stress choice, not assignment.

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