A Psychiatrist Retires: The Happening

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The author uses his own recent experience as a basis for discussing the actualities of retiring and closing a private, solo, psychiatric practice of psychotherapy and psychoanalysis. The extended process includes a personal decision about whether, when, and how to retire; preparation of patients and arrangements for their ongoing care; dealing with legal requirements and professional obligations; and the mechanics of closing an office one has occupied for decades. Not the least of concerns is one's own personal transitions in lifestyle, professional persona, attachments to patients, and engagement in psychotherapeutic or psychoanalytic treatment relationships. *(Journal of Psychiatric Practice* **2011;17:425–428**)

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In my last column,[1] I reviewed the sparse English language literature on retirement of psychiatrists and explored the complex issues involved in making that momentous personal decision. This month I describe the complicated process of making it happen. After some hesitation, I decided to describe my own experience as it occurred and goes on unfolding—for it is a multi-year process that revolves around a singular event, the day one closes the door for once and for all. I present my own experience not as anything exceptional or exemplary, but rather as something that each of us will have to encounter some day in one fashion or another unless he or she is bestowed the mixed blessing of a sudden death.

The decision

My path toward retirement in fact began with a sudden death—that of a close friend and colleague about 4 years before the final day of my outpatient practice. I was then 74 and working close to full time, enjoying it and feeling in full vigor with a few health problems well under control. Another psychiatrist-psychoanalyst and I, coping with our own shock and grief, had the task of going through our colleague's practice records, contacting her patients and helping them deal with their reactions and arrange ongoing care. Their shock and devastation were enormous, with serious consequences in some instances. Caring for them was very stressful.

In contrast was my experience with various patients over the past four decades who had been under the care of psychiatrists and psychoanalysts who had persisted in working long past the onset of serious impairment in both physical and mental capabilities. These patients had hung on despite being aware of their therapist's diminished capacities and sensing that their progress was stalled. Several spoke of their compassion for their previous psychiatrist and their feeling that he or she needed them for morale and professional self-esteem. In one case, subsequent analysis revealed that the patient was caring for her previous analyst as she had been unable to care for her dying father, which assuaged her guilt but lacked the benefit of insight about what she was doing. She had also noticed that her terminally ill analyst appeared to be drinking alcohol as they worked, perhaps to relieve pain, but they never addressed her own serious problems with alcohol.

Ethical issues arose as I worked with such patients, particularly the conflict between a) my duty to maintain the patient's full trust in confidentiality and not to act without the patient's consent on what is revealed in psychotherapy, and b) the duty to intervene with an impaired colleague whose continued practice with diminished capacity could be harmful to patients. The stress of severe illness or altered mentation due to strokes or dementia may lead not only to poor medical judgment and medication errors but also to inappropriate or unethical behavior. Although I was aware of colleagues who practiced well into their eighties with no apparent decline in their abilities, I was determined to spare my patients the growing likelihood of a less fortunate outcome.

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Less altruistic motives were also part of my thinking. I wanted the freedom from everyday professional obligations—maintaining regular therapy schedules and being always on call—in order to travel, visit family and friends in distant places, take some beautiful days off to enjoy nature, spend long periods at our cottage on a lake, read more widely, be more physically active, prepare our home for eventual sale, and foremost, to have much more time in the companionship of my wife. As our generation of family, classmates, and friends increasingly suffered mortal illness and death, we had to face the knowledge that our own time is limited. Walter Huston's poignant rendition of "September Song" always comes to mind when I think about this, although my wife and I are perhaps more in the October or November of our lives.

Financial reasons, too, favored retirement. Our income from required minimum distributions of retirement funds and Social Security is adequate, and the added disposable income from practice, after overhead and taxes at a higher incremental rate, was limited relative to the time, effort, and responsibility it entailed. This factor had a proportionately greater impact as I reduced practice hours and as the general practice environment deteriorated due to reduced third-party payments and threats of more cutbacks from Medicare, which is commonly used as a standard by private insurance plans. The new Medicare requirements for electronic medical records and electronic prescribing, both very expensive for a solo practitioner to implement, created additional pressures as the decision approached the tipping point.

Making it happen

When my colleague died suddenly and I began to confront the inevitable, my practice consisted of several patients in psychoanalysis four or five times a week, intensive psychotherapy patients coming twice weekly, once a week, or every 2 weeks, and a sizeable number of long-term patients who had completed intensive therapy but still came in for follow-up at intervals ranging from a month to a year. Some medication management patients, never seen for less than 20–30 minutes because of the clinical value of even a limited psychotherapeutic relationship, completed the spectrum. The patients naturally fell into two groups—those in an active process of psychoanalytic treatment who could be expected to reach a beneficial, natural termination, and those with chronic conditions who had been stabilized, reached the best achievable resolution and management of their illness, and were well maintained on supportive psychodynamic psychotherapy and usually some medication. The latter group could be expected to have to make a transition to another psychiatrist or therapist, no matter when I retired. At 74, I wanted to reduce my work load and ease into a healthier and more varied lifestyle with the benefits I described earlier.

So I began the transition to working half time and dealing with retirement issues in therapy. All patients were informed that I would be retiring sometime in the next few years. I explained it to some in reference to my age, which was already well beyond the common retirement age. Those who appeared in a position to work toward further gains and a natural termination would continue their work, though the sense of open-ended timelessness was replaced by the knowledge that there would be a stopping point in a few years. Those who were probably going to need long-term care were told that I was phasing out toward retirement and that we would now have to work together on a transition to another psychiatrist or therapist. I took some afternoons off for personal time or teaching and shortened the remaining days as hours became available. I took very few new referrals, with the exception of a few psychotherapy patients whom I had treated earlier and who now returned for additional therapy or referrals I couldn't refuse. New patients were informed that I would be closing the practice in a few years.

After a year, I had reached the point where I could lower my professional liability insurance to a half-time rate, which limited me to seeing patients for no more than 20 hours a week. After 3 years, all but one of my psychoanalytic patients had reached a natural termination and the remaining one was very close. Most psychotherapy patients, likewise, were winding up their work. I selected a date about 10 months in the future and began informing patients that I would be closing my practice at that time.

Patient and therapist reactions

Inevitably such news is greeted by great anxiety. Patients' stability and confidence in treatment are disrupted. Who now would meet their needs? Isn't this like the childhood abandonments and hurts that may have contributed to their problems in the first place? Will all that they have invested in therapy (emotion-

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ally as well as financially) be lost? Will their suffering return? (Naturally, these issues arouse corresponding anxiety and guilt in the therapist, and perhaps the patient's unconscious intent is to augment that.) Anxiety may also signal the presence of hurt, angry, and abandoned feelings in the patient, which are commonly warded off through various defenses outside the patient's awareness. The feelings may simply be *repressed and denied*. Through *reaction formation*, they may be turned into the opposite, manifesting as solicitude and uncommon niceness. They may be *displaced* into unjustified fury at some other hapless person in the patient's life. Or the patient may greet the therapist's rejection by *turning passive into active*—that is, by rejecting him or her first—giving the therapist the silent treatment or quitting therapy abruptly. The patient may *identify with the aggressor* and unwittingly set up a situation where he or she rejects someone else. The defensive possibilities are endless.

Lost is the timeless quality in a fully open-ended therapy that enables patients to associate freely and follow deeply into parts of their mental life that had been beyond their awareness, without pressure for closure. But life is never truly timeless, and limits inevitably have to be confronted. The new situation opens other possibilities for working through losses and limitations in a different way from the past. My patients did continue to free associate, but sometimes the impending closure seemed to limit the deepening of exploration and self-understanding. On the other hand, patients could work through issues of loss, old feelings of abandonment, dependency, lack of confidence in their ability to manage their own mental lives, assuming agency for their own lives, and so on, within the context of our here-and-now relationship—a true transference-based process of working through and building mental structure and mastery. All of the classical manifestations of grief and mourning arose in one way or another—denial and disbelief, rage, bargaining ("perhaps we can meet for coffee once in a while and talk," or "let me take you to a Browns game this fall"), sadness, and resolution in acceptance and readiness for new relationships. One patient I had seen for over 35 years, though now only on rare occasion, expressed a longstanding wish that I'd give her the decorative tissue box in my office as a parting gift; I did so.

However, many patients showed genuine warmth and good wishes for my retirement. Gratitude for our work together appeared in cards, heartfelt notes, and token gifts as well as being sincerely and sometimes tearfully expressed in treatment hours. The tearing-up eyes weren't always solely the patient's; it was often hard to say goodbye. One patient who had overcome the symptom of excessive generosity registered both his gratitude and gleeful defiance with a parting gift of three bottles of very fine champagne, thus illustrating the psychoanalytic fact that all mental life has multiple roots. Finally, a lavish gift I couldn't insist that he analyze! In the context of the patient's issues, the transference, and what had been accomplished in our work together, it would have been inappropriate to refuse this gift at this final moment. So I accepted it and we relished his moment of triumph.

I tailored referrals to my perceptions of the needs of the patient and the personality fit with the new psychiatrist or other therapist. I checked with other practitioners to see if they were available for certain kinds of problems, without giving them the identity of patients. I gave most patients more than one name and encouraged them to meet with the people and then decide. A few wanted to find a new doctor themselves, which could be seen as expressing their annoyance with me and/or assertion of autonomy. I tried very hard to preserve each patient's privacy in the process. I offered to be available to discuss our work with the new therapist, or to provide a brief written summary or in some instances a copy of their clinical record (but not the separate psychotherapy notes) with their written and circumscribed consent. Because of serious privacy concerns, I avoid e-mail in communications with or about patients, except possibly for the mechanics of making appointments.

Logistics

Retirement takes a lot of work, especially if one has been in solo private practice for decades. There are the business arrangements of ending or terminating a lease and disposing of furnishings. My state regulations require written notice to all patients seen in the past 3 years unless the doctor-patient relationship has been explicitly and fully terminated, as well as legal notices in local and regional newspapers and a notice on the door of the office at the time of closure. The notice must state the fact of retirement and closure of the practice plus information about where clinical records will be maintained and how they can be accessed. How long to maintain records is a seri-

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ous question. For reasons of tax liability and supporting Medicare claims, 7 years after the services rendered may be sufficient. However, various legal experts seem to concur that some malpractice claims may emerge long after the usual legal statute of limitations, that there is no clearly safe time to dispose of records, and that if possible they should be preserved indefinitely. If one does dispose of records, it should be in a guaranteed secure fashion and one should systematically document the disposition of each record. Extensive resources on this subject are available from the American Psychiatric Association and one's state and local medical society. Legal consultation may be advisable. I brought the records of almost 50 years of patient care home to locked filing cabinets in my basement.

Addresses must be changed on bank accounts and with business associates such as accountants and laboratories, hospitals, professional associations, insurance carriers (third-party payers as well as professional and business liability insurers), state licensing boards, the Drug Enforcement Agency, and numerous publications. For me, the most onerous task was dealing with Medicare, which requires precise completion of gigantic forms that one obtains online or completes through the Medicare electronic data entry system. I am keeping my license, malpractice insurance, and DEA number active for the time being to allow for possible need for follow-up work with my patients, supervision in a psychiatric residency, or temporary needs in covering for other psychiatrists. The Medicare transition was complicated by current demands to revalidate enrollment and enable electronic funds transfer, as well as having to apply for an exemption from the requirement to prescribe electronically or face an additional reduction in Medicare's meager fee scale. (I have always participated in Medicare because I support national health insurance, but the current times are trying to that loyalty.)

The aftermath

Immediately after closing my office, my wife and I embarked on a previously unfeasible 5-week stay at our lakeside cottage. This delightful time was a distraction from the full reality of retirement, since it was a vacation. There were a couple of occasions for popping the champagne corks. However, reality did intrude itself on numerous occasions as I tackled the whole business of changing addresses and informing official agencies of the state and national governments. Then we returned home to the task of disposing of remaining office furnishings and fitting things into our household.

I am experiencing a mourning process for my patients. There is an aching sadness. I find myself wondering how they are doing, what is happening in the various dimensions of their lives that we have worked with, how it's working out with the new psychiatrist. There are some with whom I wish I could have a follow-up visit, but this would interfere with their transition to new treatment relationships. I miss the medical center where I had worked for 32 years and where I had many friends on the medical and support staffs. But I don't miss the daily routine of sitting still for hour after hour with patients. And I enjoy a sense of freedom about being able to order my days as I wish, step outside and take a walk whenever I want, sing or listen to music, and attend a school soccer, lacrosse, or cross-country match on a weekday afternoon and watch my granddaughters run like the wind. If we want to travel in mid-week to see new places, enjoy nature, or visit friends or our grandchildren on the East coast, that's fine too.

Am I totally retired? I have to confess—I couldn't entirely give up that professional persona. It's now more fun and more relaxed to conduct a seminar or a case conference with medical students, psychiatric residents, or psychoanalytic candidates. I especially enjoy interviewing patients in case conferences. The reading, planning, and other preparations for these teaching activities don't seem as burdensome as when they were crowded around long days at the office. I still have various professional organizational responsibilities that I shall taper off. I plan to continue writing (including producing these columns) as long as I have something to say and someone is willing to publish it. So I have not given up being either a psychiatrist or a psychoanalyst. I don't know if I can ever do that, nor would I want to. One can't simply stop thinking psychoanalytically about subjective mental life—it's so rich and meaningful. But I can enjoy a whole lot more in life in these waning days of autumn.

Reference

1. Clemens N. A psychiatrist retires: An oxymoron? J Psychiatr Pract 2011;17:351–4.

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