It's over: The exit dilemma

Laurance Jerrold
Brooklyn, NY

The other day I got a phone call from Dr Straightened M. Goode. He spoke of the dilemma he found himself in and asked if I had any advice regarding the legalities of his predicament. After we spoke, he suggested I write about his dilemma for the benefit of all the other Dr Goodes out there who might find themselves in a similar situation. So here goes.

It's about that time. Bull riding, mutton busting, and barrel racing are just getting too darn hard. It's time to think about hanging up your spurs, sitting on the rocker with a beer, and watching the sun set over the western frontier. The problem is of course that you're not a cowboy, you're an orthodontist. Maybe a cowboy wannabe, but that's another story. No, the problem is you want to wind down and exit from 40 years of the joyful bliss known as clinical orthodontic practice. As an orthodontist you always envisioned yourself easing out of practice on your own terms; in orthodontic parlance, you want to slowly resorb away.

You've been successful but maybe you made a few mistakes along the way. You were always independent, so you never brought someone in to take over the practice from you whenever you eventually decided that the time had arrived. You were financially secure, so you did not mind cutting down from the hectic schedule of your heyday to 2 days a week, and maybe light on those days. You let your referral base shrink as you really did not need or want more. The bottom line is that it was good for you. That slow downhill slide was subtle but it was okay because it fulfilled you; you stayed "active"; and you provided a service for your patients. But, now the time has come to face the economic and practical realities of your current lot in life.

You decide it's not feasible to continue working this small amount of time given the associated overhead costs. Salaries and benefits—big ones since your staff has been with you forever—utilities, insurance, rent/mortgage, lab, supplies, et cetera; well, you get the picture. If you were to stay in practice and bring someone in, maybe you would be looking at major equipment upgrades and office remodeling. Again, you reflect and the bottom line is, it's time to call it a day. You're done. Not tomorrow, but you're done.

Ah, but you still have a pesky little problem to deal with: What do you do with your very part-time practice? This was Dr Goode's exit dilemma.

Over the years, many of Dr. Goode's fee-for-service referrers had retired or sold to younger doctors who had no relationship with him. As new patients became scarcer, he started participating with third-party payers and Medicaid. Although this was fine for him at the time, most of the other orthodontic practices in his area were higher end and are now not interested in taking over his patients. Younger docs coming out of their training programs haven't been interested either because they had such a high debt load that they needed more than what his practice had to offer. He was, he believed, too small to sell, but staying open for a year or two to finish the dwindling number of cases was just not financially, practically, or emotionally feasible. He wasn't sure of his legal obligation to his patients, hence the phone call to me.

What Dr Goode is faced with from a legal perspective is dealing with terminating the doctor-patient relationship and whether or not certain actions related to terminating that relationship could result in claims of abandonment being levied against him. There are 6 permissible reasons that a doctor can unilaterally terminate the doctor-patient relationship. In no particular order, they are:

- The patient is not following instructions to the extent that it may have a negative impact on care.
- The patient is not keeping appointments to the extent that it may have a negative impact on care.
- The patient is not conforming to accepted modes of behavior to the extent that it is creating a hostile work environment for your employees, negatively affecting other patients, or negatively affecting clinical operations.
- The patient is not paying for services rendered.
- The patient is inappropriately trying to dictate the treatment plan, or you and the patient are unable to agree on acceptable treatment goals or treatment mechanotherapies.

Chair, Division of Orthodontics, and Program Director, Orthodontics and Dentofacial Orthopedics, NYU Langone Hospital, Brooklyn, New York, NY.
Am J Orthod Dentofacial Orthop 2019;156:157-9
0889-5406/$36.00
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https://doi.org/10.1016/j.ajodo.2019.04.018

- The doctor dies or becomes disabled (this includes retirement).

Let's focus on the last one. You are not required to work until you drop dead at the chair. At some point, every practitioner will either die, become disabled, change one's practice venue, or retire (forced or voluntarily). With death, you no longer have any responsibility to provide continued coverage; you are, after all, dead. With permanent disability, assuming the disability allows you to do so, you do have the responsibility to aid in attempting to provide adequate substitute coverage for your patients. Changing the location of your practice may or may not result in needing to provide coverage. It's the retirement scenario that brings your obligations to center stage.

When you are planning on retirement, your obligation is to provide the patient with notice of your intention and to provide adequate time for the patient to seek and obtain substitute care. Notice involves telling your patients why you will no longer be treating them and documenting this notice; certified mail or an explicit chart entry, for example, is a must. You should account for the possibility of some delays in the transition; therefore, it may be prudent, depending on the clinical circumstances of the transfer, to remove "active" mechanotherapy and place the patient in more "passive" appliances until the transition can be accomplished.

During this reasonable period of time that the patient is seeking care elsewhere, you are obligated to continue treating the patient and be available for emergencies, consultations, referrals, et cetera. Obviously you may attempt to obtain someone to take over your practice, but you are not obligated to do so, because "winding down" is perfectly permissible as long as the notice and time requisites are met. Assuming you could not get someone to take over your practice or to accept your patients into their practice, if the patient asks for help in seeking substituted care you are free to make recommendations. If you have none, you should refer the patient to the local Dental Society, a local teaching hospital, a dental school, or provide them with online listings of local practitioners.

You do not want to engage in any type of activity that may be viewed as interfering with the patient's ability to seek substitute care. Therefore, you will make a patient's records readily available to the patient or to a subsequent treating practitioner on their signing the proper authorization form relating to the release of their records, regardless of whether or not there is an outstanding balance on the patient's account. You do not want to remove their appliances, unless they state that they will not be seeking substitute care, because this may interfere with their ability to have someone take over the case as the patient may now have to pay a second large appliance fee or down payment to the new doctor. You do not want to "bad-mouth" the patient in any way based on past dealings with them because this may affect another's choice to accept the patient in transfer.

Assuming you have provided the patient with notice, informed them that they still need continued therapy, continued treating the patient for a reasonable period of time during which they were instructed that they needed to find substitute care, and provided help or guidance in that regard if requested, you probably don't have to worry about patient abandonment. Yes, there are exceptions, but generally the above protocol is a decent roadmap to the rocking chair. Enjoy the beer and the sunset.

COMMENTARY

At this point the first words out of your mouth should be: Really, this is where you are going to leave this? What about the money, what about the ethics, what about my good name and reputation in the community, what about …? Well, once we start talking about all of that stuff, we are leaving the legal matter behind (except for maybe the money part).

If you knew the sun was starting to set, why did you keep starting new cases knowing that at some point you were going to retire? From an ethical perspective, when patients come to you, they expect to be treated by you. Not informing them of your intention was at best misleading and at worst dishonest. The ethical principles of veracity and informed consent should have been preeminent. Think about it. You take your kid to Dr Goode because of his reputation in the community, you trust him, you accept what he says and after you have given him a large down payment plus a couple of monthly payments, you are told, "Oh, by the way, I'll be retiring in a few months, you gotta go find another doc to finish junior's care." No way is that gonna sit well with you. Time for the old internet rodeo. Time to start screaming to however many people follow you about how old Doc Goode is trying to pull a fast one.

The solution, of course, would have been for Dr Goode to be up front and tell new patients that he will be retiring, he's not quite sure when, but his intention is to get a fine young doctor with fabulous training to come in and take over his practice after a smooth period of transition. Whatever financial terms are agreed on will be honored by the new doctor. If, knowing this, potential patients choose to start, then no harm,

no foul. If they choose to look elsewhere, that's fine too; Dr Goode did the right thing.

What about the money? Consider the principle of Justice that stands for the fair and reasonably appropriate sharing, distribution, and utilization of manpower goods and services within the health care delivery system. Justice also encompasses the concepts of "getting one's just deserts": mercy, professional collegiality, and reparations. Under the principle of Justice, is accepting a down payment of around 30% a fair and equitable way to treat a patient knowing you are going to leave them in the middle of treatment to fend for themselves regarding finding someone to take over when the lion's share of the fee has already been paid to someone else, like you? From the legal perspective, you may be dealing with a claim of *quantum meruit*, the proposition that one is entitled to be paid relative to the amount of work performed. The corollary also applies in that the patient is entitled to have a certain amount of services performed relative to the amount of money paid. What about all the dead wood? You know, all those cases that dragged on forever, are fully paid up but still need treatment, or those whose treatments were paid up front by a third-party financer? This is a major problem when trying to change a practice. It causes patients to become angry and disappointed, and to look for redress, often through a lawsuit.

Here's an idea to deal with the exit dilemma: Give your practice away. I was friends with a different Dr Goode going way back. He had the same problem: a day and a half a week practice with an overhead that resulted in him essentially working for next to nothing. He wanted to work for about another year. I was only in practice a couple of years myself. I had purchased 2 small practices, working at each one about 2 days a week, so I offered him the following: bring your patients over to my "main office," which was located in the next town from his, on the days I'm not here. Use the office overhead free. My staff, my supplies, my everything, except laboratory. At the end of the year you leave and I get everything, the good and the bad. I got the 1 or 2 referrers he had left; I got whatever was left on his contracts; I got the goodwill and earned a reputation as a nice young doctor. What did he get? He got 1 year of practice overhead free, under which he was running close to 60%. In essence, that became the selling price of his practice: 1-year's gross. He also got to walk away and not worry about patients coming back to haunt him. Oh, I got 2 other things. I prevented another young doc from coming in and competing with me, and I got a ton of experience dealing with the deadwood. Why would I do that to myself? It's called collegiality, it's called being a professional, it's called promoting the reputation of the specialty, it's also called being a good guy. Okay, you wanna call it whatever you wanna call it, I can live with that.

But Larry, look at the liability you assumed, and for what? To be honest, for me the potential upside was greater than the potential downside. I was young, I was hungry, I wanted to learn, I wasn't afraid of my shadow, I was helping out a colleague with a problem, and I was providing a public service. Really, what else is there? Orthodontics has provided 3 generations of my family with the means to make a wonderful living, and for more than 40 years I have been doing something I really enjoy. Sometimes, owing to circumstances beyond anyone's control, like retirement, a doctor's ugly divorce, legal action forcing a doctor to close his office, a doctor's sudden death—and I've seen all of these and more—patients are put in a crappy position. Right then and right there you have a choice. You can either step up and help out, or not.

I close with 2 hopes. The first is that all of the Dr. Goodes out there find a good guy or gal to help him and his patients out of their respective exit dilemmas. The second is I hope you never find yourself faced with the same dilemma. Unfortunately, history tells us that some of you will.