

The Warmest of Handoffs: A Neighborhood Physician's Transfer of Care

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ABSTRACT

Transitioning care of a patient from an outgoing to an incoming physician provides a precious opportunity to transfer knowledge and trust. We explore this process from the perspectives of 2 practitioners, an incoming physician who recently completed training and a retiring physician leaving a practice of 40 years. The method we arrived at for this transfer provided the space for collaboration on what the essence of caring for a unique individual will entail. We discovered that a handoff of care is the intergenerational transfer of culture. It involves worrying and watching and relaxing into hopefulness. It is both witnessing and launching a life's work. It is reliving and inheriting and reinventing relationship.

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This is the story of transitioning patient care from a retiring family physician to her recently trained replacement. Our story is set at Neighborhood Family Practice (NFP), a federally qualified health center in Cleveland, Ohio, one of the poorest cities in the United States. We were founded in 1980 and have grown from a single family physician in a small office to a network of 6 offices with integrated behavioral health, midwifery, dental, and pharmacy departments, and many community programs.

The retiring physician (A.R.), was one of 2 founding physicians. As medical director for most of the life of the practice, she helped to establish a culture and tradition of psychosocial attentiveness when providing acute, chronic, preventive, and social care to patients. The physician taking over much of A.R.'s practice (C.M.) recently completed his training in family medicine and a fellowship in health and media, and came to NFP to become part of its culture and tradition. To facilitate orientation of new clinicians, NFP uses a schedule-sharing protocol that pairs an incoming clinician with an established clinician during their orientation.

C.M. On my first day, at my first job out of training, I met none other than the physician whose name was on the outside of the building. I would be inheriting her patients as she prepared for retirement. I had heard her name, "Dr Reichsman," spoken with a sense of reverence owing to her 40-year career dedicated exclusively to our community health center. I was thankful to find someone not exhausted or jaded, nor patronizing to a young physician. Instead, she was energized and quirky (always in purple, her favorite color), but not in a weird way. She exuded the qualities I hoped to emulate—thoughtful and a master listener. I, too, was making my first impression, hoping to convey my ability as a physician and earn the trust of my new colleagues. As the month progressed, I wondered if Dr Reichsman felt I could care for her patients as she had. What occupied her thoughts the last months of her career? How did she feel the hand off of each patient was going?

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A.R. At the end of my career I am thinking about the beginning of it. I had the great fortune in medical school, 46 years ago, to work directly with the psychosomaticist George Engel, who coined the term "biopsychosocial." As I reflected on my retirement, tasked with handing over my patients to a young doctor, I thought of what it means to care for the whole person. I learned from Engel, and from decades of practice how to pull out the physiologic details embedded in the psychosocial context. I learned to listen with an open heart. Can I ensure the new young doctor

would use these tools of caring for the whole person? Would he be interested in the family stories behind the symptoms just as I have been? I was concerned about this process. But when I met Dr Corey Meador, and he listened intently and responded thoughtfully, I knew that this was going to work.

C.M. I relished our huddles outside of the patient room, trying to glean the nebulous quality that makes a neighborhood physician beloved. We didn't talk about recent labs or even diagnosis—our time was better spent discussing *why* patients kept coming back to this office for decades. Dr Reichsman would, in a matter of 2 minutes, convey to me what she thought was the essence of each patient. She told me about the patient's personality. She told me their career, about their household, and the peculiarities each patient held regarding their health care. No matter what medicine I prescribe or recommendation I give, it would be futile if rapport was not established. How, as a physician, can I avoid becoming the center of attention in the exam room and allow the patient to express themselves fully? This was Dr Reichsman's life's work.

A.R. The context of the patient often explains the most important thing about how to care for them. I needed to convey this to Corey. Our huddles allowed me to pass on my passion for using family trees in understanding family dynamics. I sketched a family tree outside of the room to illustrate the understanding I had gathered over many years of interaction with the family members. Corey appreciated the depth with which I could explain the intricacies of one family. The grandmother cared for her grandchildren while their mother, whom I had known since her birth when I was the delivering clinician, was now struggling with drug addiction. I knew each of my patients' major life events and had provided support and advice over the years. Our shared visits allowed me to introduce him to patients, demonstrate my approach, and observe his style of interactions. I could see that my first impressions were accurate; he valued the patients' stories. He knew how to put them at ease, listening with an open heart.

C.M. Countless patients would cry when Dr Reichsman and I would see them together, sad to see their doctor of so many years and generations retire. But I could tell the patients appreciated the handoff. They were more comfortable knowing that we had reviewed their history together and could speak freely to me knowing Dr Reichsman was there to moderate. I felt that with the way we did the handoff, I skipped years of trust building with some of her most difficult patients, simply inheriting their trust from Dr Reichsman.

A.R. I ended each day of patient care emotionally drained; the patients were in tears and I was often as well. There were some lighter moments of transition, sharing memories of births, weddings, and family connections. However, the most surprising transfer—a patient named Michael—was a moment of comic relief. His stiff personality defied easy

psychiatric diagnosis and he had long avoided seeing a behavioral specialist. The stereotyped phrases he repeated kept people at arm's length. He guarded his supposed psychic abilities from me for years; I worried he wouldn't bond with someone new. But Michael blurted out his secrets to Corey, skipping over the time it took for Michael to feel comfortable with me. Michael shared with Corey samples of the delusions which shape his world. I was both reassured and amused watching this transfer of care, enabled by the confidence Michael had in Corey by my being there.

Corey listened intently to our patients and responded so thoughtfully that I relaxed and knew that even though I wouldn't be living through their stories with them, they were in good hands as Corey developed his own relationships on a path of new shared experiences. Our process allowed me to reflect deeply on my relationships with the patients which helped me manage the emotional task of disengagement.

C.M. In contemplation of the handoff, I realize the purpose is as much for the clinician as it is for the patient. We do not often get to reflect on what, beyond the necessities of medical care, the patient needs from us and what we have learned from them. The dedicated time for the handoff allowed me to learn what cannot be expressed on the computer, the cherished information that sometimes only a patient's physician can know. Observing the passage of this information helps to ensure that the symbolic link to the medical field, which can be fragile for many patients, is not broken.

A.R. and C.M. In feeling our way through these visits we found that we had created a method for transferring culture and tradition from one generation to the next. We discovered that the schedule-sharing orientation became a potent tool for effective patient transfer. We encourage others to take advantage of this process if the retiring clinician has a long-established practice and deep relationships with their patients. C.M. has received feedback from transferred patients about the comfort that they derived from the process. A.R. found that our method relieved her anxiety about leaving her beloved NFP; not only was her approach to these specific patients and her knowledge of them passed down but, the cultural and ethical underpinning of NFP was strengthened.

In the end, we discovered that a handoff of care is the intergenerational transfer of culture. It involves worrying and watching and relaxing into hopefulness. It is both witnessing and launching a life's work. It is reliving and inheriting and reinventing relationship.



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