An Analysis of the Impact of the Loss of a Primary Care Physician on a Patient Population

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A case study was undertaken to analyze the effect of the loss of a primary care physician upon the population he served. While the physician in this study retired, the effects of his retirement can be extrapolated to the situations of sickness, death, etc, in which the services of a primary care physician are lost. A sample population of the patients who had lost their "family doctor" was interviewed in depth regarding the problems incurred by this loss. The mechanisms of informing the patients, transfer of patient records, exchange of responsibility and continuity of care, patterns of primary vs specialty care, and use of the Emergency Room before and after the retirement were investigated.

It was found that only one out of every six families established a reliable and permanent relationship with a new physician within six months without experiencing "great difficulty." While recognizing the limitations of one case study, recommendations are made to mitigate the "difficult" aspects of such transfers in the future.

One of the most frequently discussed problems in medical care is the shortage of primary care physicians, both in absolute numbers and relative to population growth and demographic change. The primary care physician gap has been amply documented both quantitatively via statistical analysis of geographic and population need, and qualitatively through the pleas of communities and individuals who have no doctor. This need has resulted in a national effort to produce more health personnel, including primary care physicians. Recently, however, the better utilization of present resources has been emphasized along with the need to increase the total number of service personnel. One aspect of this utilization is the problem of the transfer of a primary care physician's practice when he or she is no longer available, because of leaving the area, disability, death, or retirement. Although this is a small fragment of the overall dilemma of health-care delivery, it is important in two ways: (1) for the physician or patients involved in an inadequate transfer it can be a distressing experience which perhaps could be avoided, and (2) the problems engaged in the transfer exemplify some of the deficits in the health-care delivery system as a whole.

There is virtually no literature pertinent to the subject of the transfer of a physician's practice, whether through disability, death, or retirement. There are also no comprehensive guidelines recommended by appropriate societies, agencies, or organizational bodies regarding steps to be taken by the physician, patients, or the physician's family in the case of his or her death. Too often it only becomes a matter of concern to the physician imminently faced with the problem, or perhaps not even to him or her, and then it is the plight of the individual patient to "fend for himself." The traditional nature of the solo, highly individualistic family doctor has at times prevented the cooperative planning that could avert potential problems and mitigate against the normal human approach of procrastination in the area of retirement or death. Although the problem of the loss of a doctor is pertinent to any physician with an ongoing practice, it is especially crucial to the family doctor upon whom a large group of patients is likely to be critically dependent.

This paper will report the findings of a study of the impact of loss of a family physician through retirement. The purpose of the study was to find out if the transfer of patients did indeed create a problem and, if so, to suggest alternatives to the usual method of transfer.

Methods

An analysis was done of the experience of a randomly selected group of patients (30 families) who had lost the services of their family doctor through his retirement. The practice was in a semiurban area in New England with the population consisting mostly of "blue-collar" workers. The local population had risen from 45,000 in 1945 to 75,000 in 1970, while the number of family physicians serving the area had dropped from 35 to 22 over the same period. The family doctor in question (hereafter referred to as Dr. Smith) had been in practice over 20 years and had an estimated 20,000 files on record at the time of his retirement. However, there were no "dead," "inactive," or "transient" files. The doctor's decision to retire was unknown to most of his patients. He took the following steps to inform them: (1) He placed an advertisement in the local newspaper about one month before his retirement running for one day which mentioned the retirement and instructions to call his office for "referral"; (2) He usually

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Table 1. Use of the Primary Care Physician, Specialist, and Emergency Room Before and After Retirement

Problem	Dr. Smith (before retirement) or new family doctor (after retirement)		Emergency Room		Specialist		Uncertain	
	Before	After	Before	After	Before	After	Before	After
"Cut"	20	15	10	15	–	–	–	–
"Pain in stomach"	28	24	2	4	–	–	–	2
"Arthritis"	30	24	–	1	–	1	–	4
"Needed shots"	30	25	–	1	–	–	–	4
"Needed a doctor at night"	27	20	3	8	–	–	–	2
"Child with a bad sore throat" (only 23 families with children)	23	19	–	1	–	–	–	3
"Pregnancy" (23 eligible)	18	8	–	–	5	10	–	5
"Heart trouble"	27	22	–	2	1	1	2	5
"Emotional problems"	26	23	–	1	–	3	4	3

mentioned it to his patients when he saw them in his office in the weeks (it is unknown exactly how long) preceding his departure; and (3) If someone called his office and requested a transfer to a specific doctor, the patient's records would be forwarded to that doctor. It was in no way assumed by either Dr. Smith or the other doctors that the latter would assume responsibility for those patients whose files were forwarded to him. Further investigation showed that this was not made explicitly clear to the patients, many of whom assumed that they were now the patient of the doctor to whom they requested referral.

The sample of patients to be interviewed was taken not from Dr. Smith's own records, but rather from the files of the local hospital Emergency Room where the admission form included the name of the family doctor. The charts were pulled of all the patients who listed Dr. Smith as their family doctor and who were seen in the Emergency Room in the six months prior to his departure and, from these, families were randomly selected. All of these patients turned out to be "regular" patients of Dr. Smith and fairly representative of his practice. Although this method of sampling slightly skewed an analysis of Emergency Room usage, it conveniently located "active" patients of Dr. Smith who had not necessarily seen him in the preceding six months (although many had). These families were personally interviewed about six months after Dr. Smith's departure. An interview of the remaining physicians in the area was also attempted but the response was so poor as to be non-representative (8 out of 22 doctors responded).

Results

Some of the pertinent findings from the experience of the families were as follows:

1. *Demographic data.* The total number of families interviewed was 30, encompassing 135 individuals. Data relating to age, employment, and education showed the sample to be quite similar to the general population in the area and analogous to the populations noted by Haggerty et al[1] and similar studies. The mean length of time that a family had utilized Dr. Smith was 15.2 years. Only 11 percent of the patients had used other doctors prior to Dr. Smith's leaving, and the majority of these were referred by Dr. Smith for subspecialty problems. As would be expected from the type of sample, 100 percent of the families preferred using a "generalist" to a "specialist" for reasons similar to those noted by Hill et al[2] and Cahal.[3] Similar to Hill's finding that most of the patients in his study preferred having a family doctor, were loyal to him, and trusted him more than other doctors, the general opinion was quite favorable to Dr. Smith, exemplified by one patient's statement that, "Dr. Smith made you feel comfortable and wanted; he was kind of like the old country doctor – kind, gentle – an extraordinary doctor." Comparing the "need for health care" there was no difference between before and after Dr. Smith's retirement in the majority of patients (86 percent), and the remaining 14 percent were equally divided between greater or lesser need.

2. *The use of other doctors after retirement.* In the six months after Dr. Smith left, 43 percent of the patients saw another doctor for a total of 132 visits. In 94 percent of these visits they would have seen Dr. Smith if he had still been available. The reasons for doctors' visits after Dr. Smith's retirement were similar to those given for visits prior to his leaving and were comparable to the usual breakdown of family practice visits (Haggerty et al[1]).

In only three families had there been no visits to a doctor since Dr. Smith left, but these three are all interesting in that two of the three had not needed a doctor since he left, but both had no idea of what they would have done if they had needed a doctor; or, indeed, what they would do when they needed a doctor in the future. The third family was perhaps the most representative of the more severe problems that existed in this situation, since in this family all five of the family members had needed to be seen by a physician for acute illnesses and none was ever seen due to the inability of the family to locate a physician who would take them. After calling six different doctors, the family "surrendered" hope of obtaining a doctor. Anger, frustration, and resentment are registered in their statement: "We called six doctors and we couldn't get a doctor – the family was all sick and we couldn't get a doctor . . . I was so mad I wanted to call the medical board, and Dr. A said he didn't give a damn if I called the medical board . . . If something had happened to our family it would have been the doctors' fault – it's their responsibility to take care of us when we're sick. Now if we need anything, we go to the Emergency Room. . . ."

This seemingly militant statement came from a family that was not "chronically disenfranchised" in the usual sense (in that they are white, middle-class Americans) but had been recently made economically and emotionally "poor" by a three-week layoff secondary to illness of the "breadwinner." This statement is not intended to be representative of all families in the study. Indeed, few were as vitriolic in their condemnation of the physicians involved. Most families viewed the problems they faced as being one of the mechanics of the situation rather than a reflection of the personalities of the doctors involved. The statement does serve to illustrate the strong feelings of ill will toward doctors that exist in certain parts of the community.

The above family's situation also highlighted the effect of Dr. Smith's retirement upon the local Emergency Room. Although the design of the sample precludes statistical analysis of Emergency Room utilization (having been drawn from known Emergency Room users), the category of "doctor unavailable" (of the reasons given for Emergency Room use) increased from 37 percent before Dr. Smith's retirement to 50 percent after his retirement. This is consistent with the findings of Weinerman et al[4] and Alpert et al[5] who noted that the main variable in Emergency Room use was whether or not the patient had a private doctor. Thirty percent of the families thought they would use the Emergency Room for notably different reasons after Dr. Smith left. Only two families looked to the Emergency Room as their sole source of care after Dr. Smith's retirement. To assess the possibility of increased use of "specialists" as well as the Emergency Room in a hypothetical situation, the patients were asked to whom they would go for the problems seen in Table 1, comparing before and after Dr. Smith's retirement. There were few large shifts in any one problem, and the small trend toward increased use of the Emergency Room and even smaller shift to specialists (primarily Obstetrics/Gynecology) may represent the same cohort of patients in each problem grouping. Thirteen percent of the families indicated a projected increase in the use of specialists. (While there were 22 general practitioners still in the area, the patients only requested ten of these; primarily these were the younger and more stable doctors.)

3. *Continuity of care in chronic disease.* One of the hypotheses of the study was that the loss of the primary care physician might occasion a break in the continuity of care, especially in "chronic" disease processes. Last and White[6] note the particular importance of continuity in this area. In this study, 18 individuals (13.4 percent) were considered to have chronic or "special" problems requiring extended care (ranging from heart disease, asthma, and hypertension to Meniere's disease and a fractured leg). Of these 18 patients, three felt that there was a definite break in the continuity of care they received. These three patients included a man with hypertension who attempted to be seen by eight doctors and was unsuccessful in doing so, a man with arthritis who had difficulty getting continuation of therapeutic injections, and a woman who broke her leg just prior to Dr. Smith's retirement and had difficulty with follow-up.

Table 2
Sources of Learning About Retirement

Source	Number	Percentage
Dr. Smith during a visit	12	40
Newspaper	12	40
Friends	4	13
Relatives	2	7

4. *Mechanics of the transition.* In this sample of patients, ten families (33 percent) knew about Dr. Smith's retirement more than a month before he left, 19 (63 percent) knew less than a month before he retired, and one family (3 percent) learned of his retirement only after he left. The media through which the families learned of their doctor's retirement are seen in Table 2. Since the main source of communication other than the newspaper was a visit to Dr. Smith before he left, if a family had not needed medical care in the few months prior to Dr. Smith's leaving, they stood a good chance of not being informed about his retirement. Also, many patients felt that the newspaper advertisement, which mentioned the transfer of records to another doctor, implied that the doctor to whom the records were transferred would assume as patients all those whose records he received. In some cases, this was not true. In general, the longer the interval between Dr. Smith's leaving and the time when a family first needed medical care, the more difficult it became for them to find a doctor. Apparently many of the remaining doctors were accepting the transfer patients on a "first come, first serve" basis, ie, for only two weeks after Dr. Smith left, and the patients were unaware of this.

5. *Families who had difficulty.* In answers to several different approaches to the subject, *the responses consistently indicated that about one half of the families had a "difficult time" after Dr. Smith retired.* In almost all the families it was quite clear one way or the other, ie, those who "had difficulty" had great difficulty, and

those who "did not" noticed few problems. There were few marginal situations; the two groups seemed like separate poles rather than part of a continuum. Responses showed that the problem existed primarily in acquiring a new physician, rather than the patient's satisfaction with the new doctor once found.

Each family had a unique experience, and beyond gauging difficulty, it is difficult to group these experiences. Perhaps the most accurate assessment of the situation (and certainly of the feelings of the patients) is to be seen in the unsolicited statements of the patients. Among those who had difficulty, the following statements are representative:

Family #3 – "We asked Dr. Smith to recommend a doctor. He wouldn't, but mentioned Dr. A. We didn't know what to do and we called Dr. A's office (before Dr. Smith left), and they said that we might be seen in an emergency but they didn't know about taking us on as regular patients. Dr. Smith's office was surprised that Dr. A's office wasn't accepting any more patients but they sent the records anyhow. We haven't needed a doctor since then, but we have no idea of who would take care of the family if we needed one. Dr. A has our records but we don't know if we're his patients."

Family #5 – "When we heard about Dr. Smith's retirement (about one month after) we asked Dr. B to take our family on and he said he would if the records could be sent to him. We called Dr. Smith's office which was closed and we couldn't get the records sent. In September my mother needed a doctor and called Dr. C. He took her but she had to wait 10 days for an appointment, and we feel she needed care much quicker than that."

Family #14 – "Dr. Smith wouldn't recommend any new doctor. We didn't think any more of it and didn't have the records sent anywhere. I had been seeing Dr. Smith every two to three weeks for hypertension, and [after Dr. Smith left] I tried about eight doctors . . . my blood pressure was going up, my job was in jeopardy, and I was decreasing my medication because it was running out and I couldn't get a doctor to renew it. I was very upset, climbing the walls, when after several months we were accepted by Dr. D who got our records. It was a frightening thing not to know who to turn to when you're sick."

Family #18 – "I was told by Dr. Smith when I went for a check-up; I never would have seen the paper – it probably missed an awful lot of people. I asked Dr. Smith to refer us and he wouldn't, although he did mention Dr. A. We asked Dr. Smith to send our records to Dr. A – then the last week in July we needed an appointment and Dr. A was on vacation, so we took our son to the Emergency Room. Then in October we needed an appointment and we were told by Dr. A's office that they weren't accepting any new patients. We didn't know anything about a time limit – we figured as long as our records were accepted, we were accepted as patients. . . . When we finally needed a doctor, we didn't have one."

Family #23 – "We called eight doctors and we couldn't get anybody. If we needed anything we went to the Emergency Room for it. Then, after two months of looking, we found Dr. E in November and now he's our family doctor."

Family #24 –"My father used to get an arthritis shot once a month and now he hasn't gotten any since Dr. Smith left. He doesn't know where to go . . . It wasn't a matter of who you wanted, it was who you could get."

Family #25 – "It was a bad thing – all these patients who had entrusted their care to the doctor suddenly had this real big problem. I blame the hospital – it seems that they should have been able to do something about it. The hospital should have a knowledge of all the doctors and it didn't fulfill its responsibility."

Family #27 – "It was a sudden decision, we needed a doctor quick. We didn't have any preference, we went to Dr. F. Now we would like to have another doctor but I don't know how to do it. I don't know if that's against medical ethics. What do you do – tell the one doctor you want him to transfer the records to another doctor"?

Family #28 – "We didn't have our records sent anywhere because at the time we didn't know any doctors – we didn't need one at the time. We don't know where our records are; we figured Dr. Smith destroyed the records when he left – they would help now. With my 84-year-old father, I have no idea who to go to."

Family #29 – "Dr. Smith always made you feel comfortable and wanted; he was kind of like the old time country doctor – kind, gentle – an extraordinary doctor. Dr. Smith had Dr. A check on me, but then Dr. A died. We don't have any doctor now. If we get sick, I have no idea what we would do. Whoever's in charge of the doctor business should tell you where to get a doctor."

The above statements are not meant to be factual analyses of the situation but rather a presentation of the feelings of those patients faced with a dilemma. There were many reactions expressed ranging from anger and bitterness to a resigned gratitude "that things worked out." There seemed to be two underlying feelings, however, which were pervasive in the statements of all those who had difficulty, *viz*, fear and frustration. The fear was of the possibility, at times perceived to be imminent, of not "being able to get a doctor when you're sick." The implied, and often stated, added dimension was the fear that a "total stranger" (eg, the Emergency Room doctor) could not give a person the health care he perceived was needed. Indeed, although everyone interviewed attested to the desirability of a family doctor, it was those who were without one who were most eloquent in stating the reasons why a family doctor was essential to them, and, in the process, essentially defining the goals of family practice. This element of fear was at times misplaced and inappropriate but, nevertheless, was all too real to the person who was experiencing it.

The feeling of frustration was universal to all those who had difficulty and was real and appropriate, as well as perceived. The statements above express the various courses that were taken to obtain medical help, resulting in varying degrees of success or failure. The one common denominator was the feeling of "not knowing what to do," with its corollary "someone else should know what to do." Suggestions of hospital, medical society, or health department culpability for this are interspersed with the more general feeling of a person in a desperate predicament in which he has no experience or "know-how" to cope. This is most aptly stated by the elderly

man (Family #29) who could not get a doctor and stated, "Whoever's in charge of the doctor business should tell you where to get a doctor." It was too apparent through the fear and frustration of these patients that no one was going to tell them where to get a doctor because no one was in charge of the "doctor business."

6. *Families who did not have difficulty.* It is interesting to look at the experiences of those who claimed little difficulty, and intriguing to speculate what variables placed the two groups at separate poles rather than as part of a continuum. Was the real "difficulty" simply the limited number of doctors with a capacity for only 50 percent of Dr. Smith's patients, and the distribution being purely random as to who were the "haves" and who the "have-nots"? This question cannot be definitely answered here but certain other avenues to "getting a doctor" certainly suggest themselves. One is the time factor, ie, those who were the first to seek an appointment often fared much better than those who waited longer to try to get an appointment. Table 3 offers another view, ie, the source of the new physician in those who had little difficulty. If the two families who had little difficulty because they had not yet needed a doctor are excluded, then over 50 percent of the families who had a stable relationship with a new doctor had had a member of either their immediate or close family previously cared for by that doctor. In a competitive situation (into which this apparently developed), it helped "to have an edge," such as a sister who had been faithfully going to the "new" doctor for many years. The family of the nurse who "knew the doctor well" also found a distinct advantage. Perhaps the most representative families are those who found their new doctor through friends, telephone book, or chance. These families total 5, or 39 percent, of those who have achieved a reliable relationship with a new doctor. They represent, however, only 17 percent of all the families in the study, ie, *only one out of every six families who were faced with the loss of their primary care physician established a reliable and permanent relationship with a new doctor in six months without "great difficulty" and without having used an "advantage"* (as described above). This does not change the fact that only one out of two families stated they had "great difficulty" with the transition, or imply that using "advantages" is not honorable or "average." (It is not certain if the average, or representative, family would have entry to an "advantage.")

Table 3. Sources of New Physician in Patients Who "Had Little Difficulty"

Member of family had been to doctor previously (eg, during Dr. Smith's vacation)		4
Close relatives of family were patients of doctor		3
Nurse at the hospital		3
Friends were patients of doctor		1
Miscellaneous		2
Have not yet been to a doctor (but believe they could get an appointment if needed)		
Records supposedly with new doctor	1	
Records unknown	1	
		2
		15

7. *The experience of the doctors.* The response to a survey of the remaining physicians in the community was inadequate to draw "hard" statistical conclusions in most of the questions. However, the following trends were evident:

a. There was little or no planning done for the transition of the retirement.

b. Some physicians were burdened by the disproportionate distribution of the families.

c. Some doctors felt the old records were not helpful, and would have appreciated "off-service summaries."

d. None of the physicians saw any role for an agency to mitigate the problems imposed on patients and doctors by a situation such as the loss of a primary care physician. (This is in contrast to 50 percent of the families who felt that the traditional methods of dealing with such a situation had been inadequate for them.)

8. *Suggestions of the families.* All statements by family members of "what should be done" express their need for someone or some agency to assist them in their dilemma. Suggestions for this responsibility included the local medical society, the Health Department, and the hospital.

Discussion

There is no "usual practice" of transferral of a practice, and each physician is left to his or her own initiative and ingenuity, both of which are frequently lacking at the time of retirement or illness. Similarly, with the sudden death of a physician there exist no routine procedures for patients or the family of the physician. Such elementary legal matters as who should have jurisdiction of the physician's records have not been defined. Also, no accurate record is available in many areas pertaining to which physicians are still alive, no less practicing (the "yellow pages" of the telephone book provide frequently the best, although not very professional, list). Many medical societies do not know the status of their members, and medical licensure boards frequently relate to a physician's practice in terms of "fee paid."

Some primary care physicians, when faced by retirement or disability, actively recruit a young or new physician into the community to assume the ongoing practice. Sometimes the practice must be "bought"; often it is gladly given away. Although this is theoretically the optimum arrangement (ie, a permanent, ongoing, one-to-one replacement), this search for a replacement is frequently unsuccessful. The caseload is then shifted to the physician's colleagues. If he is in a group this can be done with some facility, especially if the group has used records in common, shared call

responsibility and otherwise functioned as a team. However, most of the physicians who most likely will be stopping practice through retirement, death, or disability, *viz,* the older physician, are not going to be functioning in a group situation. Therefore, the caseload of the solo practitioner must be distributed to other doctors in the community with whom the patients have had no previous contact.

If transfer occurs in an urban area, there exists for the patient the alternative of "medical center" outpatient call. If the patient population in need is located in rural, semirural, or even in suburban areas, this alternative does not conveniently exist and the patient must seek care through the established community physicians. If, for some unusual reason, there is a surplus of primary care physicians in the area, it may not be difficult for the patient to find a doctor. But having found a new doctor does not insure against a large gap in continuity of care. In the more likely case of a community with too few physicians, the finding of a new doctor can be nearly impossible. It must be emphasized that, under the present "non-system" transfer, it is usually the *patient's* responsibility to insure continuity of care (via finding a new physician, getting records transferred, etc).

Consistent with the "case report" nature of this study, the only "hard" deduction that can be made is that a certain number of patients involved in the retirement of this *one* physician in this *one* community had what they considered to be great difficulty in achieving further medical care after his retirement. It is not suggested that this study is applicable to all cases of retiring physicians or to all populations that lose the service of their doctor. However, the experience in this case report suggests several points: (1) reaffirmation of the acute and chronic need of many communities for primary care physicians, (2) the problem of allocation of health resources that are available, and (3) the need of some patients for assistance in obtaining appropriate health care.

In order to assist patients to find a new physician, the following approaches are suggested:

1. The recognition by national, state, and local medical societies, hospitals, Boards of Health, Health Departments, and associated health agencies of the need to assist patients in negotiating the health-care maze.

2. The coordinated effort of the above-named groups to establish a local point of reference at the community level that would serve as an intermediary in helping patients to locate existing health resources. This need not be a "new" agency with an additional bureaucracy and expense but simply a different and better utilization of existing agencies.

3. The adequate publication of this facility so that those in need of its services would be aware of it, ie, telephone directory, hospital Emergency Room, etc. (Some medical societies have an emergency number which connects callers with a doctor on call. This usually is for emergency service rather than acceptance into a practice.)

4. The identification of this "agency" with an established and respected institution in the community (hospital, health board, etc).

5. The knowledge by the "agency" of all existing health care resources, the geographical distribution, specialty interest, size of practice and age of physician, coverage procedures, hospital affiliation and access to other referral services, and *availability of entrance into practice.*

6. The full cooperation of the physicians of the area with each other and this "agency" in establishing a plan of disposition of a doctor's patients upon his unexpected death or disability and, in the case of retirement known in advance, adequate provisions for a smooth transition at the time of retirement.

7. Assistance by this agency to the family of a deceased physician if they are burdened with: (a) disposition of patient records, (b) notification of patients, and (c) temporary coverage of patients.

8. The establishment of guidelines by national and state organizations for the procedure to be followed when a physician retires regarding: (a) notification of patients (when, how, etc), (b) transfer of patients to new health resources, and (c) cooperation with the "agency" that would be helping his patients.

9. The establishment of guidelines for the handling of patients' records at the termination of a doctor's practice, especially regarding custody, remuneration, transcription, and dispersal.

10. Increased efforts by state governments and medical societies to assist those communities with a need for primary care physicians in the details of recruitment, mobilization of community support and appeal for physicians; negotiating with federal programs; contact with larger medical centers, etc.

11. The continued emphasis on efforts that would lessen the need for such an agency; *viz,* (a) larger and more cooperative group practices, (b) more mutual ongoing coverage of doctors in solo practice on off-duty hours, (c) more uniform, problem-oriented, legible record systems that can easily be of use to another doctor (a centralized record system utilizing dictation, computerization, microfilm, and immediate retrieval is rapidly becoming necessary in an outpatient situation), and (d) increased production of medical personnel and distribution to areas of need.

The above suggestions are approaches to the problem discussed in the study, which is important not only in its own right but also as a symptom of more pervasive problems in health care. The most accurate assessment of these problems was perhaps stated by one patient who observed, "whoever is in charge of the doctor business should tell you where to get a doctor." It was to underscore the fact that nobody was "in charge" and some of the patients in this study were not "told where to get a doctor" that this study was undertaken. It is hoped that future and existing health services can decide who is in charge and that the patient will be the beneficiary of this organization.

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