Policy Statement
The purpose of this policy is to provide guidance to RWJMG Attending Physicians for managing interactions with patients when the patient-physician relationship is not maximal and to outline the process for terminating a patient from an individual Provider, Department/Division, or the entire practice. Legal, ethical and risk management best practices have been considered in developing this policy.

Reason for Policy
As noted in the Robert Wood Johnson Medical Group (RWJMG) Mission Statement: “The Robert Wood Johnson Medical Group is dedicated to providing the highest quality medical care, with respect and compassion for our patients, in a safe and efficient manner, in support of the teaching, research, and community outreach missions of the UMDNJ-Robert Wood Johnson Medical School.” We must also recognize that our mission is not that of a private medical practice, but rather a public institution with a mandate to ensure the health of New Jersey residents.

Relationships may be terminated by the patient or the physician. Under most circumstances, a physician has the right to terminate the patient-physician relationship, so long as the patient is notified in writing and given sufficient time to engage the services of another physician. The theory of abandonment and medical ethics require
that once a patient engages a physician, that physician is under an obligation to provide the patient with continuous care and attention until the relationship is properly terminated. Terminating a patient-physician relationship can be difficult for the physician and the patient. Studies have shown that patients view termination in a very negative light.

3. **Who Should Read This Policy**
   All faculty and staff of the Rutgers RWJMG.

4. **Related Documents**
   Terminating a Physician-Patient Relationship Procedure
   Appendix A: Terminating a Patient from an Individual Provider letter
   Appendix B: Terminating a Patient from a Department/Division letter
   Appendix C: Terminating a Patient from Rutgers RWJMG letter (entire practice)

5. **Contacts**
   Office of the Dean, RWJMS (732-235-6300)

6. **The Policy**
   It is the position of the RWJMG that every reasonable effort shall be undertaken to rehabilitate the patient-Provider relationship in order to avoid termination. When termination has been deemed necessary, it must be decided whether to terminate from an individual Provider, Department/Division, or whether the termination applies to the entire practice.

   In instances of frequent no-show, cancellations, or non-adherence with recommended medical treatment plans, every reasonable effort will be undertaken in order to avoid discharging the patient.

   Other occurrences may lend themselves more to termination from an individual Provider or Department/Division, such as a patient who is not compliant with a signed contract, such as in the pain management service,

   However, some occurrences may be so egregious as to necessitate termination from the entire practice. For example, sentinel events such as violent behavior, abusive verbal behavior, or sexual improprieties.

**References**


Appendix C: Terminate Patient from Rutgers RWJMG (Entire Practice)

Date:
(Note: Termination date stated below in the body of the letter must be 30 days + 2 days for mail delivery from the date of the letter)

Patient name:
Date of Birth:
Address:
City/State/Zip Code:

Dear [Insert Patient Name]:

This letter is to notify you that the Rutgers Robert Wood Johnson Medical Group is terminating all Patient-Provider relationship. No Provider in the Group will provide care to you after [insert termination month/day/year], thirty (30) days from the delivery of this notice.

As required by law, we will provide to you all necessary emergency care or emergency services, including the provision of necessary prescriptions, until the termination date noted above. Emergency care or emergency services means “medical care or services required in circumstances where your life or health may be threatened or compromised unless timely medical care is provided.” Please know that in the event such emergency care is required, it shall not imply that our Patient-Provider relationship been re-established.

[Note: If patient has a scheduled upcoming appointment, please insert the following statement.] Please note that I have canceled your appointment with [Insert Provider Name] on [Insert Date] at [Insert Time].

Finally, I will provide a copy of your professional treatment record and/or billing records, as may be requested, within thirty (30) days from my receipt of a written request from you or your authorized representative, and as required by law. Please contact [insert the name and phone number of the person] to request medical/billing records.

Sincerely,

[Insert the name, title, and signature of person sending letter].

[Send by regular mail and by certified mail, Return Receipt Requested]
Appendix B: Terminate Patient from a Department/Division

Date:
(Note: Termination date stated below in the body of the letter must be 30 days + 2 days for mail delivery from the date of the letter)

Patient name:
Date of Birth:
Address:
City/State/Zip Code:

Dear [Insert Patient Name]:

This letter is to notify you that the [Insert Name of Department or Division] of the Rutgers Robert Wood Johnson Medical Group is terminating our Patient-Provider relationship. No Provider in the [insert Name of Department or Division] will provide care to you after [insert termination month/day/year], thirty (30) days from the delivery of this notice.

As required by law, we will provide to you all necessary emergency care or emergency services, including the provision of necessary prescriptions, until the termination date noted above. Emergency care or emergency services means “medical care or services required in circumstances where your life or health may be threatened or compromised unless timely medical care is provided.” Please know that in the event such emergency care is required, it shall not imply that our Patient-Provider relationship has been re-established.

[Note: If patient has a scheduled upcoming appointment, please insert the following statement.] Please note that I have canceled your appointment with [Insert Provider Name] on [Insert Date] at [Insert Time].

Finally, I will provide a copy of your professional treatment record and/or billing records, as may be requested, within thirty (30) days from my receipt of a written request from you or your authorized representative, and as required by law. Please contact [insert the name and phone number of the person] to request medical/billing records.

Sincerely,

[Insert the name, title, and signature of person sending letter].

[Send by regular mail and by certified mail, Return Receipt Requested]
Appendix A: Terminate Patient from Individual Provider

Date:
(Note: Termination date stated below in the body of the letter must be 30 days + 2 days for mail delivery from the date of the letter)

Patient name:
Date of Birth:
Address:
City/State/Zip Code:

Dear [Insert Patient Name]:

This letter is to notify you that I am terminating our Patient-Provider relationship. I will no longer provide care to you after [insert termination month/day/year], thirty (30) days from the delivery of this notice.

As required by law, I will provide to you all necessary emergency care or emergency services, including the provision of necessary prescriptions, until the termination date noted above. Emergency care or emergency services means “medical care or services required in circumstances where your life or health may be threatened or compromised unless timely medical care is provided.’ Please know that in the event such emergency care is required, it shall not imply that our Patient-Provider relationship been re-established.

[If patient has a scheduled upcoming appointment] Please note that we have canceled your appointment with me on [Insert Date] at [Insert Time].

Finally, I will provide a copy of your professional treatment record and/or billing records, as may be requested, within thirty (30) days from my receipt of a written request from you or your authorized representative, and as required by law. Please contact [insert the name and phone number of the person] to request medical/billing records.

Sincerely,

[Type in Provider Name and Credentials, and obtain Provider signature above typewritten name]

Send by regular mail and by certified mail, Return Receipt Requested