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Patient dismissal: The right way to do it

Under what circumstances is it permissible for a physician to "fire" a patient? We present a balanced—and legal—approach.

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PRACTICE RECOMMENDATIONS

› *Unless a single incident irreparably damaged your relationship with a patient, exhaust all efforts at resolution before deciding on dismissal.* (C)

› *Establish policies that help you set limits on problem behavior—eg, drug-seeking or angry outbursts—while continuing to care for the patient.* (C)

› *When dismissal is unavoidable, inform the patient in writing that you will be available to handle medical emergencies until he or she has found another physician.* (C)

Strength of recommendation (SOR)

(A) Good-quality patient-oriented evidence

(B) Inconsistent or limited-quality patient-oriented evidence

(C) Consensus, usual practice, opinion, disease-oriented evidence, case series

CASE 1 ▶ Nonpayment

Susan L, a 53-year-old who'd been a patient of Dr. O's for the past 6 years, received a bill for a visit that had occurred nearly 2 years earlier. She called the office and told the receptionist that she had never been billed for this visit and didn't think she should have to pay after such a lengthy delay. When she received a past due notice, Susan called and asked to speak to the physician—and to schedule an appointment. She was told that she could do neither until her account was current.

Eventually, the unpaid bill was sent to a collection agency, and Susan received a letter threatening legal action. In response, she sent a letter of her own—certified, return receipt requested—detailing her reason for not paying and threatening to sue Dr. O for abandonment.*

With the national unemployment rate hovering at a record high, unpaid medical bills may be your most pressing problem—and potential grounds for patient dismissal. Judging from a recent survey in which primary care physicians identified nearly one patient in 5 as "difficult,"[1] it's unlikely that nonpayment is the only patient conundrum you face.

Indeed, there are many ways a patient can be difficult, including exhibiting habitual hostility, chronic drug-seeking behavior, or consistent noncompliance; breaking appointments at the last minute; or being a no-show. You may wish you could "fire" the worst offenders but be concerned about professional and ethical responsibilities and the legal risk you might face. Ironically, though, struggling to maintain a chronically stressed physician-patient relationship is often riskier than a well-timed termination.[2]

The key here, however, is the persistent or extreme nature of the difficulty.[3] When a dismissal is prompted by a one-time occurrence or lower-level offense, what constitutes a reasonable response is not always clear-cut.

CONTINUED

Adapted from actual cases, with details changed to protect the privacy of the parties involved.

Under what circumstances is it appropriate to end your relationship with a patient? When you do terminate the relationship, what steps can you take to safeguard the patient and avoid charges of abandonment? Here's a look at these questions—and some answers.

Professional responsibility: How far does it go?

As a physician, you've pledged to "do no harm." And you've likely been taught—as it states in the American College of Physicians (ACP) ethics manual—that you have "a moral duty to care for all patients."[4] The American Medical Association's code of ethics cites a similar standard: the obligation to place patients' welfare above your own interests.[5]

According to the ACP, the physician-patient relationship should be discontinued only under "exceptional circumstances."[6] But not everyone agrees, not only on what constitutes "exceptional," but on whether that is the correct threshold for termination.

A health care attorney writing in *American Medical News*, for example, takes a more liberal view. It's time to dismiss, he asserts, when the doctor-patient relationship doesn't work.[7] By that standard, virtually any ongoing problem could be construed as evidence of an "irreparable breakdown" of the physician-patient relationship (**TABLE**).

Before reaching a final decision about patient dismissal, exhaust every reasonable effort to communicate, set achievable goals, and meet the patient's needs.

We can work it out

Legally, a doctor can dismiss a patient for virtually any reason, or fail to give any explanation at all.[2] Ethically, dismissal should be your last option, not your first choice.

In a home study course titled "Challenging physician-patient interactions," the American Academy of Family Physicians (AAFP) advises doctors to be certain they have exhausted every reasonable effort to communicate, set achievable goals, and meet the patient's needs.[3] The steps you take to try to mend a damaged patient relationship, of course, will depend on what caused the rift in the first place. Here are some examples.

Nonpayment. You are not compelled (or expected) to indefinitely continue to treat a patient who's unable—or unwilling—to pay you, of course. But if he or she is out of work and has fallen on hard times or has a single unpaid bill, discussing the problem and attempting to accommodate the patient's financial limitations (and establish a realistic payment plan) is a reasonable approach.

Having a billing clerk handle most communications regarding unpaid bills may be a good idea. But when a situation escalates, as in the case of Susan L (**CASE 1**), foregoing a direct discussion and expecting a subordinate to handle an abrupt patient termination is not (ethically or legally) appropriate.[7]

TABLE

Key reasons to "fire" a patient

- Persistent failure to keep scheduled appointments or adhere to agreed-upon treatment plans
- Repeated failure to pay reasonable medical bills
- Ongoing rude, disruptive, or unreasonably demanding behavior
- Habitual noncompliance
- Falsifying or providing misleading medical history
- Seductive behavior toward physician or staff
- Sentinel incident (eg, verbal threat, violence, criminal activity)

Sources: Kodner C. *FP Essentials*. 2008.[3]
Harris S. *Am Med News*. 2008.[7]

CASE 2 ▶ A drug-seeking patient

Laura K, age 34, had always been a challenging patient. She suffered from a collection of pain-producing maladies, including migraines, fibromyalgia, and low back pain. Controlling her pain required increasing amounts of narcotics, sometimes in doses that exceeded therapeutic recommendations.

Recently she'd begun calling her primary care physician's office for early refills; more than once, she claimed her prescription had been lost or stolen. When Laura called to report that the oxycodone prescribed 4 days ago had been stolen from her purse and to request a refill, the physician refused to speak with her—and instructed the receptionist to tell her she needed to find another physician.

Laura called several other local physicians, but none was able to see her. She then

went to the emergency department. The ED physician evaluated her and offered her a prescription for a mild analgesic, but refused her request for oxycodone.

That night, Laura attempted suicide. Although she survived, she was left with significant neurologic deficits. She sued the physician who had refused to speak to her on a variety of counts of negligence, including a charge of abandonment.

At deposition, experts for the plaintiff testified that refusing to see and evaluate a current patient for her ongoing problems without giving substantial notice constituted abandonment—and was a substantial cause of Laura's suicide attempt. On the advice of counsel, the physician agreed to a $150,000 settlement.

Do not delegate notification of dismissal to a staff member.

Drug-seeking. Behavior like that of Laura K (**CASE 2**), whose requests for narcotics and claims of lost pills or prescriptions occurred with increasing regularity, can't be ignored. The AAFP course, which states that patients should not be dismissed "on the grounds of drug-seeking behaviors alone,"[3] recommends that physicians develop policies for prescribing controlled substances and handling drug-seeking patients. Such a policy—which might include limits on the frequency of renewals and the duration of a single prescription, among other provisions—should be communicated to every patient who seeks opioid analgesics.[3] The Federation of State Medical Boards recommends the use of a written agreement, spelling out your responsibilities as well as those of the patient, for individuals at high risk of abuse (http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf).

While the existence of a policy or written contract may not alter the behavior of a drug-seeking patient, it can prevent you from being caught off-guard or reacting as rashly as Laura K's physician did. Indeed, Laura's doctor made 2 key missteps: acting without warning, and expecting a receptionist to deliver the dismissal message.

A better approach, from the AAFP's perspective, is to calmly maintain the limits you've set, remind the patient that you want to help, and offer treatment alternatives, such as nonopioid analgesics.[3] Discussions in response to drug-seeking behavior, of course, should always be delivered—and documented—by the physician.

Noncompliance. This is a particularly complex problem, as issues of patient autonomy and physician authority are involved. A case study presented in the AAFP home study course describes the thoughts and feelings of a physician who considered dismissing a pediatric patient because the child's mother refused to allow him to be vaccinated. The physician ultimately decided to continue to treat the child, after determining that the physician-patient relationship could still be beneficial *and* planning to revisit the vaccination issue with the mother at a later date.[3] (Another physician, faced with a similar issue, wrote a *New York Times* article about his decision to dismiss a young patient. His reasoning? Accepting the mother's refusal to allow her son to get a tetanus booster would compromise "my conscience and my professional ethics. I couldn't do that."[8])

Although it is important to recognize the difference between noncompliance and an individual's right to refuse recommended treatment,[9] you, too, may encounter situations in which a patient's, or parent's, repeated failure—to follow an agreed-upon therapeutic regimen, perhaps, or adhere to a schedule of visits needed to manage a chronic condition—causes your relationship with the patient to deteriorate to a point where dismissal is warranted. Here, as with other potential causes of dismissal, the patient should be adequately warned, the discussion documented, and action taken only if nothing changes.

Anger. As is the case with drug-seeking, the AAFP course advises physicians to anticipate and develop policies for handling situations in which a patient's anger escalates and creates a real or perceived threat.[3] While this is commonly done in acute care facilities, it is often overlooked in outpatient settings.

Among the issues to address: equipping offices and exam rooms with an emergency call button or intercom, knowing where to position yourself to ensure that you can't be trapped in a room by a threatening patient, and considering how to respond in a way that defuses—rather than escalates—the anger. Calmly ask the patient what he or she is upset about, listen carefully, and apologize,

if appropriate, for your role in the upsetting incident. Then move on to the purpose of the visit, stating, for example, "Now, what brings you in today?"[3]

It is crucial to set boundaries (although it's probably not a good idea to attempt it at the time of the outburst), making it clear, for example, that profanity is not acceptable; directing anger at nurses or other staff members is not permitted; and what the consequences of continued outbursts will be.[3]

A single incident that's grounds for dismissal

Despite the emphasis on resolving problems with patients, there are times when dismissal can and should occur, with little warning and no negotiation. In its home study course, the AAFP describes this as a "sentinel incident"—a single occurrence so egregious that it damages the physician-patient relationship beyond repair.[3]

A threat of violence or a physical assault itself would rise to that level. Some other examples: a sexual assault or blatant sexual advance, falsifying medical records, and theft or another type of criminal activity carried out in the physician's office.

When a sentinel incident occurs, the best course is likely to be to forego any attempt at resolution, call the police or your facility's security officer, and, if appropriate, to immediately prepare to "fire" the patient.

Dismissal without abandonment: Here's how

In the vast majority of cases, dismissing a patient does not in and of itself constitute patient abandonment. Even if the termination is unduly abrupt, as was the case for Susan (**CASE 1**) and Laura (**CASE 2**), it doesn't constitute abandonment unless the patient is dismissed during a course of treatment and unable to find a physician to provide ongoing care.

Neither was true in Susan's case, and her threat of a lawsuit based on charges of abandonment never came to fruition. Not so for Laura, who was abruptly terminated during ongoing treatment—and who nonetheless made numerous attempts to find another doctor to care for her, without success. The attorney for Laura's physician advised that the severe consequences of dismissing without going through the proper channels made a trial defense untenable.

Although most charges of patient abandonment never rise to the level required for a successful lawsuit, attorneys often include it in a litany of charges in an attempt to damage the physician's credibility with a jury. You can usually avoid that scenario by taking the right steps when you dismiss a patient.

CASE 3► Pregnant patient, rural physician

As part of his rural family medicine practice, Dr. J provided obstetrical care. Dr. J had a partner and they alternated call nights, but his partner did not do OB. Dr. J made it a point, however, to always be on call for his obstetrical patients as they neared delivery. Having no patients imminently due, he took a one-week vacation out of town.

One of his patients went into premature labor and went to the local hospital. Dr. J's partner was called to attend, but indicated he did not do OB work and advised the emergency physician to call "any obstetrician around." One obstetrical group covered the region and the on-call physician was at another hospital doing a C-section and requested that the patient be transferred to that hospital for evaluation. After a series of delays, the patient was transferred and delivered a preterm infant who showed signs of neurological injury after a lengthy ICU stay.

The family sued all providers involved on several grounds, including patient abandonment. Plaintiff experts testified that the standard of care would be for Dr. J to be in attendance for such emergencies or, failing that, to provide for adequate coverage of his pregnant patient. They also testified that it was reasonable for the patient to have gone to the local hospital where her delivery was planned and that Dr. J should have arranged for the local OB group to provide emergency coverage. The case concluded with an $800,000 pretrial settlement.

> A dismissal with little warning is appropriate after a threat of violence or a blatant sexual advance.

Ensure that dismissal is an option

While we've already established that physicians have the legal right to dismiss patients, regardless of the reason, there are instances

that make it far more difficult—and legally risky—to do so.

A primary care physician in a rural area is a case in point (CASE 3). If you are the only doctor in the area and the patient has no viable means of getting care from another provider, you may want to reconsider the dismissal. It is far easier to establish that a patient in such an underserved area was abandoned, even—as Dr. J found out—for failing to ensure full coverage during a vacation or leave of absence.

Rural physicians can help prevent charges of abandonment by advising patients of the special call challenges a rural setting presents. Doctors should make sure their patients know what to do if an emergency occurs when the practice is closed or a physician is out of town, and document the discussion in the medical record.

A physician in a staff-model HMO may face similar problems. Unless the HMO has another outpatient clinic in the vicinity, dismissal could leave the patient with no means of receiving affordable health care.

Options in such a case might include asking a colleague at the same clinic to accept a patient whom you would like to dismiss or finding a way to manage the patient's behavior. If a patient has been excessively angry or threatening in the past, for example, it is often advisable to sit down with the patient (with security nearby) to discuss the parameters of expected behavior and develop a contract for future care. The contract might include a requirement that the patient call in advance so that security can be present when he or she arrives, for example, or that the patient agree to abstain from profanity and threats.

Before you terminate a patient, make sure he or she has access to other primary care providers.

Know the laws in your state. Before you terminate a patient, check with your state medical board or local medical society to make sure your actions will be in compliance with any relevant state rules and regulations.

When you dismiss, cover all bases

Send a letter to the patient by certified mail, return receipt requested, notifying him or her of the dismissal and agreeing to provide emergency care for a reasonable time—typically, 30 days—while the patient seeks another physician. It is advisable, too, to help the patient locate other potential clinicians—by, say, including contact information for your county medical society or the patient's health insurer's list of in-network providers, or referring an indigent patient to Medicaid or a sliding scale clinic. It is a good idea to offer to transfer records to the new physician, as well.

It is not mandatory to document the reason for the dismissal in the letter, but some sources recommend that you do so. If you're uncertain how to proceed, check with legal counsel before you send the letter. (You can find sample dismissal letters at www.ttuhsc.edu/som/clinic/forms/ACForm8.11.A.pdf and in "Terminating a patient: Is it time to part ways?" at http://www.aafp.org/fpm/2005/0900/p34.html.)

The events that led up to the dismissal, however, including any discussions you had with the patient about them, *must* be documented in the medical record. Put a copy of the letter and the certified mail receipt in the chart, as well. JFP

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References

1. Hinchey SA, Jackson JL. A cohort study assessing difficult patient encounters in a walk-in primary care clinic, predictors and outcomes. *J Gen Intern Med*. 2011; Jan 25 [Epub ahead of print].
2. Schleiter K. Difficult patient-physician relationships and the risk of medical malpractice litigation. *Virtual Mentor*. 2009;11:242-246.
3. Kodner C. Challenging physician-patient interactions. *FP Essentials*. ed 354. AAFP home study. Leawood, Kan: American Academy of Family Physicians; November 2008.
4. Snyder L, Leffler C; Ethics and Human Rights Committee, American College of Physicians. Ethics manual: fifth ed. *Ann Intern Med*. 2005;142:560-582.
5. American Medical Association (AMA). Opinion 10.015. The patient-physician relationship. Code of Medical Ethics. Chicago, Ill: AMA. 2008. Available at: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.shtml. Accessed February 11, 2011.
6. American College of Physicians. Ethical considerations for the use of patient incentives to promote personal responsibility for health: West Virginia Medicaid and beyond [position paper]. Philadelphia: American College of Physicians; 2010.
7. Harris SM. Take care when firing a patient. *Am Med News*. February 4, 2008. Available at: http://www.ama-assn.org/amednews/2008/02/04/bica0204.htm. Accessed February 11, 2011.
8. Parikh RK. Showing the patient the door, permanently. *New York Times*. June 10, 2008. Available at: http://www.nytimes.com/2008/06/10/health/views/10case.html. Accessed February 15, 2011.
9. Summey-Lowman B. Patient non-compliance—a powerful legal defense. *Healthcare Risk Manag*. 2009;15:1-2.