Operations

Dismissing patients: How to do it the right way

Positive outcomes depend on the physician-patient relationship, but what can you do if it doesn't work out?

by **SUSAN KREIMER,** *Contributing author*

HIGHLIGHTS

- The decision to dismiss a patient requires employing tact in the face of disagreement.
- Measures to take before dismissal include speaking directly with a patient before making a final decision or mailing a "pre-withdrawal letter" expressing noncompliance concerns.

BREAKING UP WITH patients can be difficult. Fortunately, the need to sever ties doesn't arise often. But as insurers increasingly evaluate physicians based on quality measures, managing noncompliant patients becomes more challenging.

Even with payers' growing emphasis on patient outcomes, physicians are reluctant to dismiss noncompliant patients, making it a rare occurrence. "In the family medicine world, discharging a patient along those lines is not something that we do much at all," says Wanda D. Filer, MD, FAAFP, president of the American Academy of Family Physicians (AAFP). "We have a lot of patients who have difficulty with compliance and there can be many reasons, so we try to explore what it is."

In some cases, physicians may sense that patients want to comply with instructions but encounter obstacles in their path. The provider should try to distinguish between patients who aren't making efforts to heed recommendations and those who lack the resources to do so, says David Meyers, MD, FAAFP, chief medical officer of the Agency for Healthcare Research and Quality in Rockville, Maryland.

"For most physicians, the practice of medicine is about establishing a healing relationship," he says. "It's about the power of a therapeutic relationship. Sometimes relationships aren't working, and we have to make changes."

Taking a step back and examining the bigger picture allows for a more candid assessment. A nurse, office manager, or social worker could assist in pinpointing the underlying problem and may offer a viable solution. For example, if a patient is missing appointments because of transportation hurdles, it may be best to schedule visits at times when buses or trains are running more frequently, Meyers says.

Enhancing compliance also entails dispensing advice that helps patients remember to take their medications and to manage side effects. "If I prescribe a medicine to somebody, and hopefully, through good communication discover they're not tak-

ing it, the problem isn't that the patient isn't following my advice, but that I didn't help the patient find a solution that worked for them," he explains.

Perhaps a patient is leery of taking a particular medication because a family member had an adverse reaction to it. By asking questions with in a spirit of compassion and curiosity, a physician can empower the patient to feel more comfortable opening up about his or her fears and motivations, says Ana Maria Lopez, MD, MPH, FACP, chair the ethics, professionalism, and human rights committee at the American College of Physicians and a professor at the University of Utah School of Medicine in Salt Lake City.

In the case of weight management, advising a patient to shed some pounds is one thing, but bringing about the necessary lifestyle changes is another. "If the patient comes back and hasn't lost the weight or any weight, is that nonadherence or is the patient in a way saying, 'I don't have the tools to do it?' " says Lopez, a medical oncologist. To engage a patient in setting and achieving weight-loss goals, a physician could enlist the expertise of a dietitian or a community exercise coordinator.

"There are lots of ways where a physician and patient can communicate to really understand what the issues are that may be affecting the adherence to care," Lopez says. "That's the important piece—how we can work together so that the patient is enabled to follow through and have a good outcome."

RECOGNIZING WHEN IT'S BEST TO PART WAYS

Family physicians in particular value their long-term, continuous relationships with patients. "Oftentimes, many, many years have gone by, [without discharging a patient]" says Filer, a family physician at Family First Health in York, Pennsylvania. "But clearly, there is the rare circumstance where it occurs. Every family physician has had a few cases in their career where, for a variety of reasons, it isn't a good fit, the patient has become quite disruptive, or it's just not a good therapeutic relationship."

A physician also may ask a patient to see another clinician because of the individual's lack of trust in the care being delivered. "One of the most important factors for true healing requires trust in the provider," says William S. Andereck, MD, FACP, director and senior scholar of the Program in Medicine and Human Values at California Pacific Medical Center in San Francisco. "You can treat diseases, but to truly heal the patient and their condition, they need to trust you."

Recognizing that it's best to part ways becomes necessary in some physician-patient relationships. Proper protocol calls for informing a patient in writing of your decision while stating that he or she can count on you for emergencies until another provider takes over the care, generally within 30 days. Awareness of your state's laws and regulations can help guide your decision-making.

Assuring continuity of care during this transition is paramount. Timing also comes into play. While a patient may choose to switch to another physician at any time, "a provider should refrain from initiating a separation when a patient is seriously ill," says Lopez, who also serves as associate vice president for health equity and inclusion at the University of Utah Health Sciences Center.

"Patient abandonment is unethical," she says. "There are some very specific guidelines, most important of which is to be sure the patient is cared for, so that the patient's health should not be jeopardized in any way."

Even in less precarious situations, the decision to break up with a patient requires using tact in the face of disagreement. "In certain respects, it can be like a divorce. It is certainly, on all occasions, a difficult conversation to have," says Sidney S. Welch, JD, MPH, an attorney in the Atlanta office of Polsinelli PC and co-chair of the law firm's healthcare innovation practice.

"As a general rule, nobody is obligated to take on a patient unless they want to establish that physician-patient relationship," she explains. "But once you have done that, then if you're going to get out of it, you have to do it in a way that supports patient care and meets those obligations and legal requirements."

DEVELOP A CONSISTENT POLICY

A medical practice can benefit from developing a consistent policy for provider-patient termination, and from maintaining accurate and thorough documentation in the patient's medical record of any noncompliance and corresponding conversations, says Welch, a member of the Health Law Section's governing council of the American Bar Association.

Other measures include speaking directly with a patient before making a final decision. A physician could mail a "pre-withdrawal letter" gently expressing noncompliance concerns, she says. The physician should send the follow-up termination letter via certified mail with return receipt to the patient and the insurance carrier, noting discontinuation of care in 30 days (or as otherwise mandated by state law) of a specific date. Offering to transfer medical records with permission is also part of this process.

Filer's approach toward patients who don't comply with her instructions tends to be effective. Her office assistant, who has worked in the practice for two decades, calls and kindly reminds patients about missed appointments and outstanding physician orders for X-rays. "That's part of leveraging those relationships and that team over time," Filer explains.

When patients don't get laboratory tests as prescribed, Filer conveys the message that she can't continue to provide care even though it's her mission to help. For example, she tells patients with high blood sugar levels that she "wants to prevent their diabetes from causing havoc."

Filer takes a view of patients with diabetes that goes beyond their A1C results. She identifies risk factors that may cause their blood sugar to spiral out of control. One of her patients who is visually impaired recently was living in crowded and dilapidated housing without any family members and was worried about falling through holes in the floor.

"There are many reasons why her sugars are out of control," Filer says of the patient. She and her staff enlisted a social worker's help and "got all sorts of interventions underway."

Steps for dismissing over noncompliance —*Susan Kreimer*

1. Develop a policy for provider-patient termination that may be internal, external, or both.
2. Keep accurate and detailed documentation in the medical record of any patient noncompliance.
3. When appropriate, talk with the patient before making a final determination, and consider sending a "pre-withdrawal letter" that gently expresses your noncompliance concerns.
4. Consider discussing the situation with a colleague, risk-management professional, or legal advisor.
5. Explain to the patient that he or she is being terminated from care and provide an explicit reason why. Do not delegate this task to a staff member; speak directly with the patient.
6. Inform your clinic's staff about the termination.
7. Send a certified letter with return receipt to the patient and the insurance carrier, noting the termination and indicating that care will be discontinued in 30 days (or as otherwise mandated by state law); include the exact date.
8. Assure the patient of your willingness to handle interim care.
9. Provide names and contact information for suggested potential alternate providers.
10. Offer to transfer medical records with written permission.

Source: Sidney S. Welch, JD, MPH, a shareholder who serves clients nationally from the Atlanta office of Polsinelli PC and is co-chair of the law firm's healthcare innovation practice. Welch is also a member of the Health Law Section's governing council at the American Bar Association.

CONSIDERATIONS BEFORE DISMISSAL

Dealing with underserved populations requires delving into the root causes of a medical problem. In rural areas, Filer notes, patients may lack transportation to pick up their prescriptions from a pharmacy. Others may opt not to obtain their medications, equipment or supplies because copays pose hardships.

For some patients, living on a tight budget means having to make choices among medicine, food, or electricity.

A patient may not be using a continuous positive airway pressure (CPAP) device for obstructive sleep apnea because electricity has been turned off due to nonpayment. Writing a letter to the utility company on a patient's behalf—or turning to a social worker with this request—can help resolve the issue, at least temporarily, Filer says.

"It's all about the context in which the patients live with their families and in their communities that becomes really important to achieving quality goals," she says.

The American Medical Association (AMA) also notes that "successful medical care requires an ongoing collaborative effort between patients and physicians. Physician and patient are bound in a partnership that

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requires both individuals to take an active role in the healing process," according to the AMA's Code of Medical Ethics.

"Such a partnership does not imply that both partners have identical responsibilities or equal power," the code continues. "While physicians have the responsibility to provide healthcare services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program."

WHAT ABOUT PATIENT RESPONSIBILITY?

Since the advent of healthcare insurance reform under the Affordable Care Act, many physicians have voiced disappointment that the legislation overlooks patient responsibility as part of the collaborative equation, Welch says. "Without patient willingness to assume responsibilities toward a shared goal of improved health, physicians find it difficult to achieve meaningful change," she says.

Some physicians have asked patients to sign contracts spelling out the provider's expectations of them, such as adhering to a medication regimen in controlling a chronic disease. Although such a document may not be legally binding in court, Welch notes that it reinforces the importance of a patient's role in his or her own treatment's success.

Family caregivers also can have an impact on patient compliance, but only if an individual voluntarily agrees to their involvement. "It's not every wife who is nagging her husband that he ought to give up smoking," says Gail Gibson Hunt, chief executive officer of the National Alliance for Caregiving in Bethesda, Maryland. These patients typically have a chronic illness that requires oversight. "The physician just can't say, 'I'm going to talk to your wife about this.'" Doing so would be a breach of privacy under the Health Insurance Portability and Accountability Act (HIPAA).

In many circumstances, the family caregiver is an integral participant in accompanying a patient to office visits and managing care at home, she adds. The caregiver may prepare and serve meals, help the patient with personal hygiene shower and taking medications on time, provide wound or colostomy care and assist with other activities of daily living, particularly in situations involving dementia.

These tasks may leave the caregiver feeling overwhelmed, so the physician should ask if he or she needs support as well, says Hunt, who serves on the governing board of the Patient-Centered Outcomes Research Institute, a nonprofit organization established by Congress.

Discharging a patient due to noncompliance is often a last resort in a long process of collaboration that has failed, the AAFP's Filer says while noting, "The value and importance of a healthy, long-term, comprehensive patient-physician relationship cannot be overstated." ◘

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