Where does the nephrologist stand with a non-compliant, abusive dialysis patient?

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Abstract
Physicians have sworn to treat for the good of their patients. However, there are often conflicting needs and pressures which are ethical, medical, and legal which impact the ability of the physician to provide that care. Although most dialysis patients work with the physician and dialysis facility to obtain quality care, there are a few which are noncompliant and even abusive. This small minority requires an inordinate amount of work and presents the physician with a variety of ethical and legal issues. Unlike many other specialties, dialysis care presents additional problems due to the frequent interactions, limited treatment options, and morbid consequences of lack of care. This article outlines these issues and summarizes the difficult position that the nephrologist encounters when dealing with a noncompliant or abusive patient.

REVIEW
As a rite of passage, medical students beginning a career in medicine take the Hippocratic Oath. The oath includes this statement, “I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.” It is doubtful that many new physicians would question this statement. Yet the complexity of medicine often leaves seasoned physicians struggling. The obligation to treat a non-compliant, abusive dialysis patient is one area where the struggle continues.

Dialysis therapy usually requires a patient to come to a center three times a week for a four hour treatment. Not only are dialysis patients challenged by the required time (not to mention the travel time), they are challenged medically, emotionally, and financially. These challenges particularly in the face of personality disorders and substance abuse set the stage for noncompliance and abusive behavior.

Mild cases can be handled with behavior contracts and counseling. Unhappy patients can also be transferred to other units either for convenience to their home, new surroundings, or change in dialysis time- schedule. Depending on the nephrology practice, the nephrologist may or may not change as the patient transfers units. On the other end of the spectrum is the habitually noncompliant patient who misses treatments and cuts treatment times. The patient suffers by decreased toxin removal and volume expansion and may at times require emergency room visits for emergent dialysis.

Extreme cases may result in the patient being discharged from the unit. If solely on the basis of not coming for treatment most of these can be handled internally or by transfers. Friedman and Balint both discuss the issues with noncompliance and advocate for the patient and healthcare team to work together to solve problems. Friedman concludes his article by stating, “There are limits to all human interactions, including physician tolerance for combat during provision of regimens intended to benefit patients.”

It is this extreme end of the spectrum- the abusive non-compliant patient that creates the real medical, ethical and legal problems. In addition to missing treatments or cutting times, the patient may be loud, verbally abusive to staff or other patients and at times both threatening in body language and actions and rarely physically abusive. Although uncommon, dialysis patients have threatened staff with weapons such as knives and guns and there have been cases of patients shooting dialysis staff at or near the dialysis unit. Implications of physician and staff personal risk in treating difficult ESRD patients and suggestions for care have been described.

Certainly recommendations for counseling, behavior modification programs, and substance abuse programs may help. A few patients even with these interventions continue
to be disruptive to other patients, prevent staff from working in a violence free environment and limit their ability to get adequate if not quality care. Most chronic unit companies have policies and procedures for dismissing these patients and some renal networks have published recommendations and guidelines. These include steps to dismiss the patient once attempts at behavior contracts and written warnings have failed or immediately if physical violence has occurred.

The older Federal ESRD regulations (Section 45.2138(b)(2)) allowed for transfer of patients for medical reasons or for the patient’s welfare or that of other patients, or for non-payment of fees. It required advance notice to ensure orderly transfer or discharge. However, this wording was rather vague. New Federal laws (494.70 and 494.180), provide additional regulations regarding involuntary discharge of a patient. Patients must meet one of four conditions to be involuntarily discharged and the steps shown in table 1 must be followed.

The four conditions are:

1. The patient or payer no longer reimburses the facility for the ordered services;
2. The facility ceases to operate;
3. The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs; or
4. The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired

These CMS guidelines require an attempt to place the patient in another unit but do not require that a unit be found. If no unit is found, the patient may be given lists of surrounding units, however, these are patients that have often been at other units or are known by staff from other units. Many of these, particularly on their own, will not find other dialysis units willing to accept them. That usually leaves the patient relegated to seeking medical care on an episodic basis from emergency rooms. This is clearly suboptimal care, but in comparison to their noncompliant treatments, may be similar.

From a nephrologist’s standpoint it is usually the chronic unit and not the nephrologist who has dismisses the patient. Yet without a unit to accept the patient, the nephrologist may have little choice but to also dismiss the patient. There are multiple laws and policies which must guide the nephrologist’s decision to refuse to begin chronic care for a patient or to terminate a patient from the physician patient relationship. These are shown in table 2.

By law, all ESRD patients are disabled. Patients cannot be discriminated on the basis of their disability. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), protect the disabled from discrimination. Efforts should be made to accommodate the patient including the accessibility of the unit. In the cases of non-compliant abusive patients and the decision to terminate their care, it is the behavior not the disability that drives the decision. It is critical that the documentation show that it was the disruptive or abusive behavior which led to the termination of care. Likewise, patients should not be refused at chronic units for disabilities which can be accommodated within the chronic dialysis system, for example hearing impairment, non-English speaking, or wheelchair use.

TheAMA Ethical and judicial affairs committee published their report in 2000 on the limits placed on physicians to choose their patients. This report only focused on accepting a patient not on continued care when a doctor-patient relationship already exists. First they stated that patients and physicians should be able to freely choose. However for physicians this choice is not absolute. Circumstances where the physician must treat are: emergency situations, patient characteristics (not on the basis of race, color, religion, national origin, sexual orientation or other discrimination, infectious diseases), and pre-existing contracts. There are justifiable reasons to refuse to treat. These are: a treatment beyond the physician’s current competence, invalid treatment requests, and conflicts with the physician’s religious, moral, or personal beliefs. The council also recognized that some patients may pose a physical threat not only to other patients but also to treating physicians. The issue of personal risk in treating a potentially violent patient was stated to deserve a more in-depth analysis then allowed by the report.

This AMA policy would cover nephrologists’ decisions not to accept a non-compliant abusive patient as a new patient but would not help with the decision to terminate the care of a dialysis patient. There is another AMA guide that at least addresses the violence issue. The AMA supports the violence free work place. H-5.997 Violence Against Medical Facilities and Health Care Practitioners and Their Families states:

The AMA supports the right of access to medical care and
Where does the nephrologist stand with a non-compliant, abusive dialysis patient?

opposes (1) violence and all acts of intimidation directed against physicians and other health care providers and their families and (2) violence directed against medical facilities, including abortion clinics and family planning centers, as an infringement of the individual’s right of access to the services of such centers. (Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99)

This ruling primarily addresses violence against family planning and abortion centers. However, the stance that the AMA would oppose violence and intimidation of physicians and other staff would be relative.

The rights to safety for the staff must be taken into consideration and the steps taken to ensure their safety. The Occupational Safety and Health Act of 1970 (OSHA) makes it the responsibility of the facility to ensure the safety of their staff and patients. Law enforcement should be contacted when physical aggression occurs or severe threats of harm are made.

Federal Regulations discussed above require advance notice and one documented attempt to place the patient in another unit. In the instance of non-compliant abusive patients, it may be impossible to find another unit to accept the patient prior to discharge. The guidelines published by renal networks (the administrative division of dialysis patients across the country) states that giving a list of other dialysis units and their phone numbers is adequate. The advance notice portion prohibits abandonment of the patient. A textbook definition of abandonment was set forth by the North Carolina Supreme Court in 1944. “Abandonment of a patient is the unilateral severance by the physician of the professional relationship between himself and the patient without reasonable notice at a time when continuing medical attention is still a necessity.”

Once a nephrologist undertakes treatment of a patient, i.e. establishes a patient-physician relationship, he or she has a continuing legal duty to treat that patient until the need for his or her services is at an end or until the physician-patient relationship is terminated lawfully. For chronic dialysis patients, short of a transplant, a patient will continue to need services as long as they are living. Nephrologists who improperly terminate a physician-patient relationship risk both civil lawsuits and charges of unprofessional conduct for patient abandonment. A patient suing for abandonment must prove that the injuries were a direct cause of the lack of care.

A Federal district court case addressed many of these issues.

In Brown v Bower, Brown, the patient, brought suit alleging several federal causes of action including civil rights statues, the Rehabilitation Act of 1973, the ESRD program of the Social Security Act, and the Hill-Burton Act. The court found no Federal cause of action against Dr. Bower individually. They recognized that in the past Dr. Bower had treated the patient for 10 years under very difficult circumstances including threats made to the doctor in person and threatening calls to his home. At the time of the suit Dr. Bower was not caring for the patient. The patient wanted the court to require Dr. Bower to accept him as a patient again. Although the court did not force Dr. Bower to accept the patient, it did order that the University Medical Center treat Mr. Brown. The court stated that since the medical center received Hill Burton funds it was required to offer its services in order to comply with the Hill-Burton community assurance regulations. The court did impose conditions including that the patient be accompanied by a family member, that he refrain from abusive speech and that he conform to dietary regimen expected of a dialysis patient. As dialysis must be supervised by a physician, this then required the university nephrologists to care for the patient. This included Dr. Bower.

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a statute which governs when and how a patient may be 1) refused treatment or 2) transferred from one hospital to another when he is in an unstable medical condition. EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, and it is sometimes referred to as “the COBRA law”. EMTALA is also known as Section 1867(a) of the Social Security Act. It is included as part of the section of the U.S. Code which governs Medicare. The last amendment or clarification was in 2003. EMTALA applies only to hospitals which have provider agreements for the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

The primary purpose of the statute was to prevent hospitals from rejecting patients, refusing to treat, or transferring patients to other facilities because they were unable to pay or are covered under Medicare or Medicaid programs. The essential provisions of the statute are 1) Imposes an affirmative obligation on the part of the hospital to provide a medical screening examination by a qualified medical person, to determine whether an “emergency medical condition” exists, 2) Imposes restrictions on transfers of persons who exhibit an “emergency medical condition” or
where does the nephrologist stand with a non-compliant, abusive dialysis patient?

are in active labor, which restrictions may or may not be limited to transfers made for economic reasons; 3) Imposes an affirmative duty to institute treatment if an “emergency medical condition” does exist.

This would therefore cover the necessity of the emergency room and ER staff to evaluate the dialysis patient for an emergency medical condition. Dialysis patients who have missed treatments can have acutely life threatening conditions including hyperkalemia, hypoxia from volume overload, or severe acidosis. This does not answer the question if the lack of dialysis itself constitutes an emergency condition. The definition provided under the statute includes, “A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part...” In a patient with ESRD, stopping dialysis will result in death in days to weeks from hyperkalemia, acidosis, uremia, or volume overload.

Two cases have involved EMTALA issues. A case in Michigan involved a dialysis patient who sued Sparrow Hospital because he was banned from the outpatient dialysis center (Everett v Sparrow). The patient claimed he was terminated from the dialysis unit after filing a complaint of racial harassment against the hospital. The suit also stated that the hospital had published certain information or recommendations that caused other dialysis centers to deny him treatment. The suit claimed that EMTALA had been violated by denying him chronic dialysis. The hospital denied the EMTALA issues as chronic medical conditions are not covered by this law. Another argument against the use of EMTALA to decide this case was that at the time of suit, the patient was being dialyzed as an inpatient in another hospital, and therefore not in emergent need of dialysis. The patient had in fact, been held as an inpatient for the past two months in order to receive dialysis and the hospital did not plan to discharge the patient until a chronic unit could be found for him.

A California case, Payton v. Weaver, has also addressed whether chronic dialysis services constitute an emergency and whether a nephrologist can terminate the care of a patient. Ms. Payton was a 31 year old ESRD patient who Dr. Weaver had cared for approximately six years. She had consistently refused to follow his treatment recommendations, skipped dialysis treatments and was often disruptive and uncooperative and had a drug abuse problem. On several occasions her failure to show for her routine dialysis treatments had necessitated emergency room visits. Dr. Weaver gave the patient several weeks notice that he would no longer provide her with chronic dialysis or emergent care. She sued to force Dr. Weaver to continue her care. She based her suit in terms of “right-to-life”, claiming her need for dialysis was one of emergency care. The California trial court determined that this was not a life-or-death medical emergency as usually understood. Stating that if a dialysis patient follows the treatment regimen he/she does not become an emergency and that also because Ms. Payton sought ongoing chronic care not emergency care.

The court ruled that Dr. Weaver, following the acknowledged rule of Anglo-American common law was no longer required to dialyze Ms. Payton. However, because of the nature of the case, they did require Dr. Weaver to continue dialysis care while the case was under appeal. The appeals court agreed with the trial court that Payton’s need for ongoing ESRD treatment was not a medical emergency and that Weaver had no legal obligation to provide care to Payton. They did note the legal obligation to provide her with notice of termination in order to allow her to secure other care and they ruled that Dr. Weaver had met this obligation. The court also ruled in favor of her dialysis unit saying they were not under further obligation to continue to dialyze the patient when the patient had failed to fulfill her responsibilities as a dialysis patient. The court did recognize a responsibility of the dialysis community as a whole to maintain Ms. Payton’s life- a shared burden. This responsibility was never required by the Oakland area dialysis providers as Ms. Payton died shortly after the appellate decision.

The courts’ reasoning of the Anglo-American rule was that persons are not under a duty to rescue others in trouble. This involves the distinction between “misfeasance” and “nonfeasance.” “Nonfeasance” is a failure to act while “Misfeasance” is a failure to act properly once action is taken. Under the common law there is no legal liability for nonfeasance or failing to act at all, but there is legal liability for misfeasance. This also relies on two social and legal norms that the delivery of health care in the US is primarily a function of the free market economics which allows the patient-physician relationship to be established on a consensual basis and the constitutional prohibition against servitude.
Where does the nephrologist stand with a non-compliant, abusive dialysis patient?

In summary, ESRD patients, as disabled individuals, can not be discriminated against. The AMA recognizes the physician’s right to choose patients with some limitations on this right. Legal precedence supports the nephrologist not accepting a non-compliant or abusive patient as a patient. The AMA and OSHA require a violence free workplace. Nephrologists who have privileges at hospitals with emergency services are obligated to provide emergency care when life threatening events occur but this does not require acceptance of the patient as a chronic dialysis patient.

All efforts should be made by using behavior contracts, staff education, and goal setting to work with the patient to improve their compliance. Use of psychiatric help or substance abuse programs may also be of benefit. The renal network resources should also be utilized. If available, an ethics consult may also be helpful. Only after these interventions, if the patient continues to be non-compliant and abusive, which may include violent acts or threats of violent acts, legal precedence does support the termination of the doctor-patient or patient-facility relationship. This should include documentation of the behaviors and attempted interventions and their outcomes. A notice of termination should be given in writing, which by Federal law and agreed upon by Network guidelines usually is a thirty day notice. An effort should be made to find another nephrologist and/or dialysis facility which will accept the patient and at a minimum provide the patient with a list of other dialysis units within the area. Table 3 gives the general approach to caring for difficult or potentially difficult patients.

The seasoned physician now reviews the Hippocratic Oath statement “I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.” The nephrologist must decide then on whether to accept a patient or terminate a dialysis patient using judgment, legal knowledge and ethical considerations. The Oath does not focus on an individual patient- the decision must be the best action on behalf of the staff, other patients, and the non-compliant abusive patient.

Table 1: Steps for involuntary discharge and transfer according to the Conditions for Coverage for End-Stage Renal Disease Facilities: Final Rule

- The facility must inform (all) patients of their rights including the rules and expectations of the facility regarding patient conduct and responsibilities, the internal and external grievance policies and the discharge and transfer policies both for routine and involuntary.
- The governing body must assure that the facilities policies and procedures are followed by all staff.
- The medical director must assure that the patient is not discharged unless one of the four conditions are met and if the discharge is because the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired then the interdisciplinary team must do steps 4-9.
- Document the reassessments, ongoing problem(s) and efforts to resolve the problem(s) in the patient’s medical record.
- Provides the patient and the local ESRD Network with a 30-day notice of planned discharge.
- Obtain a written physician’s order that must be signed by both the medical director and the patient’s attending physician concurring with the patients discharge or transfer.
- Contact another facility, attempt to place the patient there, and document that effort.
- Notify the State survey agency of the involuntary transfer or discharge
- This procedure may be abbreviated in the case of immediate severe threats to the health and safety of others.

Table 2: Main laws, guidelines and legal cases regarding care of difficult dialysis patients

- Federal Law 494.70 and 494.180- Regulations for when and how a dialysis patient may be involuntarily discharged
- Section 504 of the Rehabilitation Act of 1973 and the Americans with Disability Act- Patients cannot be discriminated upon due to their disability
- Occupational Safety and Health Act of 1970 (OSHA)- Facilities must ensure the safety of the patients and staff
- Consolidated Omnibus Budget Reconciliation Act
Where does the nephrologist stand with a non-compliant, abusive dialysis patient?

of 1986 (last clarified 2003 sometimes referred to as the COBRA law), Emergency Medical Treatment and Active Labor Act (EMTALA) Section 1867(a) of the Social Security Act. – Facilities must provide emergency evaluation and treatment

- AMA guideline- Ethics and Judicial Committee report 2000- Discusses the limits placed on physicians to accept a new patient.

- AMA guideline H-5.997 Violence Against Medical Facilities and Health Care Practitioners and Their Families - Opposes violence and intimidation of physicians and staff

Legal Cases

- Brown v Bower- Facilities receiving Hill Burton funds can be required to treat the patient

- Everett v Sparrow- ESRD is a chronic condition

- Payton v Weaver- Missing dialysis does not in itself constitute a medical emergency requiring treatment, a physician can with notification stop caring for a patient, and the community did have a shared responsibility to dialyze the patient

Table 3: Approach to Difficult or Potentially Difficult Patients

- Be Knowledgeable- Know the Federal and state laws and physician standards for caring for patients

- Be Proactive- Evaluate new potential patient’s needs and potential issues including transportation, co-morbid conditions, substance abuse issues, social situations, and language barriers prior to accepting the patient. Once issues arise, address early rather than allow to build and become unmanageable.

- Team Work- Involve the patient, family, staff, care providers, ESRD network representatives and ethics consultants as needed to establish care plans and expectations

- Network- Work with other facilities to share ideas, and potentially difficult patients

- Document- Document behaviors, plans, modifications, and if dismissing the patient be sure that documentation shows that requirements were followed

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