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ADA implications for the physician's office

by Mary Kathleen Evans, JD

A disability can be very isolating, as it can prevent a person from moving freely in society. It can create hurdles to equal educational, employment, and commercial opportunities. To overcome barriers to equality for the disabled, the Americans with Disabilities Act of 1990 (ADA) was passed by Congress and signed by President George Bush on July 26, 1990. [1]

ADA's Title III states, "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." Physician's offices are included in the definition of "public accommodations." Therefore, no matter the size or number of employees, a physician's office must be accessible to persons with disabilities. [2]

After the ADA was enacted, there were a number of Supreme Court decisions construing the definition of "disability" restrictively. Congress later thought these decisions and the EEOC's original ADA regulations were not serving to achieve equality for the disabled. Thus, Congress passed the ADA Amendments Act of 2008 (ADAAA), which was signed into law by President George W. Bush on September 25, 2008. [3]

Final regulations implementing the ADAAA were issued by the Equal Employment Opportunity Commission (EEOC) on March 25, 2011. [4] The effect of the ADAAA and EEOC's final regulations is to make it easier for individuals claiming protection under the law to establish that they have disabilities. [5]

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Who is considered disabled under the ADA?

"I treat people for physical or mental problems; are all of my patients considered 'disabled' under the ADA?"

A person is disabled who has a physical or mental impairment that substantially limits one or more major life activities, or has a record of having such impairments. [6] A physical or mental impairment is broadly defined to include any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or any mental or psychological disorder, such as an intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

When determining whether the disability limits "major life activities," the term "major" shall not be interpreted strictly to create a demanding standard for disability. [7] Caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others and working are "major life activities." So is the operation of a major bodily function, including functions of the immune system, special sense organs and skin; normal cell growth; and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions. [8]

An impairment need not be permanent; one that is episodic or in remission is still considered a disability if it would substantially limit a major life activity when active. [9] Thus, breast cancer in remission (impairment in the major bodily function of "normal cell growth") may be considered a disability. [10] The effects of an impairment lasting or expected to last fewer than six months can be substantially limiting. [11] Thus people with conditions that interfere with mobility (joint pain, pregnancy, fatigue) or who have temporary activity limitations such as post-surgical restrictions or orthopedic injuries are included.

Likewise, "substantially limits" is not meant to be a demanding standard. [12] The EEOC claims that basic obesity, without any other underlying condition, sufficiently impacts the life activities of bending, walking, digestion, cell growth, etc., to qualify as a disability or perceived disability. [13] Chronic depression that affected eating, sleeping, thought processes, and caused feelings of hopeless and helplessness was considered a disability under the ADA. [14] Stuttering could substantially limit the major life activity of communicating. [15]

The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures. [16] Thus, asthma and allergies are still considered disabilities under the ADA, even if symptoms are controlled by medication.

Considering the breadth of "who" is a disabled person for whom accommodations must be made under the ADA, what does the ADA require of physicians? In general, the ADA requires reasonable modifications in policies, practices, or procedures that will allow the disabled patient to access the services offered by the physician. These accommodations must be made unless the physician can demonstrate that making the modifications would fundamentally alter the nature of the services rendered. Oftentimes, making such a demonstration to the satisfaction of the EEOC is a difficult burden.

What is a reasonable accommodation?

It is important that a person with a disability receives medical services equal to those received by a person without a disability. For example, if a patient must be lying down to be thoroughly examined, then a wheelchair-bound patient should not be examined in the wheelchair. Instead, accommodations must be made for the patient to be examined lying down. In this example, physical accommodations are required; an adjustable-height examining table is an ideal solution if it is readily achievable to obtain one. A reasonable accommodation might be for a physician to have the trained personnel to transfer a wheelchair-bound patient to a fixed-height bed, to have a padded examination table the height of a wheelchair, or to have physical implements installed in examining rooms or on examination beds that would allow a patient to self-transfer.

Services to a person with a disability must be rendered in the most integrated setting appropriate for the needs of the individual. [17] Thus, a physician cannot schedule all disabled patients at the end of the day. However, a physician can have all his disabled patients seen in a particular exam room, as long as that does not result in the disabled patient waiting longer to see the physician than a non-disabled patient.

What is the best way to choose a reasonable accommodation?

Open communication can be the best ADA compliance tool. The choice of accommodation is best made in consultation with the patient, while the final choice rests with the physician.

For example, a physician is not required by the ADA to acquiesce to a hearing-impaired patient's demand for a live interpreter for each and every patient encounter. Instead, a physician may decide to have a live interpreter for the first encounter with a hearing impaired patient, but during follow-up encounters, written notes can achieve the communication necessary for the patient's care. The interpreter must be able to interpret effectively and accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary, but does not have to be "certified."

A physician is not allowed to require a patient to bring a companion to interpret for the patient, but may rely on a companion for interpretation if the patient so desires. [18] In addition, a physician should not rely on a minor child to interpret for the patient, except in an emergency. [19]

Modifications in a physician's policies can be a required accommodation. For example, a medical office with a strict "no pets allowed" policy must modify the policy by making an exception for service animals used by persons with disabilities, including a hearing dog. Inquiry into the nature of the disability, or requiring "proof" or identification of the person's disability or the animal's training, is prohibited by the ADA. Access may be denied if the animal would compromise health and/or safety standards, such as in an operating room. However, in such a situation, the physician must give the patient the opportunity to be treated without having the service animal on the premises. Note that the physician is not responsible for the care or supervision of a service animal. [20]

The ADA does not require a physician to provide an auxiliary aid or service if it would cause the physician an undue burden or would fundamentally alter the nature of the services normally provided. [21] An undue burden is something that involves significant difficulty or expense, although cost alone is not determinative. [22] It is not considered an undue burden if the cost of the auxiliary aid or service exceeds the amount the physician will receive for treating the patient. The physician may not impose a surcharge on the disabled patient for the provision of any accommodation including auxiliary aids and services. [23] As a practical matter, it may be difficult to show that an auxiliary aid or service would fundamentally alter the nature of the services normally provided by a physician in most cases.

The ADA does not require a physician to provide a disabled patient with personal devices, such as wheelchairs; individually prescribed devices, such as prescription eyeglasses or hearing aids. [24]

Physicians must remove architectural and structural communication barriers in existing facilities where readily achievable. Otherwise, they must provide readily achievable alternative measures. Thus, moving a filing cabinet from a hallway that is impeding wheelchair access is a readily achievable accommodation. However, if a support column impedes wheelchair access to a hall, then modifying procedures to allow a wheelchair-bound patient to enter through the physician's private office entrance may be required to achieve the accommodation. Or if no barrier removal options are readily achievable, the physician must provide service through readily achievable alternate methods. For example, a physician could examine a patient at no additional charge at a hospital where the physician had privileges or at the patient's home.

The ADA has extensive technical architectural and structural requirements for accessibility implemented through the ADA Accessibility Guidelines. These include, for instance, specifications for ramps, curbs and steps, door width, elevators, restrooms, etc., which are too extensive to describe in this article. It bears noting, however, that a doctor with an office located in a private home is required to make all areas of the home used by patients accessible to patients who use wheelchairs or other mobility devices if it is readily achievable to do so. [25] As with other public accommodations, barriers at the entrance to the home office, as well as barriers to approaches, restrooms, and hallways, must be removed if readily achievable.

Are individuals other than patients also protected by the ADA?

Yes, the physician's obligations under the ADA may apply to non-patients. For example, if a parent who is blind is required to grant consent for his or her child's surgery, the consent form must be communicated effectively to the blind parent. In most cases, this can be accomplished by reading the consent form or by providing the form in Braille or on audio recording.

Can a physician refer a disabled person to another doctor?

A physician can refer a patient with a disability to another doctor, if the treatment sought is outside the physician's area of specialty and he would have made a similar referral if a non-disabled person sought the same services. [26] So a physician who exclusively treats burn patients may refer an individual who is not seeking burn treatments to another provider. But, that same doctor cannot refuse to treat a patient who is seeking burn treatment because that patient is HIV-positive.

Practice eligibility requirements are prohibited

A physician practice cannot set up eligibility requirements that operate to screen out persons with disabilities. [27] Thus, having a policy that requires patients who pay by check to show a driver's license could be interpreted as screening out the visually impaired. Even setting up special times to see disabled patients (i.e., at the end of the day) could be considered to be a failure to modify practices and procedures to accommodate the disabled, because it is not equal access. [28]

What if the disabled person is a direct threat to other patients?

If a physician has determined that a disabled person represents a direct threat to the health and safety of others, the physician may decide not to treat that person. However, such a determination must be based on an individualized assessment — using reasonable judgment that relies on current medical knowledge or on objective evidence — that the physician cannot eliminate the risk without reasonable accommodations. [29]

Written policies and staff education

"I've received a complaint from the TMB that I refused to make an appointment for a patient with a disability because I did not have the right equipment in my office. I've never spoken to or treated this person who made the complaint."

Oftentimes, a physician is not personally apprised of a patient's disability or request for accommodation; instead the patient or prospective patient tells the physician's staff. For this reason, a physician should have written policies to address how the staff should handle disabled patients and their requests for accommodations. The physician should educate employees about how to handle requests for accommodations, and require the staff to

apprise the physician of any such requests. It is the physician who needs to make the ultimate decision, as it is the physician who will be held accountable.

Conclusion

The breadth of the ADA's definition of a disability leads the physician to the best practice of assuming the disability claimed and providing a reasonable accommodation. Open dialogue between the patient, the physician's staff, and the physician is the most likely path to achieving parity for the disabled and protecting the physician from untoward scrutiny.

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Clarification

In the article "Prescription monitoring program now available online" — published in Volume 4 of *the Reporter* — physicians were advised to document their query of the Texas Prescription Program database. We would like to clarify that in the patient's chart, the physician should only document the fact that the physician queried the database and what action was taken as a result of that query.

For example, "Queried DPS prescription database on September 1, 2012. Patient will not receive refills for hydrocodone."

Do not document in the chart the substantive information obtained from the database. The reason for this is that the law states that the information in the TPP database is for the exclusive use of the physician or pharmacist. If added to the patient's medical record, the information could be sent to others, such as when the records are released to another health care professional.

Terminating the patient-physician relationship: breaking up is hard to do

By Tanya Babitch and Laura Hale Brockway, ELS

Objectives

At the conclusion of this educational activity, the physician should be able to:

- recognize common reasons for termination of the patient-physician relationship;
- identify circumstances that may preclude or complicate termination of the patient-physician relationship; and
- develop strategies to terminate the patient-physician relationship when appropriate.

Course authors

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Disclosure

The authors have no commercial affiliations/interests to disclose related to this activity.

Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

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Introduction

One of the unique challenges of practicing medicine is deciding when the patient-physician relationship has reached the end of the road. Coming to the conclusion that it is time to part ways with a patient is never easy for physicians and is often accompanied by conflicted feelings. While medicine is a business, it is a business that comes with an ethical duty to patients. No physician is immune from the instinct to continue helping and caring for patients, even when it becomes difficult to do so.

Physicians vary a great deal in how they manage challenging patients — some choose to continue care and some find that they feel most comfortable ending the relationship. Neither is right or wrong, but physicians are within their rights to end a relationship that is no longer therapeutic. At the same time, however, physicians are obligated to "do no harm" to their patients. Prior to termination of the relationship, physicians should evaluate the case to ensure that the patient is not at a critical stage in treatment, will be given appropriate notice, and has the opportunity to find another physician.

Formal termination of a patient-physician relationship is only required if a relationship has actually been established. Once a relationship has been established, a physician owes the patient a duty of care. There may be some situations in which the formation of a relationship is nebulous. Physicians should assume that a relationship exists if they have offered any treatment — even if not in person. Advice given over the telephone or through electronic means is still medical advice and may establish a relationship. If in doubt, it is prudent to assume the relationship has been established and a duty to care for the patient exists.

Ending the relationship without appropriate notice could be considered a breach of this duty. "The patient-physician relationship is the result of a contract, express or implied, between a physician and patient that is voluntary and arises when a patient requests and is supplied medical information/treatment."[1] While both physician and patient have the right to terminate the relationship, the requirements for ending the relationship are more complicated for physicians.

Risks of failing to terminate the relationship appropriately

The Texas Medical Association's Board of Councilors ethics opinion on termination of the patient-physician relationship states, "The patient-physician relationship is wholly voluntary in nature and therefore may be terminated by either party. However, physicians have an ethical obligation to support continuity of care for their patients. Thus, it is unethical for a physician to terminate the patient-physician relationship without first providing reasonable notice under existing circumstances of the physician's intent to terminate the professional relationship. To terminate the patient-physician relationship without such notice may result in civil liability for abandonment."[2] In addition, lack of appropriate notice to the patient may put the physician at risk for a patient complaint and possible disciplinary action from the Texas Medical Board.

Reasons to end the relationship

Patient noncompliance with recommended treatment is a common reason physicians give for dismissing patients. Other reasons include failure to keep appointments, abusive or rude behavior to the physician or staff, or because the patient has an outstanding balance they do not attempt to pay. In addition, patient commitment of prescription fraud or failing to comply with the requirements of a pain management contract may be a cause for termination of the relationship. All of these reasons are acceptable, but some exceptions may apply. Physicians are encouraged to review possible termination on a case-by-case basis; one policy may not fit all when it comes to ending a relationship with a patient.

Proceed with caution

Physician practices are subject to state and federal civil rights laws. "A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the

public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination."[3-4] Additionally, a patient cannot be dismissed because he or she has been diagnosed with HIV/AIDS.[4]

Discrimination against patients with disabilities is prohibited by the Americans with Disabilities Act, and termination of the relationship due to the patient's disability would be considered discriminatory. "The ADA prohibits places of public accommodation, such as physician offices, from discriminating against disabled individuals in the provision of goods and services… a deaf patient successfully sued his physician for discrimination under the ADA after being discharged as a patient. The discharge occurred because the physician lost the only employee in his office who could communicate with the patient in sign language. The court held that instead of firing the patient, the physician should have made a reasonable effort to accommodate him by furnishing him written materials or using other methods to facilitate communication."[5] (For more on ADA requirements for physicians, please see article on page 1.)

Insurance providers may require that physicians either contact them or get permission to terminate the relationship before ending the relationship. Contracts with providers may require that physicians provide care to all covered patients, and may have requirements about "firing" a patient. Physicians should review contracts so that they are aware of any limitations or restrictions about ending the patient-physician relationship.

Hospital call requirements generally do not allow an on-call physician to refuse care to a patient — even if the patient has previously been dismissed from the on-call physician's outpatient practice. If a physician is taking formal call for a hospital, bylaws or hospital contracts generally require that the physician care for the patient.

Physicians should review hospital call requirements so that they are familiar with what they have agreed to. If an on-call physician treats a patient that he or she has previously terminated, it may be prudent to inform the patient that the hospital care does not re-establish the relationship once the patient has been discharged.

Termination for nonpayment

Physicians are entitled to end relationships with patients who refuse to pay their bills. However, physicians are discouraged from setting up blanket policies that allow staff to terminate relationships for nonpayment without physician review of the case. There may be circumstances in which the physician is aware but the staff is not. For example, a physician may know that a patient is undergoing a financial hardship, that a patient was not satisfied with his or her care, or that there was an outcome that was less than desirable. Careful review of the patient's record before sending a termination letter may mitigate patient complaints, and could ward off a Texas Medical Board complaint. There are times that physicians may review the case and determine that they are willing to work with the patient on payment.

While it is reasonable to terminate the relationship for nonpayment, physicians should not refuse appointments to existing patients for nonpayment. "A physician should not deny an established patient an appointment or cancel an appointment because of an unpaid balance. This results in a person being considered a patient one day and not another, depending on how the office staff feel about the size of the unpaid balance. As long as the patient-physician relationship is established and not definitively terminated, a physician owes the patient the same duty of care, otherwise there is a danger of abandonment."[6]

Physicians are encouraged to offer counseling and payment plans to patients before dismissal for nonpayment. These efforts should be documented in the billing portion of the patient's record. If efforts to collect are unsuccessful, practices may wish to send a warning letter that explains failure to pay the outstanding balance may result in termination of the patient-physician relationship. (Please see sample letter on page 10.)

If the patient does not contact the office in response to the first letter, send a second letter stating that the patient-physician relationship has been terminated. (Please see sample letter on page 10.) If the patient does contact the office and requests copies of the medical records, be aware that the patient's medical record cannot be withheld from another physician or from the patient because of an overdue account.

Difficult situations

Terminating the patient-physician relationship while the patient is in the **postoperative period or in an acute medical episode** is generally not recommended. Physicians should, whenever possible, care for the patient until they are safely through the postoperative period or acute episode — unless they can find another physician who will accept the patient and can facilitate a seamless transfer of care.

It may also be difficult to discharge **a patient in the last trimester of pregnancy**. It may not be feasible for these patients to find another physician who will accept them past 28 weeks. If a transfer of care is arranged, the physician should document the name of the new physician, that the records were sent, and that the patient has an appointment with the new physician.

If a transfer of care cannot be arranged, it is likely that a physician will need to continue treating the patient through the postpartum period. Additionally, before terminating the relationship with a pregnant patient, physicians should consider that their call duties may eventually require them to deliver a baby for a patient who has been dismissed from the practice.

Termination of the relationship with **pediatric patients** presents a challenge for physicians. Noncompliance and nonpayment are not generally the patients' fault or responsibility. If it is possible to work with the parents to improve compliance, physicians are encouraged to try. Noncompliance should be well documented in the chart. If parents are noncompliant with treatment recommendations to an extent that the patient may be harmed, it may require a call to Child Protective Services instead of simply

terminating the relationship. If the physician's relationship with parents is untenable, it is reasonable to dismiss the patient from the practice.

Patients with mental health issues may require extra patience on the part of the physician. Physicians should avoid terminating the relationship with a patient in a psychiatric crisis or with suicidal thoughts. If the treating physician is a psychiatrist, the physician "should also discuss why he does or does not believe it is important for the patient to continue in treatment, and the potential risks of not continuing treatment. This is particularly important when discussing continuing medications: for example, abruptly stopping some psychiatric medications can carry significant medical risks. The psychiatrist should be wary of prescribing large amounts of medications around the time of termination. If the patient experiences an adverse reaction to the medication but is not yet under the care of another psychiatrist, the original psychiatrist may be found liable even if the proper termination process was followed.

The most conservative approach is not to prescribe beyond the termination date. It is important to remember, however, that this process must be tailored to the needs of the individual patient. So, in a case where the psychiatrist makes a medical decision to prescribe or refill after termination, the implications for the termination process should be clear to the psychiatrist and communicated to the patient. The termination date may need to be extended or, possibly, the entire termination process begun again." [7]

Rural providers may find it more difficult to dismiss patients due to a lack of available specialists. If a patient needs continued care and there are no other physicians to provide it, physicians may need to be flexible. Offering payment plans to patients facing financial hardship and continuing to treat noncompliant patients may be necessary.

If a **patient has filed a lawsuit or a complaint with the Texas Medical Board** against a physician, the physician cannot assume that the relationship has automatically ended. Physicians are not required to end the relationship with a patient who has sued them or filed a complaint — although many wish to do so as soon as possible. If a physician feels he or she can offer the patient quality care without bias, the physician may decide to continue the relationship. If a physician wants to dismiss a patient (and there is indication that a patient plans to return to the practice), ending the relationship will still require formal termination via letter, with appropriate notice.

Steps for appropriate termination

Risk managers recommend that physicians develop a standardized process for dismissing patients. "Our process provides patients with plenty of opportunities to reconsider their behavior and re-engage in the relationship, when appropriate, and it provides the physician and staff the assurance that comes with following a reasoned, consistent approach when difficult circumstances arise." [8]

Prior to termination, physicians may wish to try counseling the patient to improve noncompliant or disruptive behavior. Any counseling should be documented in the patient's record. In addition, a warning that the continued behavior may mean an end to the patient-physician relationship may be a surprise to the patient.

Physicians who are tempted to forego the counseling process may be missing an opportunity to understand the cause of the patient's noncompliance. "Taking time to sit down with the patient with the goal of better understanding expectations or needs that are driving his or her behavior can be valuable. Some patients have unreasonable expectations, but for others, understanding the point they're trying to make can go a long way in repairing the relationship. Learning about the root cause of their dissatisfaction can help us improve the delivery of care to all our patients." [8]

A similar counseling process should be employed for patients who miss appointments or who exhibit rude behavior. "Direct statements such as, 'If you do this again, we will no longer care for you, and you will have to go to another practice,' can be quite eye-opening for some patients." [8] Again, document these discussions in the medical record.

If the counseling process is not effective and the physician decides to dismiss the patient, the next step is to send a dismissal letter to the patient. The letter should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. The dismissal letter should include the following elements.

- It should include a statement that the patient-physician relationship will terminate in a specified time period and a recommendation that the patient find another physician. The time limit given in the letter will depend on several factors such as physician specialty, size of community, and availability of other physicians. The patient should be given a reasonable amount of time to find a new physician. The current physician should remain available for care until the specified time period elapses.
- While the American Medical Association suggests "providing the patient with a brief explanation for terminating the relationship," [9] physicians are not required to state a reason for the termination. Any potentially inflammatory remarks should be left out of termination letters. Angry words to a patient — especially in writing — could be damaging to a physician. It may be more advantageous to exclude specific reasons or to include only neutral statements. While composing termination letters, physicians may wish to consider whether they would be comfortable with the wording of the termination letter if it were later reviewed by the Texas Medical Board, an attorney, or a jury.
- Describe in general terms how the patient can locate a new physician. It is not advisable to name a specific physician, clinic, or group. Refer the patient to their insurance company's list of providers, county medical society, or a physician-referral service.

Patient termination — frequently asked questions

Q: I saw a patient for prenatal care, but she was noncompliant in keeping her appointments. I formally ended the relationship with her (with appropriate notice) during the second trimester of pregnancy. She began seeing another local obstetrician whom I share call with. She is now at the hospital, and I have been called to deliver her baby. Am I required to do so, since I ended our relationship?

A: Your call agreement probably requires that you do so. Although you ended the relationship, if you share call with her current physician, you assume the duty to care for his patients when needed. Unless you have worked out special coverage with the other physician in these types of cases, you are most likely obligated to respond. However, it is reasonable to ask the patient to return to her physician for postpartum care; she is still his patient.

Q: I am a pediatrician and I see a child whose parents are divorced. The parents have joint custody and disagree on almost all aspects of care. We receive angry calls from one parent or the other after almost every appointment. It is not the patient's fault, but the situation has become unpleasant for my staff and I. May I terminate the relationship?

A: You may wish to try to discuss the issues with each of the parents to improve the situation. But if a resolution cannot be reached, it is acceptable to terminate the relationship. It is recommended that you wait until the child is well and does not have a scheduled appointment to send dismissal letters to the parents.

Q: I am an internist and have been seeing a patient for several years for chronic health issues. Recently, I received a written request that the record be sent to another local internist. The records request indicated that it was for a "transfer of care." Since it appears that the patient has decided to change physicians, do I need to send a termination letter?

A: If it seems clear that the patient has chosen to see another physician, consider sending a confirmation that the patient has ended the relationship with you. (Please see sample letter on page 10). If you would rather not give the patient the option of coming back to you, sending a letter that confirms the termination of the patient-physician relationship "closes the loop." If you would be willing to see the patient again, ask staff to call the patient and confirm that the patient has transferred care to another physician. This clarifies that the patient is receiving care elsewhere and that follow-up care has not been neglected. Any communication regarding the patient's transfer (by telephone or by letter) should be documented in the chart.

- Include an authorization for the release of the medical record and advise the patient to designate the new physician as soon as determined, sign the form, and send it to your office promptly. Indicate in the letter that the record will be copied and forwarded to the physician as soon as possible. Since you are ending the relationship with the patient, you may choose to forego copying charges for the medical record to avoid engendering additional bad feelings.
- Additionally, physicians may not withhold a copy of the patient's medical record because of an outstanding account balance.

Keep a copy of the dismissal letter and the return receipt in the patient's medical record. Once the time period specified in the letter has passed, the physician no longer has to treat the patient.

You are not *required* to dismiss noncompliant or difficult patients

Physicians with nonpaying or noncompliant patients may sometimes choose to keep a patient. Patients may have financial or social limitations that the physician sympathizes with. In these cases, there is no requirement to end the relationship. However, if continuing treatment with a noncompliant patient, documentation is extremely important. In the event of a poor medical outcome, the medical record will become a physician's best defense against allegations of inadequate care.

The patient's repeated noncompliance should be documented in detail, and all the physician's recommendations and steps taken to assist the patient in his or her treatment should be included in the record. In particular, physicians should carefully document that they repeated the treatment recommendations, that the patient was unwilling or unable to comply, and that they discussed the risks of noncompliance at length.

Confirming when the PATIENT ends the relationship with YOU

When a patient notifies the physician or staff that the patient does not intend to return to the practice, confirm it by sending a letter to the patient. Since it is likely that you share the patient's desire that they not return, it may be beneficial to formally close any loopholes. TMLT's risk management department receives numerous calls about patients who have angrily stated that they will never come back to a practice — and then they call for another appointment. If a patient orally ends a relationship and the physician is certain that they would also like to end the relationship, formal written confirmation is recommended.

If physicians are part of a group practice, consider formally terminating the patient's relationship with the group — not just one physician. If other physicians in the group would prefer not to see the patient, the termination letter should clearly state that the relationship with both the physician and the group are ending.

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Sample termination letters

When a physician decides to dismiss a patient, the patient should be notified in writing. The letter should be printed on office letterhead and sent by first-class mail and by certified mail with a return receipt requested. A blank authorization to release medical records should be enclosed.

Termination of the physician-patient relationship

Date　　Certified receipt # ________
[patient address]　　Also sent first-class mail.

Dear [patient name]:
Please be advised that I (and/or_____Group) will no longer be able to treat you as a patient. The termination of our physician-patient relationship will be effective in 30 days from the date of this letter. Your medical condition requires continuing physician supervision, and it is important for you to select another physician as soon as possible.

Contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, a copy of your medical record will be sent to your new physician. A release form is enclosed.

Sincerely,
[physician name]

Confirmation of patient-terminated relationship

Date　　Certified receipt # ________
[patient address]　　Also sent first-class mail.

Dear [patient name]:
This letter is sent to confirm your decision to discontinue care with me. Your medical condition requires physician supervision, and it is important for you to select another physician as soon as possible. I will be available to you until [30 days from date of letter].

Please contact your insurance plan or the county medical society for names of other physicians. Upon written authorization, I will provide a copy of your medical record to your new physician. A release form is enclosed to expedite the process.

Sincerely,
[physician name]

Non-payment notice/warning

Date　　Certified receipt # ________
[patient address]　　Also sent first-class mail.

Dear [patient name]:

It has come to my attention that you have received several letters regarding your outstanding account. If there has been a problem or if you are unhappy with the care that you have received in this practice, please contact me to discuss the situation. You are important to us, and I hope we can resolve any issues you have.

My business manager is also available to discuss payment of your account or to implement payment arrangements if they are needed. Should we not hear from you within 30 days, I believe that it would be mutually beneficial to terminate the physician/patient relationship so that you may locate a new physician.

I hope that we will hear from you in the near future.

Sincerely,
[physician name]

Termination for non-payment

Date　　Certified receipt # ________
[patient address]　　Also sent first-class mail.

Dear [patient name]:

On [date], I sent you a letter requesting that you contact the business manager or me regarding any problems that may have occurred resulting in non-payment of your account. In the letter, I stated that it would be necessary to terminate our physician/patient relationship if we did not hear from you.

Since we have not heard from you, please be advised that I will no longer be able to treat you as a patient. The termination of our relationship will be effective in 30 days from the date of this letter.

A release form is enclosed for your written authorization. Please contact us with the name of your new physician so we may forward your records to his or her office. At that time, your account will be closed.

Sincerely,
[physician name]

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Make sure staff is not left at a disadvantage. Keep staff informed and update systems appropriately. If your scheduling software allows alerts, use them! If a formally dismissed patient calls for an appointment, staff will immediately see that the relationship has been terminated and can act accordingly. In the alert screen, note the date that the termination letter was sent so staff can judge whether the patient is calling within the 30-day "window." If they are within the 30 days, staff should offer an appointment, but may wish to discuss the situation with the physician.

In summary, if done judiciously and with appropriate notice, termination of the patient-physician relationship need not be detrimental to either party. Careful review of each case by the physician is key — patients should not be terminated from the practice "automatically" or as a matter of policy. While physicians must be cautious when ending relationships with patients, it is generally within physicians' rights to do so.

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CME test questions

Instructions: Using black ink, read each question, select the answer, and then clearly mark your selection. Under newly revised AMA guidelines, physicians are now required to complete and pass a test following a CME activity, in order to earn CME credit. A passing score of 70% or better earns the physician 1 CME credit. Physicians will be allowed two attempts to pass the test. Please fax the completed test and evaluation forms to the Risk Management Department, attention Beni Donnelly 512-425-5996. You can also mail the test and evaluation forms to the TMLT Risk Management Department, attention Beni Donnelly, P.O. Box 160140, Austin, Texas 78716-0140. A certificate of completion will be mailed to the address you provide on the CME evaluation form.

Effective January 2012, new pricing will take effect for Reporter CME courses.

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This form can also be completed online at www.tmlt.org/reportercme

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1. Failure to appropriately terminate the patient-physician relationship may place physicians at risk for disciplinary action from the Texas Medical Board.

O a. true

O b. false

2. If a patient is repeatedly noncompliant with treatment recommendations,

O a. physicians are required by the Texas Medical Board to end the patient-physician relationship.

O b. the physician's discretion should determine whether to terminate the relationship.

O c. physicians should not terminate the relationship; noncompliance is never an adequate reason for termination.

3. Physicians should never terminate the patient-physician relationship due to nonpayment.

O a. true

O b. false

4. When dismissing a patient from the practice, it is recommended that physicians

O a. send a letter via first class mail.

O b. send a letter via first class mail and certified mail.

O c. ask staff to contact the patient to notify them that they have been dismissed from the practice.

5. Physicians are required by Texas law to give patients a reason for termination of the patient-physician relationship.

O a. true

O b. false

Statement of completion

I attest to having spent ______________ hours in this CME activity.

Physician signature ______________________________ Date ______________

Volume 5 2012

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CME evaluation form

Please complete the following regarding the article, "Terminating the patient-physician relationship."
Please fax the completed evaluation with the CME test questions.

1. The objectives for this CME were met. O Yes O No
2. The material will be useful in my practice. O Yes O No
3. Did you perceive any evidence of bias for or against any commercial products? If yes, please explain.

   O Yes O No
4. How long did it take you to complete this learning activity?

   O .5 hr O .75 hr O 1 hr O 1.25 hrs O 1.5 hrs
5. On a scale of 1 to 5, with 5 being the highest, how do you rank the effectiveness of this activity as it pertains to your practice?

   O 1 O 2 O 3 O 4 O 5
6. What will you do differently in your medical practice after reading this article?
7. Suggestions for course improvement are:
8. Suggestions for future topics include:

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Volume 5 2012

Failure to monitor patient's anticoagulation

by Louise Walling and Laura Hale Brockway, ELS

Presentation

A 77-year-old man came to a vascular surgeon. The patient had a history of leg swelling, pain, and redness, and had been treated with warfarin for claudication and chronic DVTs.

Physician action

The vascular surgeon diagnosed severe left leg venous insufficiency with venous stasis ulcers. He performed an endovenous laser ablation of the left greater saphenous vein. The procedure was successful.

Six months passed and the patient returned with complaints of chronic numbness and pain in the left leg. A venous duplex revealed no evidence of acute DVT, but the patient had chronic phlebitis changes of the left superficial femoral vein where the previous DVT had been. The vascular surgeon prescribed pregabalin for peripheral neuropathy and told the patient to return in six months.

The patient returned one month later complaining that his feet were so swollen he could not wear shoes. He had recently broken his right ankle. A venous duplex revealed that the patient had calf vein thrombosis in the posterior tibial vein. The vascular surgeon documented that the patient was at a high risk of developing an extension of the thrombosis into the deep veins. He prescribed enoxaparin and warfarin and asked the patient to visit a wound care center the next week for compression therapy. The patient was told to return in one month.

One month passed, and the patient returned after undergoing therapy. Doppler studies confirmed venous stasis disease as Class 4 to 5, and the patient was scheduled for right leg endovenous radiofrequency ablation. The vascular surgeon instructed the patient to continue wearing compression stockings. He also ordered a PT/PTT/INR and circled "next available." The vascular surgeon advised the patient to have the test performed the next day. When he later learned the patient missed the appointment to have his PT/PTT/INR drawn, he called the patient and told him to discontinue the warfarin. This phone call was not documented in the medical record.

Four days later, the patient returned for his ablation of the right greater saphenous vein from the saphenofermoral junction to the knee. The patient's warfarin levels were not checked before surgery. The patient tolerated the procedure well and the vascular surgeon noted good hemostasis in the surgical record. The leg was wrapped in multi-layer compression wraps and the patient was discharged in excellent condition.

The patient's son reported that he went to see his father the next day and noted that the leg was still bleeding. When he asked his father if the vascular surgeon had been notified, the patient responded that the office told him this was not unusual and to keep his appointment in two days. The vascular surgeon denied that his office was ever contacted by the patient or his family about the continued bleeding. If this had occurred, the patient would have been instructed to go to the emergency department.

The next day, the patient was found dead by his son. The autopsy report noted that the patient had placed a large plastic bag around his leg and there was about a half a gallon of blood in the bag. The cause of death was listed as "exsanguination status post recent endovenous radiofrequency ablation procedure."

Allegations

A lawsuit was filed against the vascular surgeon. The allegations included:

- failure to order PT/PTT/INR labs when he started the patient on anticoagulants;
- failure to obtain PT/PTT/INR labs prior to the surgery; and
- discharging the patient without collecting labs.

Legal implications

The plaintiff's expert was critical of the defendant for his failure to order and ensure PT/INR testing was done before the ablation procedure. He stated that the standard of care requires PT/INR testing before and after receiving warfarin therapy. He also criticized the defendant for performing the ablation procedure before the patient's recent fracture and DVT were given adequate time to heal. This expert also noted that the patient did not receive proper instructions on what to do if he experienced postoperative bleeding.

Vascular surgeons who reviewed this case for the defense stated that the patient's warfarin levels should have been checked before the surgery and the warfarin should have been discontinued at least 4 to 5 days before the ablation. Unfortunately, the defendant did not document his conversation with the patient to discontinue the warfarin.

Risk management considerations

Managing anticoagulation therapy in a patient with a history of claudication and DVT's requires vigilance, close patient monitoring, and good documentation.

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This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Failure to assess and communicate

by Louise Walling and Laura Hale Brockway, ELS

Presentation

A 65-year-old man was diagnosed with an 8-cm asymptomatic abdominal aortic aneurysm on December 14. He was admitted to a local hospital on December 17 for treatment. Although the patient had a history of chronic obstructive pulmonary disease, he had quit smoking four years earlier. His physician cleared him for surgery.

Physician action

On the morning of December 20, a vascular surgeon performed an endovascular repair of the abdominal aortic aneurysm. He and the assistant surgeon reviewed intraoperative angiograms to confirm placement of the stent. The surgery went as expected and the patient tolerated the procedure well.

A radiologist reviewed the intraoperative angiograms four hours after the surgery and noted that the endovascular stent graft was in place. He noted that the top of the stent graft was at level L-1, but commented that the renal arteries were "not well seen." He recommended that the angiographic images be correlated with clinical history and the surgical findings. There was no communication from the radiologist to the vascular surgeon about the over-read of these films.

Six hours after the procedure, the patient began experiencing severe back and abdominal pain and had a sudden drop in urine output. The vascular surgeon was notified two hours later. He ordered a renal duplex scan that revealed no blood flow to the kidneys, no visualization of urine in the bladder, and no evidence of hydronephrosis. This was reported at approximately 2 a.m. on December 21.

At 11:30 a.m. on December 22, the vascular surgeon took the patient back to the OR for revision of the stent graft. During the procedure, the vascular surgeon documented the presence of an occlusion of the renal arteries, so he moved the graft distally by 2 to 3 mm. A selective catheterization of the left renal artery was completed. Once good flow to the left renal artery was produced using an 8 x 15 stent, catheterization of the right renal artery was performed deploying a 6 x 15 stent. The final angiographic study showed patency of both renal arteries.

Postoperatively, the patient's creatinine values worsened and he experienced decreased urine output. He required hemodialysis. The patient also developed pneumonia and was treated with IV antibiotics. He was discharged in stable condition on January 4, but lost function of both kidneys. He required renal dialysis for the remainder of his life.

Allegations

Lawsuits were filed against the vascular surgeon and the radiologist. The allegations included:

- failure to properly, adequately, or timely assess the patient's medical condition (vascular surgeon);
- failure to timely administer proper medical care (vascular surgeon);
- failure to properly interpret the intraoperative angiograms (vascular surgeon); and
- failure to immediately communicate findings from the over-read of the angiograms (radiologist).

Legal implications

Physicians who reviewed this case for the plaintiffs and for the defense felt that the aortic stent graft was deployed in a position that blocked the renal arteries. The vascular surgeon testified that he saw good blood flow to the renal arteries during the latter phase of the endovascular repair. Although he surmised that the aortic stent graft must have migrated, he was unable to find any published studies showing that a graft could migrate proximally.

The radiologist correctly identified the problem, but there was no record that he communicated these findings to the vascular surgeon. The vascular surgeon testified that he did not ask the radiologist to report to him about the findings and he did not review the radiology report since he performed the procedure and saw the intraoperative angiograms. Further, the vascular surgeon testified that he would expect the nurses to report any postoperative symptoms such as back pain, flank pain, and lack of urine output immediately.

Risk management considerations

Communication issues are frequently a focus in malpractice suits and can be identified at various levels — physician to physician, staff to physician, or physician to patient. The vascular surgeon did not read the radiologist's report or request communication from the radiologist. The radiologist did not orally report his findings to the surgeon. In conjunction with their specialty society guidelines, physicians would benefit from developing methods to prevent communication breakdowns.

The American College of Radiology has published guidelines that include a course of action to take when reviewing films that may require "non-routine communication." "Routine reporting of imaging findings is communicated through the usual

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This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

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Ordering the PT/PTT/INR testing at critical times and implementing a process to track those patients on anticoagulation therapy is prudent risk management. If a physician calls a patient with a change in the treatment plan, it is advisable for this change to become part of the written medical record. Phone calls can serve as a key factor in a patient's health record. Staff should be educated to document patient phone calls and follow up to no-show appointments. Establishing a written policy on these processes may be used in staff training and training new employees.

When the procedure is performed within the practice, providing a copy of the patient's written post-procedure instructions in the medical record and documenting a statement that questions were addressed can also be helpful.

Disposition

This case was settled on behalf of the vascular surgeon.

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channels established by the hospital or diagnostic imaging facility. However, in emergent or other non-routine clinical situations, the interpreting physician should expedite the delivery of a diagnostic imaging report (preliminary or final) in a manner that reasonably ensures timely receipt of the findings."

The guidelines also state which situations may require non-routine communication.

"Findings that the interpreting physician reasonably believes may be seriously adverse to the patient's health and are unexpected by the treating or referring physician."

Disposition

This case was settled on behalf of the vascular surgeon and the radiologist.

Source

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