Title

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Journal

Journal of General Internal Medicine, 23

ISSN

0884-8734

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Publication Date

2008-03-01

Peer reviewed

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Running title: Physicians' Decisions About Discharging Patients

Word Count: 2160

References: 22

Tables: 2

Figures: 1

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Abstract

Background: There are few data available about factors which influence physicians' decisions to discharge patients from their practices.

Objective: To study general internists' and family medicine physicians' attitudes and experiences in discharging patients from their practices.

Design: A cross sectional mailed survey

Participants: 1000 general internists and family medicine physicians

Measurements: We studied the likelihood physicians would discharge twelve hypothetical patients from their practices, and whether they had actually discharged such patients. The effect of demographic data on the number of scenarios in which patients were likely to be discharged and the number of patients actually discharged were analyzed via ANOVA and multiple logistic regression analysis.

Results: Of 977 surveys received by subjects, 526 (54%) were completed and returned. A majority of respondents were willing to discharge patients in 5 of 12 hypothetical scenarios. Eighty-five percent had actually discharged at least one patient from their practices. Most respondents (71%) had discharged 10 or fewer patients, but 14% had discharged 11 to 200 patients. Respondents who were in private practice ($p <$

0.000001) were more likely to discharge both hypothetical and actual patients from their practices. Older physicians (>= 48 years old) were more likely to discharge actual patients from their practices ($p = 0.005$) as were physicians practicing in rural settings ($p = 0.003$).

Conclusions: Most physicians in our sample were willing to discharge actual and hypothetical patients from their practices. This tendency may have significant implications for the initiation of pay-for-performance programs. Physicians should be educated about the importance of the patient-physician relationship and their fiduciary obligations to the patient.

One of the most important aspects of medical care is the patient-physician relationship. Recent literature (1) emphasizes the importance of this relationship and its therapeutic implications for patients. The patient-physician relationship is based on the personal commitment to caring and problem solving by the physician and the patient (2).

The American Medical Association established its Code of Medical Ethics (3) for physicians in 1847, based on the Code of Medical Ethics published in 1803 by Thomas Percival, an English physician, philosopher, and writer. Major revisions to the Code of Medical Ethics have occurred over the years, with the most recent major revision in 2001. One section indicates that physicians have a fiduciary relationship with patients due to the patients' vulnerability and the special circumstances of the patient-physician relationship. Consideration of such relationships should be paramount in providing care to patients. Although from the outset physicians have a responsibility to treat their patients, this duty becomes even stronger after the patient-physician relationship is formed. This is especially true if dissolution of the relationship would harm the patient (4). Physicians therefore have an ethical and legal obligation to avoid abandonment, defined as unilateral withdrawal from the relationship by the physician without formal transfer of care to another qualified physician who is acceptable to the patient (5).

However, the ethical responsibility of physicians to maintain their relationships with patients is not without limits (6). It has been argued that physicians may refuse to accept patients when, for example, there may be harm to other patients or to the physician. This may occur when patients threaten physical violence (7,8).

One of the major dilemmas in the decision to discharge patients is a lack of standards or guidelines (3). A lack of research in this area also exists. Although one study (9), in Great Britain examined the reasons for the discharging of patients from physicians' lists, it has been stated that discharging patients from physicians' practices remains a poorly understood occurrence which warrants further research (10). Therefore, the aim of this study was to examine primary care physicians' attitudes toward and experiences with the discharging of patients from their practices.

Methods

We conducted a cross-sectional mailed survey of 1000 randomly selected internal medicine and family practice physicians in the United States. Respondents were identified through the American Medical Association (AMA) master file which is a comprehensive list of U.S. physicians not limited to AMA members. Students, residents, and non-practicing physicians were excluded. The study was approved by the Institutional Review Board of Christiana Care Health System and the survey was mailed to 500 general internists and 500 family practice physicians. The survey was accompanied by a $5 (cash) incentive. All non-respondents were sent a second mailing. Confidentiality was maintained as the survey had no identifying information, and coded envelopes (to determine non-respondents) were discarded prior to coding of the data. All responses received by June 1, 2005 were included in the analysis. The survey was pre-tested among 50 practicing physicians at Christiana Care Health System for face and content validity.

The survey (Appendix A) asked respondents about situations in which a patient might be considered for discharge from the physician's practice. Twelve case scenarios were included, which varied according to the type of challenge that the patients presented. Three scenarios were described in each of the following categories: threatened violence/illegal behavior; behavior that interferes with the patient's own health care; unethical behavior by the patient; and behavior that is disliked by the physician but not violent, unethical, or adverse to the patient's own health care. The scenarios were

developed based on reasons for discharge reported by physicians (9) and those advocated in the literature (8). Respondents were asked to indicate how likely they were to discharge the patient from their practices, based on a four point Likert-type scale (very likely discharge, likely discharge, likely not discharge, very likely not discharge). The respondents were also asked if they had actually discharged patients from their practice, the circumstances surrounding such discharges, and the manner in which they discharged patients. Demographic questions about the respondents were also included.

In addition to reporting the responses to the cases, the number of scenarios in which respondents would be somewhat likely or very likely to discharge patients from their practice was calculated as a separate variable. The effects of respondent demographic data on the total number of discharged patient scenarios, the number of discharged patient scenarios in each of the four categories, and the number of actual patients discharged were analyzed via ANOVA and multiple logistic regression models. Individual categories of scenarios were compared via chi-square analyses.

Results

Of the 1000 surveys mailed, 23 were returned due to incorrect addresses or death of the respondent. Therefore, 977 were presumed to have been received. Of the 977 physicians who received questionnaires, 526 (54%) responded. Respondents' demographic data and practice characteristics are displayed in Table 1. The responding physicians had an average age of 48 and were predominantly males practicing outpatient medicine in private practice settings. The number of responding internists and family practice physicians was 45% and 55% respectively.

A majority of respondents would be likely to discharge patients in 5 of the 12 hypothetical scenarios in our survey (Figure 1). Almost all of the physicians surveyed said that they would likely discharge patients in the event of verbal abuse/threatening behavior (97%) and illegal activity involving narcotics (90%); as compared to situations involving risks to the patient or undesirable (but not dangerous) behavior ($p<0.001$). Situations with the lowest likelihood of physician discharge were a history of filing a malpractice claim (14%) and questioning the physician's medical recommendations (16%).

Although a majority (81%) of respondents did use certified mail to notify patients of the discharge, 41 (8%) informed patients only verbally, and 28 (5%) used routine mail with or without verbal information. Of the 526 respondents, 85% had previously discharged patients from their own practice. Forty nine percent had discharged 1 to 4 patients, 22% of respondents had discharged 5 to 10 patients, and 14% had discharged between 11 and 200. The reasons for discharging patients were numerous, with the most

cited reasons being verbal abuse, narcotic drug seeking behavior and non-compliance (Table 2). Of the 107 respondents who had not discharged patients from their practice, 60 (56%) had seriously considered this at some point in their careers. Most did not discharge these patients due to a concern about abandonment (63%), rather than concerns about lack of another physician provider (22%), fear of litigation (17%), or an obligation based on insurance (14%).

Respondents who were in private practice as compared to academic, VA or HMO practices were more likely to discharge hypothetical patients ($p < 0.001$) and actual patients ($p = 0.009$) in our survey. Older physicians (>= 48 years old) were more likely to discharge actual patients from their practices ($p = 0.005$) as were physicians practicing in rural locales as compared to urban locales or suburban locales ($p = 0.003$). The percent of physicians who would discharge patients did not differ according to geographical location (i.e., state) of their practice. There were no differences found between female and male physician respondents regarding responses to both hypothetical scenarios and patients actually discharged from practices.

Discussion

In this study, respondents were most likely to discharge patients in scenarios involving dangerous or illegal behavior. A study in Great Britain (11) found that general practitioners most often discharged actual patients from their practices due to violent, threatening, or abusive behavior. This is concordant with the AMA Code of Ethics (3) regarding appropriate discharges from practices.

However, up to 52% of the respondents were likely to discharge hypothetical patients for reasons other than threatening behavior, which is discordant with the AMA Code of Ethics (3). Respondents were willing to discharge patients who were nonadherent with treatment (23%), were unwilling to obtain records from other physicians (52%), or who questioned the treatment which was recommended by the physician (16%). Despite discordance with the AMA Code of Ethics (3), some authors (12) have indicated that it may be necessary to discharge nonadherent patients, and 8-24% of general practitioners in Great Britain indicated that they discharged patients who were non-adherent or who criticized the physician (9, 11).

Thirty-nine percent of the physicians in this study were willing to discharge hypothetical patients who were non-adherent or questioned the physicians' decision-making. Such physician behavior has serious ethical and medical ramifications for patients who are cared for by physicians in pay-for-performance programs. Programs which are being planned and/or implemented may encourage "gaming" the system by participant practitioners (13). Physicians may be reluctant to provide care to patients when a guaranteed outcome is not certain (14). Medically complex patients who do not have

a single, easily controlled disease may become shunned by these physicians (15). Discharging patients as a potential solution to non-adherence must be considered when systems adopt pay-for-performance programs.

Physicians in this study had actually discharged patients from their practice for reasons similar to those contained in the hypothetical scenarios. However, 6% had discharged patients for conflict over the treatment regimen, and rarely, for smoking or for simply being an attorney. In one hypothetical discussion (16) a physician questioned whether it is ethical to refuse care to any smoker due to the adverse health consequences which would ensue and concludes that such actions are unethical. Discharging patients for these reasons are clearly discordant with the AMA Code of Ethics (3).

There is a discrepancy between physicians' responses to the hypothetical scenarios and the number of patients actually discharged from their practices. More respondents would discharge patients in the scenarios than have actually done so in practice. For example, only 40% of respondents had discharged patients for verbal abuse, compared with 97% who would so in the hypothetical scenario. It is possible that the physicians surveyed have not frequently encountered many of the patients as portrayed in the scenarios. We did not ask the physician respondents for this information. In addition, though physicians claimed that they would discharge such hypothetical patients, they may be less willing to do so with actual patients. Physicians may have found it more difficult to confront an actual patient about a discharge from the practice in comparison with hypothetical patients. Physicians may also have constraints in environments where there may be alternative sources of medical care. However, in our study physicians in

rural practices, where medical resources are fewer, were more likely to have discharged actual patients from their practices.

A majority of physicians in this survey did discharge patients via certified letters as recommended by some authors (17, 18). However, some of the respondents may have placed themselves in legal jeopardy by discharging patients via a written notice which was not certified, or in some cases with only verbal notification.

In this study, older physicians were more likely to discharge patients from their practices than younger physicians. These data contrast with a previous survey (19), in which younger primary care practitioners were more likely than their older counterparts to exclude patients from their practices. We did note that physicians in rural locations were more likely to discharge patients from their practices. This may be due to greater financial constraints on rural physicians, or due to other unexplored differences with their urban and suburban counterparts.

Eighty-five percent of respondents in our survey had discharged patients from their practices. In previous work (20), 11% of respondents had discharged patients in the previous 12 months due to a variety of boundary violations. The discrepancy may be partly attributed to the difference in time frame (12 months in the previous study vs. career-long in the current study). In addition, the previous study surveyed only academic general internists, whereas we included all practicing primary care physicians, with a predominance of respondents being physicians in private practice. Though in the minority, 36% of the respondents discharged larger numbers (5-200 patients) in their

careers. This clearly deviates from the recommendation that discharging a patient from one's practice should be a last resort to the problem (19, 21).

This study does have some limitations. We asked physician respondents how likely they were to discharge patients based on hypothetical scenarios which may not correlate with actual situations. However, open-ended responses about the reasons for actual discharges of patients correlated with the responses to the hypothetical scenarios. Another limitation is that these data are based on self-report. Finally, a relatively low response may introduce reporting or selection bias into the results. However, the physicians who responded to this survey have similar characteristics to those of the average physician practicing in the United States (22), with 78.8% of the U.S. physicians being male compared with 71% in this study, and the largest percent (25%) of physicians in the U.S. being in the age group of 45-54 years of age, compared to the mean age of 48 years in our responsdents.

In summary, although most physicians do report discharging patients in an appropriate manner and for appropriate reasons, some physicians do so for ethically questionable indications and in a manner that exposes the physicians to potential legal consequences. Discharging patients may have significant consequences in pay-for-performance systems. Physicians should be educated about the ethical and legal issues involved in discharging patients from their practice. There should also be ongoing discussion in the medical profession about when such discharges are appropriate.

Acknowledgment

The authors wish to thank Marie Hougentogler for her secretarial assistance, and the librarians of Christiana Care Health System for their assistance in performing a literature search and obtaining references. This work was supported by a grant from the Osler Fund of the Department of Medicine, Christiana Care Health System. It was presented at the Annual Meeting of the American Academy of Communication in Healthcare; Atlanta, GA, October 15, 2006.

Conflict of Interest

None of the listed authors have any conflicts of interest to declare.

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Figure 1 526 respondent internal medicine and family practice physicians' decisions to discharge hypothetical patients from their practices (mean number of scenarios likely or very likely to be discharged, from 0-12). Verb Abuse = verbal abuse toward physician/staff; Narcotics = narcotic-seeking from several physicians; Violence = violent threats against the physician; No Pay = failure to pay bills owed to the practice; No Records = refusal to release information from other physicians; Work Excuse = requests for work excuses with no documented illness; No Inform = refusal to inform spouse of HIV status; Ins Fraud = past history of use of relative's health insurance illegally to obtain health care; Miss Appt = frequent missed appointments; Noncomp = noncompliance with treatment; Question Rx = questioning of all of the physician's treatment plans; Malpractice = malpractice claim against another physician in another specialty.

Table 1

Characteristics of 526 Physician Respondents to This Survey of Discharging Patients from Practices*

Characteristic	Value
Age--years	
Mean +/- SD	48 +/- 11
Gender--number (%)	
Male	375 (71)
Female	150 (29)
Specialty--number (%)	
General Internal Medicine	234 (45)
Family Medicine	286 (55)
% of Practice as Outpatient	82 +/- 27
Practice Type--number (%)	
Private Practice	384 (73)
HMO	62 (12)
Academic Medicine	44 (8)
VA	11 (2)

Table 1

Characteristics of 526 Physician Respondents to This Survey of Discharging Patients from Practices (cont)*

Characteristic	Value
Practice Locale--number (%)	
Urban	183 (35)
Suburban	214 (41)
Rural	121 (23)
Number of patients/week	97 +/- 65
Years in Practice	20 +/- 14

*Not all respondents answered every question. Percent does not add up to 100 due to rounding and non-responses.

Table 2

Reasons 526 Respondents to This Survey Gave for Discharging Actual Patients from Their Practices*

Reason for Discharge	# (%) of Respondents
Verbal Abuse	211 (40)
Narcotic Drug-Seeking	211 (40)
Missed Appointments	82 (16)
Non-Payment	80 (15)
Violent Behavior	50 (10)
Seeing Multiple Physicians	50 (10)
Dishonesty	48 (9)
Criminal Activity (falsifying prescriptions, etc)	40 (8)
Conflicts About Medical Treatment	31 (6)
Malpractice Claims	20 (4)
Insurance Problems	3 (1)
Demanding or Angry Patient	2 (<1)
Alcoholic	1 (<1)
Smoker	1 (<1)
Attorney	1 (<1)

*Respondents were asked to indicate all categories that applied. Percent adds up to more than 100 due to multiple choices.

Appendix A

DISCHARGING PATIENTS RESEARCH GROUP

We are conducting a survey about discharging patients (informing a patient that physician will no longer care for the patient in his/her practice) from a Primary Care Physician's practice. Your participation in this survey is voluntary; however, should you choose to participate, we ask that you complete all of the questions as fully and completely as possible. Please be assured that your responses will remain absolutely confidential, and you will not be identified on this survey instrument.

Neil J. Farber, M.D. Michelle E. Jordan, DO Julie Silverstein, MD

We will present you with a number of scenarios, which might prompt you to discharge the patient from your practice (tell the patient that you will no longer be able to care for them in your practice). For each scenario, please indicate how likely you would be to remove such a patient from your practice by selecting one answer for each case.

In this setting, you would…

	Very likely discharge	Likely discharge	Likely not discharge	Very likely not discharge
A A patient who has been repeatedly verbally abusive to your office staff	☐	☐	☐	☐
B. A patient who you discover is seeing several different physicians to obtain Percocet	☐	☐	☐	☐
C. The spouse of a former patient whose care you have discontinued secondary to violent threats against you	☐	☐	☐	☐
D. A patient who repeatedly has not paid bills owed to the practice	☐	☐	☐	☐
E. A patient who refuses to allow you to obtain information from previous health providers	☐	☐	☐	☐
F. A patient who frequently asks you to write excuses for work for times that he/she has had no documented medical illness	☐	☐	☐	☐
G. A patient with newly diagnosed HIV who refuses, despite extensive counseling, to inform a spouse (of his HIV status) for whom you also provide care	☐	☐	☐	☐
H. A patient who has informed you that they previously used a relative's health insurance to obtain care for themselves from another health provider	☐	☐	☐	☐
I. A who has missed 3 appointments without calling in advance	☐	☐	☐	☐
J. A diabetic patient who is non-compliant with checking blood sugars, taking insulin, and obtaining lab work	☐	☐	☐	☐
K. A patient who questions all of your treatment plans by citing information heard on television or gathered on the Internet	☐	☐	☐	☐
L. A patient who is currently involved in a malpractice suit against a physician in another specialty	☐	☐	☐	☐