Bulletin of the Mahoning County Medical Society
Third Quarter 2014

PROASSURANCE
Treated Fairly

Physicians can fire patients, too!

By Jeremy A. Wale, JD, ProAssurance Risk Resource Advisor

The physician-patient relationship is created by mutual agreement between the physician and the patient. As such, the physician may terminate the relationship for any non-discriminatory reason. Valid reasons may include (but are not limited to) non-compliance with medical advice, combative or threatening behavior, or outstanding medical bills.

Patient non-compliance is one of the most common reasons for terminating the physician-patient relationship. Patients who routinely miss or cancel appointments or refuse to heed medical advice may be considered non-compliant.

Non-compliant patients might be your practice's biggest liability risk. Patients are less likely to get better when they don't comply with medical advice, placing them at higher risk for adverse outcomes. By properly terminating non-compliant patients, you may help reduce your risk of malpractice claims. It also is appropriate for practices to terminate hostile, aggressive, or verbally abusive patients.

Proper termination is important to help avoid a claim of patient abandonment. While the legal definition of abandonment varies from state to state, the following elements typically exist in a patient abandonment claim:

- termination of a professional relationship between the physician and patient without good reason or at an unreasonable time;
- termination occurred when the patient was in need of continuing medical care;
- the patient was not given reasonable notice sufficient to secure an alternate physician; and
- the patient was harmed as a result.i

The American Medical Association (AMA) summarizes your responsibility this way: once a physician-patient relationship exists, physicians are ethically obligated to place the patient's welfare above all other considerations, including the physician's own self-interest.ii

Once you've determined it's prudent to terminate a patient from your practice, lower the risk of a patient's claim of abandonment or malpractice by:

- Evaluating the patient's condition and rendering stabilizing care, if needed. Avoid discharging a patient during treatment for an acute condition until the treatment is finished or the condition is resolved.
- When possible, discuss the termination and your reason(s) for termination with the patient. You may conduct the conversation via telephone or in person. We encourage the physician to have this conversation with the patient. Be sure to document this discussion in the patient's medical record.
- Send a written letter to the patient confirming his or her termination from the practice. We suggest sending the letter by both regular mail and certified mail with return-receipt requested. If you choose to include the reason for termination in the letter, be sure you are objective and tactful in your choice of words. We suggest you include the following:
  - A specified period of time during which you will continue to provide care. The AMA suggests at least 30 days' notice; however, there is at least one state that requires at least 60 days' notice. Review your state's laws before you terminate a physician-patient relationship.
  - A statement encouraging the patient to find another physician as quickly as possible.
  - Referral services to aid the patient in finding another physician. These services may include the local medical society or the state board of medicine.

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Bulletin

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November 27, 2014	*Thanksgiving Holiday*
December 11 ~ 14, 2014	*Disney on Ice, Covelli Centre*
December 17, 2014	*Hannukah begins*
December 25, 2014	*Christmas*
December 31, 2014	*New Year's Eve*

In Memoriam

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FROM THE DESK OF THE EDITOR

Michal T. Engle, MD

"So how much does it cost?"

Have you ever been to one of those marketplaces where there are hundreds of vendors selling everything from shoes to fruit? My wife drags me to these places sometimes, and the one thing I hate about them is that there are no prices marked at many vendors. I'll see an item that interests me, but then I'm forced to ask, "So how much does it cost?" I often think the vendor takes a quick look at my nice shoes and clothes and gives me an inflated price because he knows I can afford it. Well, isn't healthcare today run in a similar fashion?

Clearly, the U.S. health care market is unlike any other market: patients rarely know what they'll pay for services until they've received them; health care providers bill different payers different prices for the same services; and privately insured patients pay more to subsidize the shortfalls left by uninsured patients. Further, prices for health services vary significantly among providers, even for common procedures such as laboratory tests or mammograms. Just take a look at the price of an MRI of the spine: Costs range from around $600 to upwards of $2500 depending upon the location/ provider.

For these reasons, consumer advocates as well as some employers and health plans are pushing for greater price transparency. They argue that if consumers realized that they could receive high-quality services from lower-cost providers, they would seek them out. This, in turn, could encourage competition among providers based on the value of care — not just on reputation and market share.

We have to be careful though. Consumers (patients) are not necessarily equipped with the information they need to make informed decisions about healthcare. How often do we hear a patient ask to be referred to a particular physician because "my neighbor went there and liked him". Healthcare providers, as well as insurers, sometimes make claims about the equality of care without giving patients the full story. For example, Anthem insurance has been directing my patients to an MRI facility with old, inferior imaging. They tell the patient "it's the same as at _____". It's not the same, but certainly costs Anthem less!

Price transparency can be a great tool in helping reduce the cost of healthcare delivery, but we must proceed with caution. There needs to be a component of regulation that forces providers and insurers to give consumers "apples to apples" comparisons. If not, healthcare will go the way of many other consumer products where the price ends up being the primary driving force and quality is considered secondary. We as physicians owe it to ourselves and our patients to fight against that trend.

From the President

by Sean T. McGrath, MD

I am composing this article as I fly home from a warm and snowless trip to Florida with my family. It is definitely nice to get away from work and spend some quality time with the wife and children. In this instance, with my In-Laws as well. Too often, as physicians, we get wrapped up in our work and all the regulations and pressures put upon us by society, government, and our professional licensing boards. We need to remember to take some time for ourselves and our families to make sure we maintain some sort of calm in this never-ending storm.

There has been a lot of chatter on the OSMA blog relating to MOC which is propagated by each specialty board in order to create revenue; I'm sorry, I meant to say in order to assure we have a well-educated physician base in the USA that is appropriately board certified so members of society feel safer when visiting the doctor. When I started in private practice just seven years ago, board certification looked very different. For my senior partner it must look like being back in medical school compared to what it was when he was first out in practice! It continues to change, and always in favor of the specialty boards educational products available at a hefty price. We can use other sources for CME less and less as though the sources we have used for years are no longer acceptable. It is beginning to look more and more like a monopolizing program of forced sales with little choice.
Many of us are over specialized these days. Our scope of practice has become narrowed within our own specialties. Yet, we must choose from a limited array of CME choices that often times have little to no bearing on our day to day practice. This is all simply a façade to pretend to meet a need that has been overstated as a mandate by the general public.

I do believe we need to maintain our knowledge base as physicians. I also believe we need to search out the information we need to add to our repertoire. The rapidly changing face of medicine is faster and broader than the board's ability to create new, expensive, and accredited CME materials. I think non-board affiliated societies and outside CME sources are better equipped to create materials that have true meaning and relevance to our daily practices.

We as physicians need to take a lead role in our life-long learning objectives. If we continue to sit in the back seat, THEY will continue to take advantage of us. We must start to make a stand against unnecessary regulations and inappropriate sources of CME. We DO need to keep reading and learning everyday as we see patient's with unusual presentations and when new developments in our field come available (although not covered by insurance due to being an experimental procedure or medication!). WE must stand up for ourselves as no one else is going to do it for us.

I encourage everyone to log into your specialty boards website and really look at the requirements for your current cycle of certification and your next cycle (I promise there are differences including more requirements with specific timing of purchases of their materials). Think about the time requirements and the benefits you will actually get from those very specific requirements. Next, think about the time away from patients and family and vacations like the one I am ending right now. Just think about it and let it stew for a while.

Now think about how you can make a positive change. Think about the ways for you to best stay updated in your field of medicine. If your answer is by using your board's available products, then continue on with your day. If you think there is a better way, then type a letter to your board and have everyone in your office sign it. Send the same letter to the OSMA. Start practicing the word "NO". Get ready to use the word BOYCOTT. Now, think really hard and long about this one, but what about the work STRIKE. We know about the power of one, but true power comes in numbers and unison. It will never work as a small number, it will have to be most or all to make any changes. We need to toughen up and come together, truly together. Not together with attorneys and politicians leading, together with 100% physician leadership.

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Continued from Page 1

- Information on how the patient can get a copy of his or her medical record. You may want to consider including a release-of-records form to make this process easier.
- A signature. We encourage the terminating physician to personally sign the letter and retain a copy of the letter in the patient's medical record.

We also encourage you to contact any third-party payer or managed care provider that may be involved in the patient's care. Some third-party payers and managed care providers have specific contractual obligations you must follow prior to terminating one of their covered patients.

I American Medical Association. Ending the patient-physician relationship. 2013. Accessed August 25, 2014.

II American Medical Association, Code of Medical Ethics Opinion 10.015.

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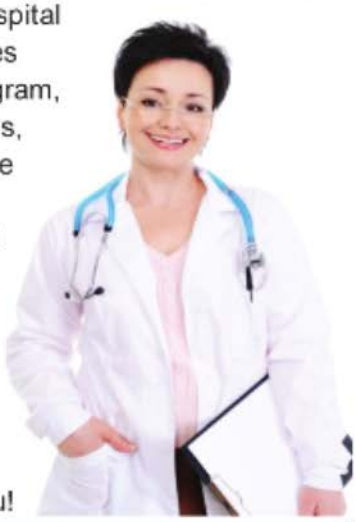

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Dr. Roy Morcos has moved his office to:
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