ETHICS IN ACTION

NONCOMPLIANT PATIENTS

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A 33-year-old male patient arrives by EMS in respiratory distress. His vitals in the field included a heart rate of 130, blood pressure of 195/110, respirations of 30 and room air pulse oximetry of 88%. He was started on CPAP by EMS. On exam he appears clearly fluid-overloaded with rales in both lung fields. You note an AV fistula in his left upper arm, and upon questioning he admits that he has not gone to dialysis in over a week for "personal" reasons. Further workup shows pulmonary edema on his chest radiograph, and lab abnormalities including hemoglobin of 6.6, potassium of 7.5 nonhemolyzed with diffusely peaked t waves on his EKG, and bicarbonate of 13 on BMP. He clearly needs emergency hemodialysis, and so you arrange admission to the medical ICU and contact the on-call nephrologist. The nephrologist is familiar with this patient; she tells you that he was fired from their service two months ago for continued noncompliance and that the nephrology staff made clear they would not dialyze him again should he come back to the hospital. She suggests finding another hospital to transfer him to for dialysis. The patient clearly is not stable for transfer, and you have the capacity to care for him at your facility. Even if they have fired the patient from their practice, can the nephrologist refuse to dialyze him, given his life-threatening condition?

Noncompliant patients are a great source of frustration for health care providers across the medical community. There is evidence showing that among patients with some of the most complicated chronic conditions (diabetes, congestive heart failure, chronic kidney disease), noncompliance is a major factor in readmission rates. Mortality and disease-related complication rates are also higher in noncompliant patients. (Clin J Am Soc Nephrol 2011 142-52). There have been several factors associated with noncompliance: underlying mental illness or substance abuse; lower socioeconomic status and the barriers to care associated with it; insurance status; and legal issues. While the causes are myriad, the end result is the same: a difficult relationship between physician and patient.

The concept of being able to "fire" a patient from one's practice has been around for several decades. Both state and federal laws, as well as evolving changes in professional codes of ethics, have formalized the process for informing a patient that a provider will no longer provide care for her. Typically there has to be documentation of expectations for both patient and physician (on the patient's end this includes paying bills, following through with treatments and showing up for scheduled appointments). In the event that patient noncompliance reaches the point that a provider wants to terminate the physician-patient relationship, the physician must notify the patient within a suitable time frame to allow her to transition to another provider, provide copies of medical records to bring with her to the new provider, and continue necessary care until the identified time frame is over. In general, these arrangements apply only to routine ongoing care, and not to emergencies. Additionally, in circumstances where the provider is the only specialist of his or her type in an area (more rural areas where the provider may be the only psychiatrist, urologist, etc., in town), the provider may need to allow for a longer period of time for the patient to find a more distant provider.

Such arrangements are rarely if ever seen in the emergency department setting, as federal law prohibits the emergency department from refusing to provide a medical screening exam and the necessary stabilizing treatment. While care plans for expedited screening exams and referral to alternate providers in the event no medical emergency is identified are permissible, an emergency department cannot "fire" a patient the way a private practice can.

Which brings us to our current scenario. This patient clearly has a medical emergency: while the nephrologist's desire not to provide ongoing care any longer for this patient is both reasonable and ethically acceptable, refusing to provide dialysis for him in an emergency is both legally and ethically wrong. If the nephrologist is not on call that night, she can refuse to dialyze him and refer him to the on-call nephrologist. However, if she is on call, by both her legal obligations under EMTALA and the general ethical principle of nonmaleficence, she should dialyze this patient emergently (and then can refuse to provide further care once his medical emergency is stabilized).

If confronted with this issue, and the nephrologist remains recalcitrant, contacting another nephrologist on staff or, if necessary, hospital administration to force the issue may be required. Transferring this patient is obviously not in his best interest, but if no alternative exists, then he should be transferred as soon as possible, with a very carefully documented chart.

In summary, private providers can fire noncompliant patients, though such an option is rarely feasible for the ED. Further, even if the patient has been fired, if he presents with a medical emergency and his previous provider is on call, then the provider has legal and ethical obligations to care for the patient until such time as his medical emergency is stabilized, and care can then be transferred. ◗