NORTH CAROLINA MEDICAL BOARD

Episode 22 – Patient Dismissals: Preserving Patient Welfare When Cutting Ties

Intro music: 0:00

Podcast introduction: 0:10
Dismissed. Terminated. Let go. Released. Fired. No matter what you call it, if you are a patient and it happens to you it means you are out. You will no longer be able to see the medical professional who is doing the dismissing, and you will need to find a new provider.

This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters.

Many patients are surprised to learn that physicians and PAs do have the right to choose their patients and can, in fact, end the clinician-patient relationship at any time for just about any reason.

That said, there are certain expectations about how medical practices should dismiss patients. The clinician-patient relationship is the very foundation of medical practice. And, over the years, the profession has established some key principles that guide how that relationship should be managed.

Now, how well known these principles are or how reliably they are followed is debatable. Medical Board staff know firsthand from responding to telephone calls and emails from patients that dismissals are sometimes abrupt, contentious, and confusing. In the worst situations, patients may be left without appropriate refill prescriptions and with no real prospects for establishing care elsewhere.

The good news is that the North Carolina Medical Board is here to help. After listening to this episode, patients will know their basic rights upon dismissal from a medical practice. And medical professionals and practice managers will be on notice about obligations to patients when cutting ties.

Interview with Dr. Karen Burke-Haynes: 1:53
I've asked my colleague, Dr. Karen Burke-Haynes, to help me shed some light on patient dismissal. Dr. Burke-Haynes is a pediatrician with more than 30 years of experience in academic and private practice settings. She came to the North Carolina Medical Board in 2014 and was named Chief Medical Officer in 2019.

JFB: Dr. Burke-Haynes, thank you for joining me and welcome back to MedBoard Matters.

KBH: Thank you, Jean. It's a pleasure to be here.

JFB: I wanted to start by acknowledging that a good many patient dismissals seem to arise from conflicts. A lot of the patients I speak with indicate that they've received a termination letter after having words with someone at the practice, whether that's the doctor or the P.A. they see or perhaps a member of the staff. In your experience, how common a reason for dismissal is this?

KBH: Jean, thank you for highlighting this. It is an infrequent occurrence. Nonetheless, it can be a very challenging time for both the practice and…and for the patient. Communication is typically at the root of so much of it. It's most often the matter involved, whether that is a disconnect that occurs at the front desk or anywhere along that journey into the exam room with their provider.

JFB: OK, so you said it's not common. That's great to hear. You know, sometimes I think my view may get a little distorted because the people who reach out to the medical board are generally the people who have had a bad experience or who are upset in some way. Are disputes one of the main reasons or what are some other reasons, you know, other than interpersonal conflicts that could cause the clinician patient relationship to break down to the point that the medical professional just feels they can no longer continue?

KBH: I believe terminations and the frequency of them are in all likelihood, dependent upon the nature of the practice, whether it is a primary care office, a pediatric office or an adult setting, a setting in pain management. But perhaps it's a thing that varies. I would…I would consider the possibility that the frequency varies depending on the specialty that's involved. As a primary care physician who practiced for approximately 30 years, I really believe that the number of clients we had to terminate from the practice didn't exceed perhaps five over an entire career, perhaps ten at the very most. So again, in a pediatric setting, long term relationships, perhaps that's not as often, but it could vary depending on the community and the nature of the problem. And the specialty.

JFB: OK, now let's spend a little bit of time talking about a good, healthy clinician patient relationship and what elements, you know are involved in that. Because, you know, we're starting from a point of talking about dismissal and when things break down to the point that the clinician no longer feels they can continue to care for a patient. But let's pivot and talk about what a healthy patient relationship looks like. I think you've mentioned trust, you know, mutual trust is important.

KBH: Absolutely. Absolutely. There is a need and a very strong need for that to be central to the relationship and the variables that contribute to that, I think are shared by both the licensee of the board and the patient entering the exam room. To the extent that they are successful in establishing a rapport and a connection that one would call therapeutic, i.e., the patient feels connected to that provider, trusts their ability, and respects their presence as part of their care team. I do believe that the ability to form and have an extended relationship that is successful increases significantly. Breakdowns can happen. And I do think, though, that the importance and perhaps the pressure or perhaps the expectation is another way of framing it, we have at the medical board of our licensees is that professionalism rules the day and this is not something that naturally comes easily. I think we're all clinicians communicating with a diverse patient population, diverse communication styles. You can only imagine that there are going to be times when things are not going to flow well because of miscommunication, missed body language and so forth. But we do our best.

JFB: OK. All right. I'm still stuck on this idea of reasons. You know, what are the specific things that go wrong in that therapeutic relationship that create circumstances where the clinician just doesn't feel like it makes sense for them to continue treating the patient. One that comes to my mind is patient compliance. Is that something that enters into this decision for the clinician to break ties with the patient?

KBH: Absolutely. Jean, thank you for placing that in the middle of this conversation. Compliance is incredibly important to relationships. If one were to use, for instance, the matter of compliance let's say, with a diabetic and their medication and their care routine. Someone with hypertension, particularly challenging cases of hypertension, and the need then for frequent interactions with their provider and

the challenges that arise when a care plan has been initiated, but there has been no movement. A care plan has been initiated, but we're finding broken compliance. That challenges the relationship on several levels. First, I think one could note that it's a discouragement…point of discouragement. And then for a licensee who feels the responsibility of the outcome, there actually may not be an interest in continuing a relationship where one feels vulnerable to the consequences of the other half of the team, so to speak. The patient choosing not to, actively choosing not to comply with a recommended course of treatment, very challenging on several levels.

JFB: Right now, I'm guessing there would be many discussions that would take place between the treating clinician and the patient before it got to the point that the clinician concluded, “I just can't help this person because they're not taking my advice”. Is that a safe assumption?

KBH: Oh, absolutely. I would expect under the best of circumstances that there would be a series of conversations discussing this question of why there has not been. To explore the reasons why. To problem solve through those reasons. If that's at all possible. Is it a resource situation? What exactly is going on? Is it an emotional issue? Is it a depression issue? Certainly, a licensee who's highly engaged with the patient would be asking these questions and encouraging them, providing alternatives, changing medications. If it's a twice a day medication, but it needs to be once a day. Exploring these options. Exploring the reasons why. And if after all of that is done, we're still at a stalemate, I think it should not be surprising if there becomes a time when a licensee might feel they have exhausted their ability to make a difference for that patient and therefore would recommend a different setting.

JFB: Gotcha. Now, are there circumstances where it's appropriate for a patient to ask the provider or the practice to reconsider a termination? Maybe there have been clues along the way that there were problems, but the patient still feels blindsided that, gosh, I didn't think things had gotten to the point where they were going to tell me, I can't be seen here anymore. Do you think that it's ever appropriate for a patient to say, can we work this out? Or is it generally the case in your experience that once a clinician has come to that place where they feel a patient needs to be released, that their mind is made up?

KBH: Well Jean, you know, the answer to that might well vary with the structure of the practice. If it is a multi-provider practice, there may be a space, a room, an opportunity to have a conversation about reconsidering a decision to terminate. I think a patient who really ultimately values the care, values the structure, or perhaps are limited geographically should raise this question with the practice manager, perhaps with the clinician, if possible, coming in, prepared to listen and coming in prepared to share would be a good thing to do. I think there is no concern with offering that as a potential solution to a situation where miscommunication might have overwhelmed the relationship.

JFB: OK, and I should note that the medical board does have a position statement on the licensee patient relationship that does recommend if it comes to the point where a patient is going to be terminated, that they should receive a written termination letter that specifies am I being dismissed just from this one provider or am I being dismissed from the practice at large so that there would be some clue if that was even an option?

KBH: Yes.

JFB: Let's briefly review the clinicians ongoing responsibilities to a patient who's being released. That same position statement that I just referenced certainly does affirm that the licensee has the right to choose what patients they care for. But it also indicates that if a patient is terminated, they should be terminated, must be terminated in a way that supports continuity of care for that patient. What does that look like in real life? Let's say with…with refills, for example, that's a common issue that we receive calls about.

KBH: Absolutely. Great question, Jean. The most and the highest response to a situation would be to offer to that patient the opportunity for medication refills and any aspect of urgent care that they might need in that 30-day window and perhaps go just an extra measure further, if not in the letter and in a conversation to clarify what it is that we mean by urgent care. Certainly, the ability to access medication refills is the bare minimum that should be provided to that patient. Additional insights and providing options for alternative care might be appropriate, particularly for those who might have active, complex disease processes that need to be managed. Providing referrals and guiding a transfer of care is a level of service that I think licensees should be open to providing.

JFB: Mm-hmm. OK, what about access to medical records?

KBH: Always, always access to the medical records. That is a standard that should not be breached. Though, the medical records should be provided in a timely manner depending on the date of request for transfer of care.

JFB: Great. And I think there might be some exceptions in the area. We talked earlier about pain management practices. One of the circumstances that I have had to respond to on more than one occasion is a patient who reports that they've been dismissed from their chronic pain provider and that the chronic pain provider does not intend to provide them with a bridge prescription, which they're obviously very concerned about. You know, many patients will call and voice concern about being forced to do without medicine. Obviously, this is going to be dependent on the specific, unique circumstances to each case, but can you talk a little bit about what the board's expectations might be for a clinician in that situation, a pain prescriber who is dismissing a patient?

KBH: Jean, this is another very sensitive area. And perhaps I'll start by saying a single answer is not the best answer. I'll take an attempt at this by stating that there's a level of responsibility that I do believe falls with the licensee to be aware of the challenges that that patient might have in aligning themselves with ongoing care. And there should be close attention paid to how long it will take for them to secure a new medical home and to have prescriptions provided for bridge coverage. Now, there is no codified rule, regulation that states that a licensee must supervise that process. However, in light of the challenges in the community right now and finding providers who will accept and take over care for pain management, I do believe the highest and best response to expect from our licensees is attention paid to handing off care as opposed to either denying an opiate or controlled substance or setting a prescribed period of time and saying, well, you know, once that time is passed, I'm no longer responsible.

JFB: Thank you so much for those points. I wondered if you could specifically address the situation where perhaps a patient has been dismissed from a pain practice because they are non-compliant and

that could be non-compliant in that they missed a pill count, that they had a positive urine drug screen for non-prescribed medications, and anything in between, I imagine. If a prescriber dismisses a patient because they don't believe they're compliant with the treatment plan, how does that change the calculus for whether they determine what's appropriate in terms of refill prescriptions? I know that's an incredibly difficult question to answer because again, the circumstances in each case are going to be so specific.

KBH: Jean, you raise a very, very challenging scenario and it is a complex dynamic that licensees have to negotiate with their patients. I think because of the nature of controlled substances and some of the concerns around withdrawal and other patient safety issue, a licensee might want to pause and give greater consideration to what is involved to dismissing from the practice and their 30-day mandated attention to their care. I'll be more specific. Patients at this point are having some challenges in identifying new medical homes where prescribing chronic opiates, for instance, for pain is a challenge. It's finding that space where their care can be continued and without disruption. So, a licensee may want to challenge themselves to be attentive to handing that patient off into a new environment. And until they have successfully done so, perhaps providing some level of supervision until that care link has been made. To deny that might cause harm for that patient. So, it is a consideration it's something licensees should be thinking of.

JFB: Right. I think it's important to underscore that point because again, you know, the board's position is that the termination and should support continuity of care for the patient and perhaps would be important for the licensees in the audience to hear that they wouldn't get in trouble, for example, if they issue a bridge prescription to a patient who has been dismissed.

KBH: May I create a scenario? Certainly, I think a licensee who has done a urine drug screen that has been confirmed and the medication that they are prescribing is not present in that urine screen. And you are 100% convinced that this patient is diverting this medication and therefore there are no risks regarding withdrawal and no concerns about untoward circumstances. The dismissal of a patient from a pain management scenario has multiple variables that need to be considered. The responsibility to provide prescription coverage is dependent upon our licensee's level of concern about the diversion of the medication, ad opiate for instance. If there has been sufficient documentation of a negative screen for the prescribed controlled substance, that licensee would be well within the scope of acceptable standards to discharge without an obligation to continue to fill medication.

JFB: Mmm. OK.

KBH: Where there is any question, however, around that matter. If it's inconsistent use, periodic negative screens, perhaps wisdom would be such that providing a bridging prescription would be a prudent thing to do to avoid any unexpected negative consequences.

JFB: I think that's going to be a really helpful clarification for some. I had not really intended us to spend so much time on…on pain management, but it is it causes people to contact the medical board. So, I thank you for getting into the weeds with that for a bit. So, if we could, though, we had just briefly touched on at the beginning of our conversation the notion that sometimes a dismissal can arise from a negative interaction with a member of the staff. It's not even with the licensee, him or herself, but

someone at the front desk perhaps, or someone in billing. Do you have any thoughts on those types of negative interactions and how they can contribute to a decision to dismiss?

KBH: Well, Jean, those sources of complaints leading to dismissal are perhaps more common than one might imagine. The licensee is sometimes the last person to know that something on towards has happened at the front desk or there have been some challenges in the billing area. There have been situations where licensees have not been aware in larger practices that a patient has been dismissed. Not a practice that we endorse at the board. I certainly think in those cases we encourage that practices established protocols where the caring provider is made aware of the challenge. And if there is going to be a dismissal of that, that component, the medical care component is processed into the overall decision making. But front desk interactions can be a bit testy and our oftentimes the place where things start to fall apart.

JFB: It sounds like there's a real need for good communication between the front desk, the front of the house and the clinician because there are, as we've been discussing, professional obligations involved here. So, if a patient is dismissed and the principles that we've discussed aren't observed, that could be putting the provider in a vulnerable position where they would be perhaps responding to a board inquiry about why they had not complied with the board's position on patient dismissal.

KBH: Yes, that is understandably a very frustrating case situation for a scenario for a licensee to find themselves. But it has happened.

JFB: So perhaps to end on a more positive note, we've been talking about, you know, when things go wrong and reasons that clinicians or their practice staff determined that a patient should not continue as a patient. How could we perhaps avoid more of these situations? What are the ways that patients and providers can nurture healthy clinician relationships?

KBH: Great question, Jean. I believe the center of it for the clinician is self-awareness. Being in that space, being fully present and applying oneself to the art of listening. Professional demeanor, maintaining a boundary is very important because it allows us to maintain the distance required to understand and assess your patients' needs and to provide well-thought-out responses that mean something to that person to connect with them at the level at which they are presenting to your office. This is not easy, but it is certainly a craft worth dedicating oneself to…to facilitate the kinds of connections that not only help with preventing having to sever relationships, but also facilitating good patient care. The same holds for the front desk of the office. I think a licensee would be really wise to periodically pause with practice managers and their team to ask questions and to allow their staff to give them feedback about their patients. How they interact at the front desk, and any challenges that might be occurring. Preventive approach to it, and being ready, perhaps having protocols in place to assist with successful outcomes.

JFB: Great. Thank you so much for joining me and for talking through this difficult subject. I know it's not an easy one for our licensees to navigate.

KBH: Thank you, Jean, for the opportunity to speak with you about this.

Podcast Closing: 23:51
Ok, that's the big picture. Now let's drill down into the details. Remember that position statement Dr. Burke-Haynes and I talked about? It's called the Licensee-Patient Relationship and it's intended to guide licensees and set out the Board's expectations.

Bottom line, the medical board expects patient welfare to be the licensee's first consideration. And, yes, this applies even when a medical professional or medical practice determines that it's best to terminate a patient.

When providers dismiss patients, they should do it in a particular way to avoid violating their professional obligations and possibly opening themselves to an accusation of patient abandonment.

So, what is appropriate procedure for dismissing a patient? This is detailed in the section of the position statement entitled, Termination of the Licensee-Patient Relationship.

First, patients have a right to written notice that they are being dismissed. The patient or his or her representative should be notified in writing of the decision to terminate the clinician-patient relationship. The position statement specifies that a minimum of 30 days' notice should be provided. This is the minimum amount of notice. In some situations, patients may face wait times greater than 30 days before they can be seen by a different provider. In such cases, the practice may want to consider a longer winddown period for the dismissed patient or allow more than one month of prescription refills to bridge them.

Speaking of prescription refills, a patient has a right to have their medications refilled upon being discharged from a practice. The minimum expectation is a 30-day supply for medicines that are taken daily. If patients aren't able to access care within a month, it may be necessary to provide additional refills. You might be surprised how frequently the medical board hears from patients that a practice has declined to refill medication for blood pressure, depression, or other chronic medical conditions upon dismissal. Remember the medical professional who ended the clinician-patient relationship has a responsibility to support continuity of care and to uphold patient welfare. It does no one any good to force patients off of established treatment regimens. Practice staff should be educated about the prescriber's professional obligation to avoid disruptions to care, as failure to provide appropriate refills could make their employer vulnerable to complaints of patient abandonment.

As Dr. Burke-Haynes noted, there are some limited exceptions to the refill rule, typically when controlled substances are involved and the prescriber strongly suspects the patient is diverting prescribed medications. Let's say the patient's prescription history with the North Carolina Controlled Substances Reporting System indicates that prescriptions are refilled monthly, but multiple urine drug screens are negative for the prescribed drug. Since the patient doesn't appear to be taking the medication, it's safe to refuse any further refills. In many other situations – a pain patient who has missed a pill count or who has used marijuana to supplement their pain treatment – Dr. Burke-Haynes noted that it is acceptable practice to provide the patient with at least a 30-day refill to avoid forcing the patient into withdrawal.

Next, the patient has a right to receive copies of their medical records upon request. It's never appropriate to withhold access because a patient has been dismissed. Providing access to medical

records is not just a professional obligation, it's the law. If the patient makes a request, fulfill it in a timely manner.

The last consideration I'll mention is the patient's right to emergent or urgent care after being discharged from a medical practice. This is an area where a medical practice has broad discretion. It's important for practices to develop policies regarding what types of medical issues they are willing to address after informing patients that they have been discharged. It is also important to clearly communicate this policy to the dismissed patient. If urgent care centers are available in a community, patients may be directed to seek treatment there until they can establish with a new provider. Directing patients to a hospital emergency department for emergency care is another option. If you are thinking, wait a minute, don't doctors have to see patients with emergency medical needs, the answer is no, private medical practices do not. The only medical facility that cannot legally turn away patients is a hospital emergency room. That said, medical professionals should take care to ensure that practice policies reflect the ethics of the medical profession. If a recently discharged patient turns up at the practice reporting chest pain, it would not be ethical to leave them standing on the curb. An appropriate response might be to triage the patient and arrange for transport to the emergency room.

The medical board strongly recommends that practices develop written policies regarding patient dismissal and include clear direction to patients on how to request refills, medical records or ongoing medical care in written discharge letters. Having a plan and putting it in writing will help both patients and medical practices manage expectations and avoid misunderstandings. If you would like to use the medical board's Licensee-Patient Relationship position statement as a guide, you can find it on the MedBoard Matters show page at www.ncmedboard.org/podcast.

And that is about all I have to say about the topic of patient dismissals. I hope you found this episode helpful and informative. If you did, tell your friends and colleagues. As always if you have comments, questions, or suggestions, email them to podcast@ncmedboard.org.

I'm your host, Jean Fisher Brinkley. Thanks for listening, and I hope you will join me again.