MANAGING YOUR DERMATOLOGY PRACTICE

Dismissing Patients Properly

Every so often, it becomes necessary to dismiss a patient from your practice.

I get several questions a month about the "legalities" involved; the usual wording is something like, "How do I dismiss a patient without violating any laws?"

Contrary to popular opinion, there are no statutory laws that I'm aware of that specifically apply to patient dismissal. While there is a remote (and quite preventable) chance of running afoul of antidiscrimination laws, you should be concerned mostly with leaving yourself open to civil litigation—charges of abandonment and the like.

BY JOSEPH S. EASTERN, M.D.

There are no rules that dictate specific reasons for dismissal, so reasons will vary from practice to practice. A common reason is failure to pay legitimate and reasonable charges. This can include technical requirements in the event that you drop out of a health plan. Depending on the contractual rules of the plan, you may be forced to formally terminate treatment of participating patients if they have been given, and have refused, the option to pay out of pocket. Theft (including theft of insurance checks) also falls under this category.

Most patients, however, are dismissed because of interpersonal conflicts with the physician. Mostly that means persistent noncompliance with a reasonable treatment plan, but there are other valid reasons. These include unacceptable behavior, particularly in the presence of other patients, or a generally unruly or uncooperative demeanor. And most experts agree you can refuse to treat a patient who insists on treatment outside your area of expertise, or at a location other than your private office.

Since there are no hard and fast rules, your reasons for dismissal should be determined in advance, written out, and included in your practice manual. Once you have made your rules, follow them. Exceptions should be rare and made under extraordinary circumstances.

Even when circumstances warrant, dismissal should be a last resort. As with most interpersonal conflicts, your best option is reconciliation. Sit down with the patient, explain your concerns, and discuss what must be done if your doctor-patient relationship is to continue. Document this conversation in detail in the patient's chart and follow up with a letter reconfirming what you discussed.

Often, such patients are not aware (or willing to admit) that they are violating your office policies. Honest communication often will save such relationships. But be sure to make it clear that failure to address the problems you have outlined will result in dismissal from your practice.

Once again—this cannot be repeated too often—you should clearly document in the patient's chart exactly how he or she has violated your office policy. This will minimize your chances of being charged with discrimination of any sort. Be especially diligent about this step if the patient has any sort of obvious disability, whether physical or mental.

If, despite your best (documented) efforts, the problems continue and you feel you must remove the patient from your practice, following a few generally recognized guidelines will keep the process smooth and consequence free.

Begin by informing the patient, preferably via certified mail, of your decision to dismiss him or her. Clearly spell out your reasons, and include a reminder that these problems have been discussed, a warning has been given, and the problems have continued. If the patient belongs to a third-party health plan, be certain that you are acting within the stipulations of your contract with that plan, and inform the payer, in writing, of your action.

Give the patient a reasonable amount of time (30 days is common) to find another physician, and mention that you will address any emergent problems within the scope of your specialty during that 30-day period. Include a list of competent physicians in your area who might assume the patient's care (but don't guarantee that any of them will), or include the phone number of the local medical society that they can contact to find a replacement. This will minimize any potential allegations of abandonment.

Offer to transfer medical records to a newly designated physician upon written authorization to do so from the patient.

File a copy of the letter, the receipt for the certified service, and the returned signature card in the patient's chart. While the law states that a first-class letter, properly addressed and stamped, is presumed to have been delivered, you don't want any question as to whether the patient received the letter.

Finally, try to avoid dismissing a patient in the midst of a course of treatment. If this is unavoidable, you may wish to contact your malpractice carrier to review the case prior to doing so.

Forcibly ending a physician-patient relationship is a significant event, requiring the same serious consideration as any other important patient-care decision. Don't undertake it lightly. Remember, dismissing a patient should be a rare occurrence, a last resort. ■

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THE REST OF YOUR LIFE

Former Smokers Share Their Cessation Strategies

The day Dr. Robert L. Kistner turned his back on cigarette smoking was Jan. 1, 1982, a behavior he began as a 14-year-old growing up in St. Louis.

"I smoked through high school, college, and through medical school and the Air Force," said Dr. Kistner, now a vascular surgeon in Honolulu. "As I got into practice in the 1960s, I was still smoking."

For him, taking drags from a cigarette "was a very enjoyable thing to do. It was relaxing. I smoked long and heavily. I really hungered for cigarettes."

When the first Surgeon General's Report on Smoking and Health came out in 1964, "it became obvious that there was something bad about the stuff," Dr. Kistner said. "But the horrible extent of it and its far-reaching effects that we now know really well were just becoming fact. Ultimately, I was faced with [the notion that], 'this is something I really enjoy but it's not pleasing to other people and it's not good for me.' It's something I had to get rid of because I began to preach to people that they shouldn't be smoking and then I'd be reaching for a cigarette. It was incompatible."

His two young daughters also gave him flak about his habit. "Fortunately, they did not take up smoking," he said. "They were turned off by the smell of it and the dirty ashtrays."

Dr. Kistner gradually weaned himself from cigarette use in the late 1970s. First, he chose to not smoke during his workday when he was around patients. Next, he decided he wouldn't smoke at work or at home. Then, he lit up only when he left Hawaii on business travel.

In the end, he appointed Jan. 1, 1982, as his cold turkey quit date. He has not smoked since.

"For some reason, my mind was made up enough that I didn't smoke and it did not make any difference," he said. "It was a conviction. From that point on, for 6 months or 6 years, I'd walk around where somebody was smoking and just smell it. But I had no desire to pick one up."

He went on to note that physicians who currently smoke are "not only hurting themselves, but they're hurting their environment—not just by smoking but by giving the example of smoking. It's very much against the [medical] profession."

From Basketball to Cigarettes

Smoking was commonplace in Dr. Richard D. Hurt's hometown of Murray, Ky., in the early 1960s. He picked up smoking after dropping his basketball scholarship at Murray State University.

"After my first year of college, it was obvious that I was going to have to do something else to make a living besides play basketball," recalled Dr. Hurt, an internist who directs the nicotine dependence center at the Mayo Clinic, Rochester, Minn. "So I dropped my scholarship, joined a fraternity, and started drinking and smoking like what I thought everyone else did at the time."

He described himself as a heavy smoker from the get-go, puffing three packs a day through the rest of college, medical school, an internship, 2 years in the Army, and his residency.

Like many other smokers, Dr. Hurt spent years trying to quit; sometimes for as little as 30 minutes, other times for as long as a week.

One day his wife, who also smoked, phoned him at work to tell him she had signed them up to attend a smokers' clinic at Rochester Methodist Hospital. "Had it not been for her calling me that day, I don't think I would have ever stopped smoking," he said. "More than that, I would probably not be here today. She was the motivation."

The group support there "made it so I was able to focus attention on me and what I was doing," Dr. Hurt said. "There was no pharmacotherapy at that time. I was focusing my energy and attention in a way I had never done before."

For him, the hardest part was the constant urges to smoke. "I took it in time increments that were manageable," he said. "I knew I could stop smoking for an hour, but I wasn't sure about 2 hours."

After a group session on Nov. 22, 1975, he drove home and quit smoking for good.

"There's an old adage in the alcoholism treatment world: Take it 1 day at a time," he said. "Some people take it in smaller increments than that. I certainly did [in] the beginning. The urges to smoke can be very powerful and intense, but they don't last very long."

He returned to the smokers' clinic, this time as a counselor for the group sessions. This role helped to "focus attention on preventing relapse and maintaining my abstinence from smoking," he said.

Today, when he counsels smokers at Mayo's nicotine dependence center, Dr. Hurt points out that smoking "brings an end-of-life experience that none of us want. The end-of-life experience all of us want is to live to be 85 or 90 and die in our sleep after having had a good meal, a couple of drinks, and sex," he said.

"None of us want to die in a hospital, in an ICU, or in a nursing home with a protracted end of life. The message is that nonsmokers and ex-smokers have compressed morbidity. That means that nonsmokers live longer and die shorter. Smokers live shorter and die longer," Dr. Hurt said. ■

By Doug Brunk, San Diego Bureau