

Terminating a Physician-Patient Relationship: Why is “Breakin’ Up” So Hard to Do?

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The Risk Management Department regularly receives inquiries from our members asking for advice on the best way to end a physician-patient relationship. Typical reasons include: suspicion that the patient is “drug-seeking;” chronic bad conduct, such as verbal abuse or non-compliance; or just refusal to pay the bill. Under certain circumstances, what might have been an easy and straightforward separation can become awkward and legally risky.

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Consider the following scenario:

Dr. C, a cardiologist, sees a patient suffering from underlying cardiac problems. Dr. C examines and treats the patient, Mr. D. Nyle. The physician informs the patient that he’s “a heart attack, waiting to happen” unless he promptly loses weight, stops smoking, and improves his eating and exercise habits.

Mr. D. Nyle doesn’t like Dr. C’s advice. Rather than comply, Mr. D. Nyle “fires” Dr. C. Thereafter, both physician and patient go their separate ways.

Some weeks later, Dr. C is the on-call cardiologist for the hospital Emergency Department (E.D.). At about 3:00 a.m., the E.D. physician pages Dr. C to consult on an apparent heart attack victim. Of course, the victim is Mr. D. Nyle, who was brought to the E.D. by ambulance after he collapsed at home. Mr. D. Nyle has the classic signs of a serious myocardial infarction.

Question: What does Dr. C do?

While driving in to the E.D., Dr. C recalls that he was “fired” by Mr. D. Nyle.

Shouldn’t that absolve him of any duty to care for this patient? But, he is concerned that his on-call status may complicate the decision.

Such a dilemma is hardly inconceivable. Even for physicians who are meticulous about documenting exactly how a physician-patient relationship ends, certain circumstances will require thoughtful analysis in order to minimize the risks. Whether or not he was “fired,” should Dr. C undertake D. Nyle’s care now?

Do special risks arise for Dr. C because of the way their prior physician-patient relationship ended? What risks arise if Dr. C refuses to undertake D. Nyle’s care?

With the above-described scenario in mind, we can review some of the basic characteristics of the relationship, and derive some strategies to minimize risks.

First, the physician-patient relationship is voluntary and a physician may decline to enter into the relationship,



altogether. No physician is required to care for a particular patient (absent a statutory or contractual duty – discussed below). However, once a physician-patient relationship exists, the physician has both legal and ethical duties to care for the patient, if medically necessary. Little is needed to create the physician-patient relationship. Providing advice over the telephone or a verbal promise to treat may be sufficient. And, whether or not a physician-patient relationship existed will always be determined retrospectively.

Second, either party may terminate a physician-patient relationship, but it must be a “proper” termination. A patient may simply decide to end the relationship (e.g., by “firing” the physician). But, regardless of who initiated the termination, a physician should give formal (i.e., written) advance notice of the termination, allowing the patient an opportunity to arrange for alternative care. The Medical Board of California advises licensed physicians that, in order to avoid allegations of abandonment (unprofessional conduct), the physician “... should notify patients of the following in writing:

- The last day the physician will be available to render medical care, assuring the patient has been provided at least 15 days of emergency treatment and prescriptions before discontinuing the physician’s availability.
- Alternative sources of medical care, i.e., refer patient to other physicians, by name, or to the local medical society’s referral service.
- The information necessary to obtain the medical records compiled during the patient’s care (whom to contact, how, and where).”

(see: www.medbd.ca.gov)

Third, under the law of patient abandonment, a physician has a duty to ensure continuity of care. If a physician terminates the relationship when his patient still needs care, but without providing alternative care, the physician may be legally liable for damages for abandonment. Abandonment is a violation of a physician’s fiduciary duty to ensure that a required course of treatment is carried out, unless the physician-patient relationship is properly terminated.

Fourth, a physician’s contract may specify a duty to treat the patient, thus creating a physician-patient relationship. A physician under contract with a health plan (i.e., receiving compensation to provide all the patient’s necessary medical care) probably has a physician-patient relationship, even if he never met the patient. If the patient’s condition requires care, whether or not an emergency, the physician may not disclaim any duty to provide care. The same obligations arise when the physician is contracted to serve as the on-call E.D. specialist.

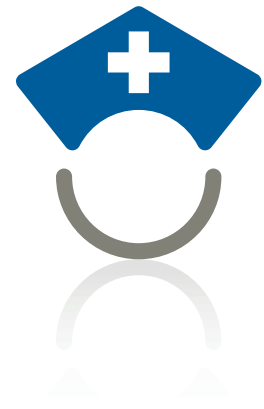
With these “basics” in mind, what is the prudent course of conduct for Dr. C? Clearly, Mr. D. Nyle “fired” Dr. C, thus ending their relationship. But, may Dr. C rely solely on the firing to refuse to assume care for Mr. D. Nyle in the E.D.?

Answer: Probably not! There is no objective evidence that a physician-patient relationship was irreversibly terminated. While a patient may terminate the relationship, a patient can also change his mind! Here, it seems likely that a patient in Mr. D. Nyle’s plight would tend to forget the “firing” if he desperately needs a cardiologist. In any event, relying upon the patient’s decision is risky (and gives rise to a problem of proof) should the patient later deny that any “firing” occurred. And, if Dr. C is the designated cardiologist on-call that morning, he may have a separate contractual duty to treat Mr. D. Nyle.

Failure to treat Mr. D. Nyle in this situation could expose Dr. C to charges of abandonment and professional discipline, up to and including license revocation. If, however, Dr. C had documented the termination of his relationship with Mr. D. Nyle at the time of the “firing,” and Dr. C was not the on-call cardiologist, he may decline to re-establish the physician-patient relationship (changing any of the particular factors may affect the advisability of declining or rendering care).

Discontinuing a Patient from Your Practice and a sample letter are available by calling the CAP Risk Management Hotline at 800-252-0555. Questions regarding specific instances of discharging a patient from your practice should be directed to the same number.

Recent OIG Advisory Opinion on Emergency Department On-Call Pay



A recently published opinion may be good news for hospital medical staff challenged to provide 24-hour specialty coverage for their Emergency Departments (E.D.). On September 27, 2007, the U.S. Department of Health & Human Services, Office of the Inspector General (OIG) posted Advisory Opinion No. 07-10. This advisory opinion was the first to address physicians' on-call coverage and uncompensated care arrangement employed by a hospital in order to ensure adequate specialty on-call coverage for the Emergency Department .

This advisory opinion was quite instructive, in that it identified several factors that would allow the OIG to find that payments by a hospital to physicians did not violate federal fraud & abuse laws. Previously, the OIG made it clear that on-call pay programs would be “scrutinized closely” on a case-by-case basis to insure that the program was not sham (i.e., money paid, but no discernable services), or merely a means to pay physicians in exchange for referring Medicare patients to the hospital. Most hospital medical staff bylaws already make specialty on-call service mandatory. Thus, taking payment could represent “double pay” (i.e., if physicians bill and collect fees for services actually provided to patients).

Under the arrangement described in the advisory opinion, the hospital agreed to pay nearly all medical and surgical specialists if they: (1) took E.D. call, (2) responded within minimum time limits, (3) provided in-patient follow-up care, regardless of the patient's ability to pay, (4) consulted while on call for other physicians' patients, and (5) promptly completed medical records. Payments were set at standard amounts (per diem) for each specialty, for each day served on-call. All payments were at “fair market value” as verified by a nationally recognized consulting firm. And, each physician was still required to provide a minimum of one and one-half days per month of uncompensated call coverage.

The OIG opinion identified the following critical factors: (1) the on-call program was open to all qualified physicians; (2) physician responsibilities were equally distributed among all physicians; (3) physicians were

obliged to provide follow-up care to all patients, regardless of ability to pay; (4) services provided to patients were adequately documented; and (5) the program was structured so that all payments to physicians were absorbed by the hospital, and none were charged to the Medicare or Medicaid (Medi-Cal) programs.

In ruling favorably on the program, the OIG noted that the hospital had difficulty, historically, obtaining sufficient physicians to provide on-call E.D. coverage. In the past, the hospital was forced to transfer patients to other facilities in order to obtain some specialty services. According to the OIG, such circumstances “lower the risk that the arrangement was instituted as a way to funnel unlawful remuneration to physicians for their referrals.” In summary, the OIG explained that any on-call E.D. coverage program must meet a documented need; it must obligate physicians to provide meaningful and objectively necessary services; and it should compensate physicians in a reasonable manner, in light of the nature of services provided and the likelihood of third party reimbursement.

The entire advisory opinion may be accessed at: <http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpno7-10A.pdf>

¹ OIG Advisory Opinions are published periodically to provide guidance re: whether particular transactions and/or relationships violate federal fraud & abuse laws. Each Advisory Opinion addresses a specific situation (here, an E.D. on-call arrangement proposed by an unnamed hospital) and may, or may not, apply to different situations. OIG Advisory Opinions are merely guidelines; not binding on DHHS.



WARNING: Don't Go Into the Medical Board of California Alone

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The first a physician may know that a patient or family has complained to the Medical Board of California (MBC) about medical care may be when the physician receives a request to appear before a MBC hearing.

At other times, the request to appear may be generated by a report to the MBC of a closed professional liability claim because the indemnity paid exceeded \$30,000.

Just as a physician would not try to represent himself or herself in a case in Superior Court, in this instance the physician also needs legal guidance. The Cooperative of American Physicians, Inc. recommends that physicians avail themselves of legal representation. Outcomes from such appearances can be severe and the physician's medical license may be at risk. The cost for such guidance may cause hesitation, but it should not. As a Cooperative of American Physicians member, you have \$25,000 of MEDefense coverage for legal costs when medical care is being defended before the MBC.

To report a request for appearance, physician members should call NAS Insurance at 818-382-2030 immediately upon receipt of the request for appearance or an inquiry regarding the care. As appropriate, NAS will suggest legal counsel to the physician from a panel of attorneys.

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