

"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

- Ludwig Wittgenstein

Hot Topic

Firing Patients

The principle of beneficence is an essential aspect of patient care. Often times, it is the reason many providers choose to go into the field of medicine, a quintessential desire to promote good for patients and other people. At times, this obligation to do good comes into conflict with the patient's own preferences, which ethics describes as a conflict between the principles of beneficence and autonomy. This is a normal situation and is typically resolved through open communication and shared decision making ([Barry & Edgman-Levitan, 2012, p 780-781](#)).

But at what point does the patient's nonadherence to medical recommendations impact the provider/patient relationship so much that a beneficial relationship is no longer possible? As [Capozzi, Rhodes, & Gantsoudes \(2008\)](#) state, "it seems fair to say that patients should also do their part in promoting the health and healing of their bodies. It is also fair to say that there are limits to a physician's obligation to provide care (p. 208). When is a provider permitted to dismiss (we will avoid the use of the word fire) a patient?"

When To Avoid It

An overly simplistic answer is that a provider should not dismiss a patient. The principle of respect for autonomy "affirms that each and every person has moral value and dignity in his or her own right" and a fundamental aspect of the principle is "acknowledging the moral right of every competent individual to choose and follow his or her own plan of life and action." ([Jonsen, Siegler, & Winslade, 2015, p. 49](#))

This includes the patient's right to make decisions that the provider does not agree with. Health care providers should do everything within their ability to inform patients what they recommend but allow for the patient to make those decision for themselves. Patients will make decision that the provider does not agree with, but that should not be grounds for firing because "the irresponsible or unhealthy behavior of a patient does not release a physician from his or her responsibility to that patient. Even though each of us should endeavor to be a good steward of the body, a patient's failure to do so is quite common." ([Capozzi, Rhodes, & Gantsoudes, 2008, p. 209](#))

But should is an idealistic stance, seeing things as a way we would want them to be but not as they actually are. Too often in medicine, we have to come down from "should" to a more pragmatic solution. There are several reasons for firing a patient. These include inappropriate behavior, falsifying medical history, failure to pay bills, and verbal and/or physical violence. But probably the most frequent reason is the patient's failure to comply with a treatment plan ([Sanfilippo & Smith, p. 45](#)). This is one of the more challenging reason for dismissal because of the nature of patient nonadherence.

When It's About Nonadherence

True patient nonadherence is a reasonable reason for dismissal because of the nature of the physician/patient relationship. If a patient actively chooses to not adhere to a treatment plan, then the physician cannot properly engage with that patient in the future. For how can you properly provide for a patient if you know the patient does not trust the physician enough to follow their advice?

The establishment of trust is essential for a proper relationship, so much so that the American Medical Association addresses it in the beginning of its Code of Ethics. In Opinion 1.1.1., the Code states, "The practice of medicine, and

its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare" ([AMA Code of Ethics](#)).

Keep in mind this is a specific situation of active nonadherence, where the patient has capacity, understands the situation, has resources and ability to follow the treatment, and consciously chooses to not comply. This is typically referred to an Informed Refusal. If the patient does not understand the treatment plan enough to properly follow, or socioeconomic factors impact the patient's ability to adhere, that is not informed refusal, but rather a subjective nonadherence. There may be many reasons for a patient to not adhere to treatment plan, including lack of means, being overwhelmed, or have other goals. In fact, even physicians fail to complete courses of antibiotics and other treatment plans when prescribed to the them ([Capozzi, Rhodes, & Gantsoudes, 2008, p. 209](#)). Therefore, these should not be grounds for patient dismissal but rather the opening of a long, often more challenging patient/physician relationship.

When It May Be Appropriate

But there is a point a point where dismissing a patient is ethically supported. As discussed, these should be extreme situations, where all attempts have been made to continue but the patient actively chooses dismissal, either by violence or informed refusal. In these cases, ending the relationship is ethically permitted if handled properly. This includes two elements towards the patient; reasonable notice and reasonable opportunity to find another clinician ([Sanfilippo & Smith, 2015, p. 46](#)).

Dismissing a patient is a decision that should never be taken lightly. It should not be the abandoning of a patient who wants to continue care, but rather a difficult act that a patient knowingly chooses. And even then, action is required so that the patient, if he/she chooses, may establish a beneficial relationship with another provider.

Bioethics in the News

[Renée C. Fox, Founding Figure of Medical Sociology, Dies at 92](#)

[Recommendations on COVID-19 triage: international comparison and ethical analysis](#)

[Bioethics must 'break out' of ivory tower and engage society, academic says](#)

[Are you a burnt-out bioethicist? If so, you've got company](#)

[Yale professors design COVID-19 vaccine allocation frameworks](#)

Case Study

The patient is a 54-year-old male, suffering from multiple medical condition including shortness of breath, COPD, renal complications, and confusion. The patient does have a history of alcohol and substance abuse. The patient does have decision making capacity but is also supported and spoken for (not in an official way) by this large family. The family and the patient are particularly demanding, regarding care, attention, and the direction of care.

The medical team have expressed concern for multiple reasons. One, the patient is approaching medical standard for discharge, but would likely need to go to a skilled nursing facility or rehab, but due to a history of noncompliant/nonadherence behavior, finding an accepting facility would be very difficult. Two, the patient and the family do not believe the patient is ready for discharge, not accepting the opinion of the medical team. They are demanding additional testing, care, and procedures. These procedures are not standard or indicated for the patient in his current state. When this is brought up and discussed, the family and the patient become extremely agitated and aggressive, raising voices and threatening lawsuits. The medical team, particularly the attending

physician, believe there is nothing more they can provide, and are considering firing (dismissing) the patient. There is a complication, because the patient has been dismissed from most other hospitals and therefore would not be able to access care if dismissed. The physician and team requested ethics for support.

Ethical Musings

The Physician's Oath

"I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant" ([Hippocratic Oath – Classical Version](#)).

While this may be familiar to many, it will not be to many others. This is the opening statement of the original Hippocratic Oath from 400 BCE. This oath may be highly outdated. For example, the original oath states, "I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work", which would make standard medicine difficult and surgery impossible, but there is a fundamental value of an oath, or a promise, by a physician. Oaths are an important aspect of modern medical practice, with 98% of physicians in the United States having taken some form of oath ([Sriharan et al.](#)), but even more important in the public and popular imagination.

Self-Imposed Obligation

The fundamental value of taking an oath is the personal understanding of the now self-imposed obligations one is assuming. There are several different types or ways of thinking of obligation. Obligations are requirements of action, and are by their nature limitations of the person's freedom. These are standards that restrict particular actions and compel others. Some often state types of obligations, including legal, moral, political, and self-imposed (which could be a combination of the others). One can feel moral distress and be in an ethical dilemma when different obligations are in conflict with one another. When one holds an obligation, one is not truly free or have freedom of action for one is always bonded by that obligation. Such restrictiveness and limiting of freedom is often seen as ethically permissible due to the obligations being self-imposed.

A typical statement in a modern medical oath is "I will assist my patients to make informed decisions that coincide with their own values and beliefs and will uphold patient confidentiality" (Sriharan et al.). This statement appears to place high value on the principle of autonomy, with the medical decisions being of the patient's values and beliefs. It is also in line with modern approaches of shared decision making ([Legare & Witteman](#)). But where does this place the principle of beneficence and professional obligations? As mentioned, ethical dilemmas arise when competing obligations exist.

Mutual Obligation

Relative to the topic of this Dispatch, does the dismissing of a patient violate the medical oath and thus the self-imposed obligation of the physician? This can be resolved but thinking about what that obligation really is.

In the matter of informed refusal dismissal, the patient is aware of the limits of the relationship and what the physician is able/willing to do. As the oath states, the physician took the obligation of assisting the patient to make decisions that are in line with the patient's beliefs and values. This could involve the dismissal of a patient to another physician who is more willing and able to provide medical care in the manner the patient is desiring.

In situations involving threats and violence, according to several action theory philosophers, obligation is not an individual action but rather a shared activity. Margaret Gilbert "has objected that reductive approaches overlook the mutual obligations between participants essential to shared activity: each participant is obligated to the others

to do his or her share of the activity, and unilateral withdrawal constitutes a violation of this obligation” [\(SEoP\)](#). While the physician has an obligation to the patient, the patient has an obligation to the physician (not to threaten, assault, etc). This would mean that in both of these situation, the obligation (and the oath the physician took) is not violated by the dismissing of a patient.