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Must A Physician Treat A Disruptive Or Abusive Patient Or Can The Doctor Fire That Person?

By Samuel D. Hodge, Jr.¹

*“The art of medicine consists of amusing the patient while nature cures the disease.”
– Voltaire*

Andy Spence was found unconscious outside a bar bleeding profusely from the head. He was transported to the nearest hospital and Fatima Khadijah, M.D., an emergency room physician, stitched his scalp and ordered a CT scan. Blood work revealed a blood/alcohol level of .25, well above the legal limit for intoxication. Mr. Spence awakened a short time later and was immediately combative. The physician, who is Muslim and wearing a Hijab, tried to calm him down but her presence only inflamed the situation. Spence pulled out his cell phone and began shouting at the doctor while he filmed the encounter. He told the physician in the crudest language imaginable to get out of the room and demanded to see a “real doctor” who was from the United States. Dr. Khadijah calmly replied that she was not going to take his abuse and would send in a nurse.

Incensed, the patient ripped out his IV, stumbled into the hallway and started yelling that if an American doctor did not immediately see him, he was leaving and would post the video for the world to see. The supervising nurse approached the patient and explained the need for him to return to his room so that he could be monitored for a possible brain injury. Spence pushed past the woman and left the hospital in a huff. Dr. Khadijah then noted in the chart that the patient left

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the hospital against medical advice and that Spence would not allow her to treat him because she is Muslim.

The results of the CT Scan were completed and posted by radiology in the patient's chart. The images revealed that Mr. Spence had a large subdural hematoma. A nurse immediately called the patient's residence and left a message indicating that he needed to quickly come back to the hospital. Several hours later, Mr. Spence's wife returned home and found him on the floor unresponsive. He was transported by ambulance to the hospital where he underwent emergency brain surgery. Unfortunately, the patient was left permanently incapacitated.

This hypothetical raises several legal, medical and ethical issues concerning the right of a physician to refuse to treat a disruptive or abusive patient and the duty owed to someone who leaves a hospital against medical advice.

I. The Problem Patient

Problem patients are part of the practice of medicine and all physicians will be exposed to this unpleasant experience. An irritable patient may be triggered by a minor inconvenience or the anxiousness of dealing with an illness. Regardless of the reason, patients are taking out their frustrations on the medical staff with increased frequency.² This annoyance can result in the disregarding of a physician's instructions, leaving a hospital against medical advice, or physically assaulting a member of the medical staff.

Physicians are responding to these disruptive, deceitful, noncompliant or threatening patients by refusing to treat them. In most instances, the doctor-patient relationship is voluntary

² *How to Deal with 'Problem' Patients at Your Healthcare Practice*, PATIENTPOP (June 5, 2018), <https://www.patientpop.com/blog/running-a-practice/patient-experience/5-strategies-for-dealing-with-problem-patients-and-when-you-should-let-them-go/>.

and can be terminated by either party with certain limitations.³ Physicians in private practice have more latitude to deny treatment than those in Medicare compliant hospitals, but there are times that even these facilities can refuse to treat the person.⁴

This article consists of several parts. First, Part One will discuss the troublesome patient and the various ways a person can receive that designation. Next, Part Two will examine the circumstances under which a physician can refuse to see a patient or terminate that relationship. Finally, Part Three will highlight some of the cases that have arisen involving problem patients in various contexts.

A. Workplace Violence

The news about violence in a healthcare setting is becoming all too familiar: a heart specialist is killed in a Boston hospital by the son of a deceased patient; a physician is shot for declining to give narcotics to the murder's wife; and a surgeon is killed while riding his bicycle by a person holding a two decades old grudge over treatment rendered to a family member.⁵ These cases demonstrate that the days of a patient placing a doctor on a pedestal are gone. Healthcare providers are now confronted by individuals who are abusive, combative, or threatening.⁶

Most people don't appreciate that medical facilities are the most common location for workplace violence. Statistically, 45% of all incidents of violence at work happen in a health care setting and the rates of injury requiring lost time from work are more than four times greater

³ Bob Baizer, *Can a Doctor Deny Me Treatment? When, Why, and What are my Options*, BAIZLAW.COM, <https://www.baizlaw.com/can-doctor-deny-treatment-options/> (last visited Oct. 18, 2019).

⁴ *Id.*

⁵ *Hazardous to Your Health: Violence in the Health-Care Workplace*, ASH CLINICAL NEWS (Dec. 1, 2018) <https://www.ashclinicalnews.org/features/hazardous-health-violence-health-care-workplace/>.

⁶ Sharon Peters & Alison Hay Petersen, *Ensuring Safety and Compliance During Difficult Patient Encounters* (Feb. 5, 2018).

than the national average for all employees.⁷ Emergency room violence is increasing and a survey reveals that the majority of emergency room physicians have been the subject of violence. Patients are the culprits 97% of the time and the top five offenses include a “hit or slap (44%), spit (30%), punch (28%), kick (27%), and scratch (17%).”⁸ No specific diagnosis or type of patient is predictive of an outburst and research shows that acute psychiatric care, geriatric long-term treatment, high-volume urban emergency departments, and residential social services present the greatest dangers.⁹

A number of these incidents go unreported making the statistics even more startling since many healthcare workers feel that assaults are part of the job. For instance, only 30% of nurses report occurrences of workplace violence and 26% of emergency room physicians document these encounters.¹⁰ Many physicians and staff members acknowledge that violent outbursts by patients are usually not intentional and unavoidable on the patient’s part because of a mental illness or impairment.¹¹ This creates a hesitancy to assign blame to the patient out of concern that it will stigmatize the individual.¹²

These acts of violence are not limited to patients. Family members of those who are ill, other visitors, employees, and criminals are also offenders. A number of factors contribute to this violence including the fact that patients and their loved ones are often distraught, and health care personnel must work in stressful environments. People can also gain entrance to a hospital at any

⁷ Christian Nordqvist, *Healthcare most dangerous place for workplace injuries*, MED. NEWS TODAY (July 20, 2013), <https://www.medicalnewstoday.com/articles/263709.php>.

⁸ Christopher Cheney, *Assaults Against ER Physicians And Staff Rising*, HEALTHLEADERS (Oct. 3, 2018), <https://www.healthleadersmedia.com/clinical-care/assaults-against-er-physicians-and-staff-rising>.

⁹ ASH CLINICAL NEWS, *supra* note 5.

¹⁰ *Physical and Verbal Violence Against Health Care Workers*, SENTENTIAL EVENT ALERT, Apr. 17, 2018, at 2.

¹¹ Sharon Peters & Alison Hay Petersen, *supra* note 6.

¹² *Id.*

time, and the presence of opioids can make healthcare settings inviting targets.¹³ Other stressors include long wait times or overcrowding in the clinical setting, the lack of training of security and staff to recognize assaultive actions by patients, visitors or gang members, domestic disputes between a patient and visitor, possession of a weapon, and understaffing, particularly during mealtimes and visiting hours.¹⁴

Those who commit acts of violence can generally be placed into two classes. The first are the affective or spontaneous offenders, who are prompted by their immediate circumstances. The second refers to predatory wrongdoers, who consciously plan out their acts.¹⁵ This is an important distinction because physicians may be able to reduce the hostility of affective offenders but they might place themselves in harm's way by attempting to reason with predatory wrongdoers.¹⁶

The consequences of this violence are not limited to the physician or employee who is the subject of the confrontation. Those who witness the event can also suffer emotional aftereffects that can cause missed time from work, decreased quality of work enjoyment, burnout, and decreased productivity.¹⁷ A more troubling sequelae is that some healthcare professionals express a diminished lack of confidence in their skills and develop uncertainty about the ability to interact with patients successfully.¹⁸

Certain warning signs exist that demonstrate a patient's psychological wellbeing is deteriorating. These include a change in body language such as the tightening of a jaw, tense

¹³ *Violence in Healthcare Facilities*, ECRI INST. (May 24, 2017), <https://www.ecri.org/components/HRC/Pages/SafSec3.aspx>.

¹⁴ SENTENTIAL EVENT ALERT, *supra* note 10, at 3.

¹⁵ Bob Tedeschi, *As Patients Turn Violent, Doctors and Nurses Try to Protect Themselves*, STAT (Nov. 20, 2015), <https://www.statnews.com/2015/11/20/patients-violence-hospitals/>.

¹⁶ *Id.*

¹⁷ ECRI INST., *supra* note 13.

¹⁸ Sharon Peters & Alison Hay Petersen, *supra* note 6.

posture, raised voice, clenched fists, and other meaningful changes from earlier conduct. In these situations, the physician is encouraged to spend additional time with the patient, show empathy, respond calmly, and not answer until the patient has completed the outburst.¹⁹ If the person is uncooperative, the physician should attempt to learn the reason and calmly explain the significance of the conduct. If the patient is irrational, it makes little sense for the physician to defend his or her actions because it most likely will make the situation worse.²⁰

B. Disruptive Patient

Most patients appreciate the assistance provided by physicians. While a small number of patients resort to violence, others may become disruptive, use insensitive language and make unreasonable demands.²¹ This unacceptable behavior is generally described as any conduct that hinders a provider's ability to render care, interferes with communications, threatens the welfare of others, or causes damage to property. Such conduct also includes making verbal threats or derogatory comments, excessive noise, sexual remarks or offensive gestures, possession and use of alcohol or illicit drugs on the property, throwing objects, stealing, and knowingly giving false or misleading information.²² Nurses bear the brunt of these outburst because they have the most patient contact. In addition, gender plays a role in this scenario since 90% of nurses are female.²³

These actions have repercussions that can affect the rendering of care. However, it should be noted that disruptive patients often "act out" as the result of the stress of being ill and the fear

¹⁹ *Handling the Angry Patient*, HPSO, <http://www.hpso.com/risk-education/individuals/articles/Handling-the-Angry-Patient> (last visited Oct. 15, 2019).

²⁰ *Id.*

²¹ Shelly Schwartz, *Dealing with Disruptive Patient Behavior*, PHYSICIANS PRAC. 1 (June 9, 2014), <https://www.physicianspractice.com/difficult-patients/dealing-disruptive-patient-behavior>.

²² Kelli Blanchard, *Keeping the Peace: Considerations for Disruptive Patient Behavior Policy*, HEALTHCARE BUS. INSIGHTS (Oct. 3, 2017), <https://www.healthcarebusinessinsights.com/blog/revenue-cycle/keeping-peace-considerations-disruptive-patient-behavior-policy/>.

²³ Susan Ladika, *Violence Against Nurses: Causality of Caring*, MGMT. CARE MAG. (May 6, 2018), <https://www.managedcaremag.com/archives/2018/5/violence-against-nurses-casualties-caring>.

that their health may deteriorate; thereby causing a financial strain upon limited resources.²⁴

Mental illness also plays a role. Actions that a reasonable person would consider counterproductive are customary in those with dementia or patients suffering from personality disorders.²⁵

Being the recipient of disruptive conduct not only impacts the welfare of the targeted health care worker, but it also affects patient safety and increases the chances of an adverse event. Physicians who are exposed to continuing abuse may develop mental health problems, sleep disturbances and change employment.²⁶

Emergency rooms are particularly stressful environments, and it is common to wait hours at these facilities. This can cause tempers to flare and individuals may lash out when they believe inappropriate care is being rendered or because the pain suffered by the patient is continuing unnecessarily.²⁷ Disruptive behavior is also symptomatic of today's society and political climate where such conduct has become routine and acceptable.²⁸

Health care workers are entitled to a safe work environment and facilities have started posting signs that there is zero tolerance for abusive behavior.²⁹ For instance, it is the stated policy of Lakewood Medical Center that "it has a duty to provide a safe and secure environment for patients, staff and visitors. Violent or abusive behavior will not be tolerated, and decisive action will be taken to protect staff, patients and visitors."³⁰

²⁴ Shelly Schwartz, *supra* note 21.

²⁵ *Id.*

²⁶ *When Physicians Feel Bullied: Effective Coping Strategies*, CMPA (Mar. 2014), <https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/when-physicians-feel-bullied-effective-coping-strategies>.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ Taras Gwozdecki, *Violent and Abusive Patient/Visitor Policy*, LAKEWOOD MED. CTR. (2010), <https://www.lakewoodmedical.ca/index.cfm>

Attempts to deescalate the situation should only be attempted with those who do not present an immediate risk. This is accomplished by talking to the person in a calm manner, giving the person a chance to explain their conduct, and explaining how their actions may compromise patient care. If these efforts fail, a manager should be brought into the situation with the ability to issue an informal warning noting that the conduct is unacceptable and must cease.³¹

Repeated incidents of disruptive behavior after the issuance of an informal warning, mandates the issuance of a formal, written warning. This communication will inform the individual that the patient's relationship with the facility may be suspended if the conduct persists.³² If this remedial step fails, the health care provider should suspend the patient. This action, however, carries the risk that the patient may claim abandonment.³³ This type of medical malpractice occurs when a physician terminates the doctor-patient relationship without reasonable notice or a reasonable explanation, and the doctor fails to offer the patient an opportunity to find a different physician.³⁴

One innovative approach is demonstrated by a program at Ochsner Medical Center in New Orleans. Known as "Code Green," a staff member can obtain immediate help in dealing with a disruptive patient by sounding an alarm.³⁵ A trained team will promptly arrive and address the issues presented. If the patient does not respond appropriately, the team is allowed to post a security guard at the door or send the patient to the psychiatric wing.³⁶

³¹ Kelli Blanchard, *supra* note 22.

³² *Id.*

³³ *Id.*

³⁴ Prathyusha Chowdri, *What is Patient Abandonment?*, NOLO, <https://www.nolo.com/legal-encyclopedia/what-patient-abandonment.html> (last visited Oct. 15, 2019).

³⁵ Edward Doyle, *New Options for Handling Disruptive Patients*, TODAY'S HOSPITALIST (June 2008), <https://www.todayshospitalist.com/new-options-for-handling-disruptive-patients/>.

³⁶ *Id.*

The legislatures of several states have also taken up the mantle and require the implementation of violence prevention measures by health care employers and impose incident reporting mandates as well as anti-retaliation safeguards.³⁷ Hospitals may also be fined by state or federal OSHA agencies for not properly safeguarding their staff,³⁸ and the facilities may be sued by patients who witness or overhear disruptive conduct.³⁹ For instance, a patient at Northwestern Medicine Delnor Hospital sued the facility after an unshackled prisoner created a hostage situation involving the nursing staff. The patient thought that she heard the nurses screaming and claimed that the encounter caused her to develop post-traumatic stress disorder that made her afraid to receive medical attention at any health care facility.⁴⁰

C. The Non-Compliant Patient

A non-compliant patient generally refers to a person who fails to adhere to a recommended course of treatment or does not take prescribed medication.⁴¹ This noncompliance has reached an epidemic level and the inability by physicians to offer optimal treatment has turned into one of the most important issues in healthcare.⁴² Statistically, 75% of patients surveyed admitted to not taking medication as prescribed; 50% of pills are not consumed or used incorrectly; and 30% of people fail to fill a new prescription.⁴³

³⁷ Sharon Peters & Alison Hay Petersen, *supra* note 6 (including sample states, such as California and Oregon).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Hannah Leone, *Lawsuit: Hostage Situation at Delnor Hospital Gave Patient PTSD*, CHI. TRIB. (Apr. 24, 2017), <https://www.chicagotribune.com/suburbs/aurora-beacon-news/ct-abn-patient-sues-delnor-kane-county-st-0824-20170824-story.html>.

⁴¹ William C. Shiel, *Medical Definition of Non-Compliance*, MEDICINET, <https://www.medicinenet.com/script/main/art.asp?articlekey=10159> (last updated Dec. 27, 2018).

⁴² Neil Chesanow, *Why Are So Many Patients Noncompliant?*, MEDSCAPE (Jan. 16, 2014), <https://www.medscape.com/viewarticle/818850>.

⁴³ *Id.*

There is no simple explanation as to why patients fail to follow a doctor's instructions but many of the reasons have a psychological foundation.⁴⁴ These include:

- A patient not seeking medical attention for new symptoms in order to deny an illness or because of the fear of hearing bad news.
- An individual may not seek attention for an adverse reaction to medication or treatment because the patient was not instructed to contact the physician if a problem arises.⁴⁵
- Some patients have an inherent distrust of healthcare providers and refuse to undergo needed diagnostic testing, consultation or treatment.
- Certain people “doctor shop” and will only follow the treatment of their choice.
- Patients fail to discontinue injurious or dangerous activities after surgery.⁴⁶
- Patients fail to adhere to temporary restrictions such as returning to work too soon.
- Patients do not adhere to dietary restrictions.
- Patients continue to use over-the-counter drugs after being told to discontinue them.
- The individuals fail to give up a dangerous lifestyle such as smoking or lack of exercise.⁴⁷
- The premature leaving of a hospital against medical advice.⁴⁸

Patients with chronic conditions that only require occasional doctor visits may become noncompliant because they are not being monitored on a frequent basis. This noncompliance is usually caused by forgetfulness or the patient is not exhibiting symptoms so they stop the medication that is regulating the condition.⁴⁹ One should also not overlook the cost of drugs as a

⁴⁴ *Id.*

⁴⁵ DAN TENNENHOUSE, *Attorney's Medical Deskbook, Non-Compliance*, at 1–2 (4th ed. 2019).

⁴⁶ *Id.* at 6.

⁴⁷ *Id.* at 8.

⁴⁸ *Id.* at 9–17.

⁴⁹ Neil Chesnow, *supra* note 42.

reason to skip dosages even for life-threatening conditions.⁵⁰ In this regard, the World Health Organization estimates that about 125,000 people with treatable conditions die annually in this country because they fail to take medication as prescribed.⁵¹

Addressing these problems can be challenging since the idea of a physician being paternalistic by admonishing the patient on what to do or what not to do is considered politically incorrect. Doctors and patients also have differing views on following the proper medication dosage and lifestyle changes that have been ordered.⁵² It is the role of the physician to maximum a patient's health outcome and they are not interested in massaging the patient's feelings in the present. On the other hand, patients are more interested in leading an easier lifestyle rather than worrying about their future health status.⁵³

These conflicting views could be minimized if patients did not switch health care plans or doctors as often and insurance carriers did not raise premiums each year. The mandates of managed healthcare also require doctors to be more productive in a shorter period of time, thereby depriving the physician of the time needed to address "patient barriers to compliance."⁵⁴ This dynamic is reflected by the fact that only 55% of patients rely upon the advice of their doctors concerning treatment decisions; while the remaining individuals obtain direction from other sources such as the Internet.⁵⁵

Changing these behaviors is a complicated subject that can only be solved with a strong doctor-patient relationship and treatment decisions that are jointly made.⁵⁶

⁵⁰ *Id.*

⁵¹ William Scarlett & Steve Young, *Medical Noncompliance: The Most Ignored National Epidemic*, 116 J. AM. OSTEOPATHIC ASS'N 554, 554–55 (2016).

⁵² Neil Chesnow, *supra* note 42.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ William Scarlett & Steve Young, *supra* note 51, at 555.

D. Patients Discharged Against Medical Advice

There is no uniform definition for what constitutes a discharge against medical advice (AMA).⁵⁷ The medical profession, however, generally considers the term to encompass a competent patient who leaves the hospital before the treating physician has determined that the person is ready for discharge. AMA presents physicians with challenges because of the increased risk of litigation and likelihood of an adverse medical event.⁵⁸ Research reveals that those who leave the emergency room against medical advice are up to ten times more likely to sue the facility than other emergency department patients.⁵⁹ Also, this premature departure puts the person at risk for developing medical complications which may result in readmission to the hospital.⁶⁰

It has been estimated that the problem constitutes 2% of all hospital discharges.⁶¹ In fact, it has been determined that those who leave a hospital against medical advice are 7 times more susceptible to being readmitted within 15 days and usually for the same problem.⁶² This problem is only becoming worse in an acute care setting. It is estimated that there has been a 39% increase in the number of patients leaving a hospital against medical advice between 1997 and 2007.⁶³ The leading diagnosis for those leaving AMA were: nonspecific chest pain (7%);

⁵⁷ Sharon Peters & Alison Hay Petersen, *supra* note 6.

⁵⁸ Alexandra Godfrey, *Leaving Against Medical Advice (AMA): A Clinician's Dilemma*, NEJM J. WATCH BLOGS (May 11, 2017), <https://blogs.jwatch.org/frontlines-clinical-medicine/2017/05/11/leaving-medical-advice-ama-clinicians-dilemma/>.

⁵⁹ Matthew DeLaney, *The Proper Way to Go Against Medical Advice (AMA): 8 Elements to Address*, ALIEM (Jan. 13, 2014), <https://www.aliem.com/2014/01/proper-way-to-go-against-medical-advice/>.

⁶⁰ David J. Alfandre, *"I'm Going Home": Discharges Against Medical Advice*, 84 MAYO CLINIC PROC. 255, 255 (2009).

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Number of patients leaving against medical advice increasing*, ACCESS MGMT. Q. (Nov. 1, 2009), <https://www.reliasmedia.com/articles/114639-access-management-quarterly-number-of-patients-leaving-against-advice-increasing>.

alcohol-related disorders (6.9%); substance-related disorders (5.7%); mood disorders (3.8%); and diabetes with complications (3.4%).⁶⁴

There are a number of risk factors for a patient leaving a hospital against medical advice. These include being younger and male, having a history of substance abuse, failing to have insurance or a primary care physician, and having a prior record of AMA discharges.⁶⁵ The patients also tend to be covered by Medicare and Medicaid or have no insurance. Race is not a factor and they are heterogeneous.⁶⁶

Patients offer various reasons for leaving a hospital such as financial obligations, feeling better, the need to pick up a Social Security or public-assistance check, and family obligations.⁶⁷ Other contributing factors include drug problems, pain management issues, external commitments, wait times, the doctor's bedside disposition, being at a teaching hospital, and communication problems.⁶⁸

Informed consent is an important consideration involving care for patients who leave a hospital against medical advice. Informed consent means that the person has made a health care decision in consultation with the physician with full knowledge of the risks, benefits and alternatives without being coerced.⁶⁹ However, the term applies even if no such advice was provided by the doctor.

It has been advised that patients who wish to leave the hospital are asked certain questions to make sure they understand the meaning and consequences of their actions. These

⁶⁴ *Id.*

⁶⁵ Sri Lekha Tummalapalli & Eric R. Goodman, *What Are Best Practices for Patient Discharges against Medical Advice?*, HOSPITALIST (Jan. 2016), <https://www.the-hospitalist.org/hospitalist/article/121916/what-are-best-practices-patients-discharged-against-medical-advice>.

⁶⁶ *Id.*

⁶⁷ David J. Alfandre, *supra* note 60, at 258; *See also id.*

⁶⁸ Sri Lekha Tummalapalli & Eric R. Goodman, *supra* note 65.

⁶⁹ David J. Alfandre, *supra* note 60, at 258.

questions include: Does the patient comprehend the admitting diagnosis, prognosis, risks and benefits of leaving the hospital? Does the person know the treatment options and the risks and advantages associated with them? Is the individual capable of making an intelligent choice? Can the patient justify the reason for refusing to stay at the hospital?⁷⁰ These questions and answers should be documented in the chart so that the patient is provided with the best care possible and the file is properly documented in case of litigation.⁷¹

Most patients are asked to sign a form noting that they are leaving the hospital against a physician's wishes but these forms are confusing to many patients.⁷² In this regard, merely completing the AMA form does not exonerate a physician from liability if the doctor has not explained the risks and benefits concerning the patient's refusal of hospital care.⁷³

The form is usually drafted as a "Release from Liability" and will start by describing the dangers of leaving the hospital against medical advice. It will then go on to note:

"The patient has stated [his/her] decision to leave the hospital. Patient, and the following family members [names of family members]; have been told by me that continued hospitalization is necessary and departure from the hospital on [date of departure] would endanger the health and well-being of the patient."⁷⁴

A hospital cannot usually prevent the patient from leaving the facility⁷⁵ As noted in *Cruzan v. Dir. Missouri Dept. of Health*, "[m]ost courts have based a right to refuse treatment either solely on the common law right to informed consent or both the common law right and a constitutional privacy right."⁷⁶ The patient who leaves the hospital before the completion of

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² Alexandra Godfrey, *supra* note 58.

⁷³ Sri Lekha Tummalapalli & Eric R. Goodman, *supra* note 65.

⁷⁴ 9A AM. JUR. 2D *Release— Discharge from Hospital Against Medical Advice – Patient's Acceptance of Responsibility* § 136.54, Westlaw (database updated Nov. 2019).

⁷⁵ Aahren Rodriguez DePalma, *Restraining Patients to Prevent Injuries*, DRI 54 (Oct. 2011), <http://www.pspclaw.com/Articles/2011%20October%20FTD%20-%20Forced%20Detentions-A%20Duty-Restraining%20Patients%20to%20Prevent%20Injuries.pdf>.

⁷⁶ *Cruzan v. Dir. Mo. Dept. Health*, 497 U.S. 261, 271 (1990).

treatment is employing the privilege to refuse medical treatment.⁷⁷ Nevertheless, the hospital must still notify the individual of the dangers associated with leaving the facility.⁷⁸

II. The Physician's Right to Refuse to Treat a Person

Physicians have an obligation to serve a patient's best interests. This principle is part of the fabric of medicine. Simultaneously, practitioners are individuals with their own moral compass. Occasionally, that compass will cause a doctor to refuse to treat a patient.⁷⁹ This refusal can be traced back to Hippocrates more than 2,500 years ago. He explained good medicine as "doing away with the suffering of the sick, lessening the violence of their diseases, and refusing to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless."⁸⁰ Physicians followed the teachings of Hippocrates for centuries and took a paternalistic approach to patient care.⁸¹

Physicians in the 21st century have grown increasingly frustrated with the practice of medicine because of third party interference, the decreased ability to practice independently, the reduced personalization of medicine, and stress.⁸² At the same time, the number of problem patients has increased. These dynamics have caused physicians to terminate a doctor-patient relationship or refuse to treat an individual at the outset.

In considering the legality of this position, it must be noted that the relationship between a physician and patient is a contract, in which a doctor should have the right to refuse to provide services to an individual. That is not is not always the case and there are important restrictions on

⁷⁷ Aahren Rodriquez DePalma, *supra* note 75, at 52.

⁷⁸ *Id.* at 55.

⁷⁹ Robert D. Orr, *Autonomy, Conscience, and Professional Obligation*, 15 AM. MED. ASS'N J. ETHICS 244, 244 (2013).

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² Aubrey Westgate, *Doctors Voice Biggest Frustration with Practicing Medicine*, PHYSICIANS PRAC. (July 3, 2013), <https://www.physicianspractice.com/blog/doctors-voice-biggest-frustrations-practicing-medicine>.

when the health care provider may refuse to treat a patient.⁸³ At common law, a physician can refuse to treat a patient as long as a prior relationship did not exist. This “no duty” rule was even applicable in an emergency care situation.⁸⁴ The rule was premised upon a contractual theory that required a voluntary agreement between the parties. Once the patient ended that relationship, the physician had no duty to accept the patient back into the practice.⁸⁵ As noted by one federal court, once a patient voluntarily terminates the relationship, the doctor does not have to accept the person as a patient again. The physician in the litigation argued that his rights against involuntary servitude, provided under the 13th Amendment of the Constitution, would be violated if he was forced to reaccept the patient for treatment.⁸⁶

If physician-patient relationship exists then it may only be terminated based upon statutory and common law rules.⁸⁷ The American Medical Association has established a Council on Ethical and Judicial Affairs that is tasked with maintaining and enforcing a Code of Ethics.⁸⁸ That Council has provided guidance on terminating a patient-physician relationship in Ethics Opinion 1.1.5, which notes that the doctor has a fiduciary obligation to support the patient’s continuity of care.⁸⁹ When a physician wants to withdraw from that relationship, the patient must be timely notified in advance so that the person can locate another health care provider. The

⁸³ Jeffrey Segal, *When Can You Refuse to Treat a Patient?*, MED. JUST. (June 10, 2019), <https://medicaljustice.com/when-can-you-refuse-to-treat-a-patient/>.

⁸⁴ Julia Maltzman & Bruce D. Armon, *Can your doctor dismiss you from his/her practice - legally?*, ONCOLINK (June 19, 2005), <https://www.oncolink.org/support/insurance-legal-employment-financial-concerns/legal-concerns/can-your-doctor-dismiss-you-from-his-her-practice-legally>.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Jeffrey Segal, *supra* note 83.

⁸⁸ *About the Council on Ethical and Judicial Affairs*, AMA, <https://www.ama-assn.org/councils/council-ethical-judicial-affairs/about-council-ethical-judicial-affairs-ceja> (last visited on Oct. 18, 2019).

⁸⁹ *Terminating a Patient-Physician Relationship*, AMA, <https://www.ama-assn.org/delivering-care/ethics/terminating-patient-physician-relationship> (last visited Oct. 19, 2019); *contra AMA Principles of Medical Ethics*, AMA, <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics> (last visited Nov. 12, 2019) (stating “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”).

provider must also facilitate the transfer of care when appropriate.⁹⁰ This ethics requirement stems from the notion that the doctor-patient relationship is one of trust, which imposes an ethical obligation to place the patient's welfare above that of the doctor's own self-interests.⁹¹ The notification process must also adhere to the guidelines established by state law and medical boards.⁹²

A variety of reasons exist for why a physician would not treat a patient. The most logical one involves a patient afflicted with a medical condition beyond the doctor's expertise. For instance, it is unrealistic to expect a neurologist to diagnosis and treat skin cancer.⁹³ Additional explanations include someone displaying drug-seeking behavior,⁹⁴ a person who is disruptive or combative, the physician's failure to have an affiliation with the patient's health insurance carrier, the patient or significant other is a malpractice attorney, or the person is involved in litigation.⁹⁵ A patient may also be discharged from the practice for repeatedly failing to follow the physician's instructions or failing to keep scheduled appointments.⁹⁶

⁹⁰ *Id.*

⁹¹ *Patient-Physician Relationships*, AMA, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships> (last visited Oct. 18, 2019).

⁹² Dennis Auckley, *When the Patient-Physician Relationship is Broken*, 10 AM. MED. ASS'N J. ETHICS 548, 551 (2008) (explaining the bylaws of many hospitals and contractual agreement mandate physicians to follow AMA ethics guidelines); *See also* Daniel Meyer, *The refusal of care*, HEALTHCARE RISK MGMT. REV. (Jan. 26, 2015), <https://www.hrmronline.com/article/the-refusal-of-care>.

⁹³ Bob Baizer, *supra* note 3.

⁹⁴ Joseph P. Williams, *Study: 40% of Doctors Refuse New Chronic Pain Patients Using Opioids*, U.S. NEWS & WORLD REP. (July 12, 2019, 2:45 PM), <https://www.usnews.com/news/healthiest-communities/articles/2019-07-12/study-40-of-doctors-refuse-new-chronic-pain-patients-using-opioids> (according to the Journal of the American Medical Association more 40% doctors' offices refuse to see new patients who desire opioids for pain control).

⁹⁵ Dennis Auckley, *supra* note 92, at 551.

⁹⁶ Julia Maltzman & Bruce Armon, *supra* note 84.

There are a growing number of doctors who refuse to treat Medicaid patients. One study found that primary care physicians are 73% more prone to reject Medicaid patients as compared to those with private insurance and specialists reject Medicaid patients 63% of the time.⁹⁷

Pediatricians are also refusing to treat children who parents refuse to get them vaccinated. The American Academy of Pediatrics has endorsed this position and has issued guidelines for physicians on how to report and code vaccination discussions with parents.⁹⁸ Some even assert that cancer-related treatment should be denied to smokers because this activity is an independent risk-taking behavior that is contrary to a curative therapeutic approach.⁹⁹

The major limitation on the physician's right to refuse treatment is that it cannot be done on the basis on gender, race, or religion.¹⁰⁰ The AMA's Code of Medical Ethics also provides that a physician should treat patients regardless of their gender identity or other personal or social characteristics.¹⁰¹ These limitations have been challenged by an executive order signed by President Trump that enlarges the protections involving religious liberties.¹⁰² The rule allows health care providers the right to refuse to provide treatment if they object on a religious or moral basis. Known as the "conscience rule," it specifically references abortion, sterilization, and assisted suicide as treatment that health care providers can refuse to perform on religious

⁹⁷ Avik Roy, *'Health Affairs' Study: One-Third of Doctors Won't Accept New Medicaid Patients*, FORBES (Aug. 7, 2012), <https://www.forbes.com/sites/theapothecary/2012/08/07/health-affairs-study-one-third-of-doctors-wont-accept-new-medicaid-patients/#741f9f333f10>.

⁹⁸ Deborah Chiaravalloti, *More Pediatricians Are Dismissing Patients Who Refuse to Vaccinate*, BD. VITALS (Mar. 22, 2019), <https://www.boardvitals.com/blog/pediatricians-patients-refuse-vaccinate/>.

⁹⁹ Timothy M. Pawlick et al., *Can Physicians Refuse Treatment to Patients who Smoke?*, 5 J. ONCOLOGY PRAC. 250, 250 (2009).

¹⁰⁰ Julia Maltzman & Bruce Armon, *supra* note 84.

¹⁰¹ *Where the largest medical association stands on the new conscience rule*, PBS (May 3, 2019, 7:05 PM), <https://www.pbs.org/newshour/health/what-the-new-religious-exemptions-law-means-for-your-health-care>.

¹⁰² *Id.*

grounds.¹⁰³ It also puts sex reassignment surgery within the ambit of the order¹⁰⁴ as well as those who object to the broad approaches of preventing the spread of HIV/AIDS.¹⁰⁵

This rule was recently vacated by U.S. District Judge Paul Engelmayer. The court issued a 147-page opinion that noted the Department of Health and Human Services lacked authority to impose large portions of the rule and the agency's "stated justification for undertaking rulemaking in the first place — a purported 'significant increase' in civilian complaints relating to the conscience provisions — was factually untrue."¹⁰⁶

The Emergency Medical Treatment and Labor Act (EMTALA)¹⁰⁷ is a federal law designed to protect patients brought to the emergency room from being refused treatment in a non-discriminatory manner based upon their inability to pay, national origin, race, creed or color.¹⁰⁸ Hospitals are required to shoulder the fiscal obligations for the emergency care of the indigent and those without insurance. A violation of the law may cause the Office of Inspector General to impose fines, civil liability, or loss of involvement in the Medicare and Medicaid programs.¹⁰⁹

The legislation prevents private hospitals from patient dumping to a public hospital.¹¹⁰ Instead, the law requires hospitals to screen patients to ascertain whether an emergency medical condition is present. If such a condition is lacking, the hospital's obligations are satisfied unless

¹⁰³ Olivia Exstrum, *The Trump Administration Just Said Religious Doctors Can Refuse Medical Treatment for Patients*, MOTHER JONES (May 2, 2019), <https://www.motherjones.com/politics/2019/05/the-trump-administration-just-said-religious-doctors-can-refuse-medical-treatment-for-patients/>.

¹⁰⁴ *What the New Religious Exemptions Law Means for Your Health Care*, PBS (May 3, 2019, 7:05 PM), <https://www.pbs.org/newshour/health/what-the-new-religious-exemptions-law-means-for-your-health-care>.

¹⁰⁵ *Id.*

¹⁰⁶ Benjamin Weiser & Margot Sanger-Katz, *Judge Voids Trump-Backed 'Conscience Rule' for Health Workers*, N.Y. TIMES (Nov. 6, 2019), <https://www.nytimes.com/2019/11/06/upshot/trump-conscience-rule-overturned.html>.

¹⁰⁷ 42 U.S.C. § 1395dd (2017).

¹⁰⁸ Daniel Meyer, *supra* note 92.

¹⁰⁹ Robert A. Bitterman, *EMTALA: The Law That Forever Changed the Practice of EM*, ACEP NOW (Sept. 25, 2018), <https://www.acepnow.com/article/emtala-the-law-that-forever-changed-the-practice-of-em/>.

¹¹⁰ See ALICE G. GOSFIELD, *Health Law Handbook*, EMTALA in Plain English (29th ed. 2017).

another regulation applies to the rendering of care.¹¹¹ If an emergency condition is present, the facility must stabilize and/or transfer the person to another hospital or admit the patient for the treatment.¹¹²

As noted in *Moses v. Providence Hospital and Medical Centers, Inc.*, “EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit. The statute requires such treatment as may be required to stabilize the condition. [The Act] forbids the patient’s releases unless this condition has been stabilized.”¹¹³ This occurs when no significant deterioration of the illness is likely to occur during the person’s discharge from the hospital.¹¹⁴ Triage does not satisfy the requirement of a screening since its purpose is merely to screen patients to ascertain the severity of their emergency.¹¹⁵ Also, private physician’s offices, separate medical labs, and specialty hospitals that fail to have an emergency room, are exempt from EMTALA rules.¹¹⁶

An emergency medical condition is described as "a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."¹¹⁷ Treatment may not be delayed to ascertain if the person has insurance or the ability to pay. An emergency medical condition is automatically recognized if the person is intoxicated, suicidal or homicidal or if the

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Moses v. Providence Hosp. & Med. Ctrs., Inc.*, 561 F.3d 573, 583 (6th Cir. 2009).

¹¹⁴ *Id.* at 582.

¹¹⁵ ALICE G. GOSFIELD, *supra* note 110.

¹¹⁶ Charles R. Gueli, *Can You Sue a Hospital or Doctor for Denying Medical Treatment?*, INJ. CLAIM COACH (Apr. 3, 2019), <https://www.injuryclaimcoach.com/treatment-denial.html>.

¹¹⁷ *EMTALA Fact Sheet*, AM. C. EMERGENCY PHYSICIANS, <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/> (last visited Oct. 20, 2019).

patient is in labor.¹¹⁸ Emergency rooms are also required to post conspicuous signs that inform individuals of their entitlement to a medical screening and treatment.¹¹⁹

As a caveat, care rendered as the result of this legislation is not free. A hospital may bill and sue the patient for unpaid charges. Hospitals can't refuse to offer emergency services to those who are delinquent in the payment of a prior bill.¹²⁰ The health care provider is also not mandated to continue care after discharge, but they must send patients to places that may offer services at a discounted price or for free.

III. Court Cases

A. Leaving Against Medical Advice

Common defense asserted by hospitals when a patient leaves the facility against medical advice include a contractual waiver of liability, contributory/comparatively negligence, and assumption of the risk.¹²¹ In this regard, it is important to note that a Waiver of Liability form is used by hospitals to discourage patients from arguing that the hospital has abandon the patient. The form, however, is not used to change or waive the standards of reasonable care.¹²² The enforceability of these exculpatory agreements is not always certain in today's consumer friendly environment.

Lyons v. Walker Regional Medical Center, Inc. involves the applicability of a contributory negligence defense when a patient leaves the hospital against medical advice.¹²³ Lyons was brought to the hospital from prison complaining of lower abdominal pain, nausea and

¹¹⁸ ALICE G. GOSFIELD, *supra* note 110.

¹¹⁹ *Id.*

¹²⁰ Trisha Torrey, *EMTALA: The Emergency Medical Treatment and Labor Act*, VERYWELL HEALTH, <https://www.verywellhealth.com/emtala-the-emergency-medical-treatment-and-labor-act-2615167> (last updated Dec. 6, 2019).

¹²¹ Mark A. Hall & Carl E. Schneider, *When Patients Say No (To Save Money): An Essay on the Tectonics of Health Law*, 41 CONN. L. REV. 743, 743–80 (2009).

¹²² *Id.* at 758.

¹²³ *Lyons v. Walker Reg'l Med. Ctr., Inc.*, 868 So. 2d 1071 (Ala. 2003).

vomiting of blood for two weeks. He was told that a tube needed to be inserted into his stomach to check for blood. The patient told the nurse that he knew what was wrong and that it was his appendix. He refused to allow the procedure to be performed and signed a waiver from indicating that he was refusing treatment against medical advice. The prisoner was informed when signing the AMA form, that he understood “he could die or something else could happened to [him].”¹²⁴ When the patient signed out of the hospital, the plaintiff was not told that his blood results were still pending or that he had high blood pressure.¹²⁵ Eventually, his blood results were reported with the words “panic values exceeded.”¹²⁶ Hospital policy mandated that the lab immediately notify the charge nurse of the results in this case. The values must then be given to the physician on call.¹²⁷

When the patient’s result were posted in the computer, the nurse was in the process of completing the discharge paperwork and never bothered to look at the medical chart for the test results.¹²⁸ No one ever told the plaintiff or the doctor that the blood tests were still pending when he left the hospital and the prisoner died three days later.¹²⁹

Suit was filed and the plaintiff argued that the jury should not have been charged on contributory negligence and assumption of risk.¹³⁰ The court disagreed and said that when the nurse told the prisoner that he could die if he left the hospital, this was enough for him to appreciate the danger of his medical problems.¹³¹ The plaintiff also signed a waiver form that indicated he had been told about his condition, that he is refusing medical testing and thereby

¹²⁴ *Id.* at 1074.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.* at 1075.

¹²⁹ *Id.*

¹³⁰ *Id.* at 1076.

¹³¹ *Id.*

releasing the hospital from any liability relating to his care.¹³² As for not taking action once the panic values had been issued, the testimony demonstrated that once a patient leaves against medical advice, “the normal reporting process breaks down” and the prisoner became a nonpatient and they no longer owed him a continuing duty of follow up care.¹³³

In *Collins v. HCA Health Services of Tennessee, Inc.*, the plaintiff was hurt while trying to leave the hospital against medical advice.¹³⁴ The facts show that the plaintiff was brought to the facility by ambulance complaining of dizziness, nausea and chest pain.¹³⁵ The patient was evaluated, and it was determined that she was alert and her speech wasn’t slurred. While she suffered from a mental condition, the plaintiff was compliant with her medication.¹³⁶ The next day, the plaintiff was described as alert, agitated and stated that she felt like dying.¹³⁷ The plaintiff also told several people that she wanted to go home. A couple of hours later, Collins was discovered in her hospital room dressed and with her IV line pulled out.¹³⁸ The patient was told that the neurologist would be paged and that she could sign against the medical advice form.¹³⁹ The nurse tried to entice the patient to remain but the plaintiff kept saying that she was leaving and that no one cared about her.¹⁴⁰ She eventually signed the AMA form, found her way to the second floor and fell or dropped to the ground about 15 feet below.¹⁴¹

Suit was filed against the hospital for negligence and malpractice and the hospital moved for a summary judgment.¹⁴² In finding for the hospital, the court noted that the defendant did not

¹³² *Id.* at 1082.

¹³³ *Id.* at 1091.

¹³⁴ *Collins v. HCA Health Servs. of Tenn., Inc.*, 517 S.W.3d 84, 86 (Tenn. Ct. App. 2016).

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* at 87.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.*

owe a duty to involuntarily detain the patient.¹⁴³ The hospital only owes a patient such reasonable care for his safety as her physical and mental condition may require and to safeguard her against any known or reasonably appreciated dangers.¹⁴⁴ In this case, the patient terminated her medical care and voluntarily left the hospital. She sustained her injuries while leaving the facility against medical advice so her status as a patient ceased as well.¹⁴⁵

Kowalski v. St. Francis Hospital and Health Centers is another case dealing with whether a hospital can involuntarily detain a patient who wishes to be discharged.¹⁴⁶ Plaintiff was brought to the emergency room to be admitted to the detoxification unit. He had been admitted to the hospital on three previous occasions with suicidal thoughts and had improved with medication.¹⁴⁷ While there is no evidence that he was suicidal on the date in question, he demonstrated signs of intoxication with a .368 blood alcohol level.¹⁴⁸ Four hours after his arrival, he removed an IV and told the nurse that he was gone home by cab.¹⁴⁹ The nurse went to inform the doctor and the patient left before she returned. Hospital security was notified to no avail and the plaintiff was hit by a car a short time later.¹⁵⁰

Suit was filed against the hospital on the basis that the defendant should have prevented the patient from leaving the emergency room.¹⁵¹ The court disagreed and dismissed the claim since the hospital owed the plaintiff no duty.¹⁵² At one time, common law allowed a hospital to restrain a patient without court intervention.¹⁵³ Based upon New York's Mental Hygiene Law, a

¹⁴³ *Id.* at 91.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 92.

¹⁴⁶ *Kowalski v. St. Francis Hosp. & Health Ctrs.*, 995 N.E.2d 148, 21 N.Y.3d 480 (N.Y. 2013).

¹⁴⁷ *Id.* at 484.

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.* at 485.

¹⁵³ *Id.*

person who is involuntarily brought to a hospital may be detained for emergency treatment if there is a likelihood that the person may harm himself or others.¹⁵⁴ However, when a person comes into a facility of his own violation, as the plaintiff did in this case, the Act makes no provisions for an involuntary retention.¹⁵⁵ To detain the plaintiff in this case would have subjected them to liability for false imprisonment.¹⁵⁶

Compare this result to the Colorado case of *Blackman v. Rifkin*.¹⁵⁷ The plaintiff was brought to the emergency room in a highly intoxicated state with a wound on her scalp.¹⁵⁸ During her care, she vomited and aspirated stomach contents into her lungs causing cardiac arrest and brain damage.¹⁵⁹ The evidence demonstrated that during her treatment, the patient was combative and interfered with the hospital's ability to administer diagnostic test and render appropriate care.¹⁶⁰

The plaintiff claimed that her intoxication required more acute attention in protecting her and that the emergency room staff committed false imprisonment when they restrained her from leaving the hospital.¹⁶¹ The evidence revealed that the staff kept her in the facility by physical restraint to prevent additional harm to herself or to others.¹⁶² The court disagreed and upheld the imposition of a finding in favor of the defendants. The hospital staff was justified in confining the plaintiff because of her extreme intoxication and head trauma.¹⁶³

¹⁵⁴ *Id.* at 486.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Blackman v. Rifkin*, 759 P.2d 54 (Colo. App. 1988).

¹⁵⁸ *Id.* at 55.

¹⁵⁹ *Id.* at 56.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.* at 58.

¹⁶³ *Id.*; *Haggerty v. Anonymous Party 1*, 998 N.E.2d 286 (Ind. Ct. App. 2013).

In *Bakes v. St. Alexius Medical Center*, the plaintiff was detained against his will by security guards at a hospital, so the plaintiff sued for battery and negligence.¹⁶⁴ The plaintiff was a heavily medicated, post-surgical patient who tried to leave the hospital against medical advice. He was hurt when security guards stopped his exit.¹⁶⁵ The court noted that battery requires the willful touching of the person or a successful attempt to commit violence upon another.¹⁶⁶ Battery requires more than just an intent to touch the other person. The plaintiff must also prove that the defendant intended to cause a harmful or offensive contact.¹⁶⁷ It was a jury question as to whether the intent was harmful in this case or accidental. As for the contributory negligence charge, there was evidence that the plaintiff was combative and abusive prior to the altercation.¹⁶⁸ Therefore, his own actions could have contributed to his injuries.¹⁶⁹

In *Ingutti v. Rochester General Hospital*,¹⁷⁰ the plaintiff left the defendant's hospital against medical advice and was found two hours later disoriented and with frostbitten fingers. The plaintiff asserted that the hospital did not ensure his safety and that they should have contacted his wife or made arrangements for someone to pick him up.¹⁷¹ The court disagreed and found that the hospital did not owe a duty to prevent the patient from leaving the hospital against medical advice nor did they owe a duty to make sure that he arrived safely at home.¹⁷²

¹⁶⁴ *Bakes v. St. Alexius Med. Ctr.*, 955 N.E.2d 78 (Ill. App. Ct. 2011).

¹⁶⁵ *Id.* at 80.

¹⁶⁶ *Id.* at 86.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 88.

¹⁶⁹ *Id.*

¹⁷⁰ *Ingutti v. Rochester Gen. Hosp.*, 980 N.Y.S.2d 692 (N.Y. Sup. Ct. 2014).

¹⁷¹ *Id.* at 694.

¹⁷² *Id.*

A person who leaves a hospital without treatment is not proof that the doctor/patient relationship has automatically terminated.¹⁷³ In *South Fulton Medical Center, Inc. v Poe*,¹⁷⁴ an infant was kept at the hospital after his birth for a variety of medical problems. He was initially discharged with instructions for the parents to contact a doctor if the baby developed a temperature.¹⁷⁵ The next day, the parents went to the emergency room because the child had turned blue.¹⁷⁶ A conversation between the triage nurse and parents was described as tense with the triage nurse raising her voice. After examining the baby, the nurse told the parents that the “baby was fine right now” and that the infant was breathing properly.¹⁷⁷ The parents were then instructed to sit in the waiting room.¹⁷⁸ Believing that they were overreacting, and that the child would be fine until the next day when they could visit the pediatrician, they left the emergency room.¹⁷⁹ The clerk told the parents that the decision to leave was theirs, but the triage nurse did not know that they were leaving. The baby died a few hours later.¹⁸⁰

A malpractice suit was filed, and the hospital argued that the infant was not a patient as a matter of law, so they filed a motion for summary judgment which motion was denied.¹⁸¹ The court found that the parents had received assurances that their baby was fine, and they left the hospital based upon these representations.¹⁸² The nurse should have taken the baby to a physician immediately and she failed to classify the child with a life-threatening condition.¹⁸³ While there

¹⁷³ See PREYESH K. MANIKLAL, *MEDICAL TORTS IN GEORGIA: A HANDBOOK ON STATE AND FEDERAL LAW* (2018-2019 ed. 2018).

¹⁷⁴ *South Fulton Med. Ctr. Inc. v. Poe*, 480 S.E.2d 40 (Ga. Ct. App. 1996).

¹⁷⁵ *Id.* at 42.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.* at 44.

¹⁸³ *Id.*

can be no liability in the absence of a doctor-patient relationship, that relationship is consensual when the patient knowingly seeks the assistance of the health care provider and the facility accepts the patient.¹⁸⁴

The hospital also argued that the parents, by taking the infant from the emergency room before he could be examined, the plaintiffs severed any causal relationship between the triage nurse's assessment and the infant's death.¹⁸⁵ The court found this argument to be without merit. The dissent, however, did not believe that a patient-health care relationship had ever been created.¹⁸⁶ The parents knew that if they had remained, they would have been seen by a physician and they left on their own volition because they believed they were overreacting.¹⁸⁷

Compare this finding to *Matthews v. DeKalb County Hospital Authority*.¹⁸⁸ Mrs. Matthews arrived at the emergency room unassisted, complaining of a burning pain in the upper chest radiating to the right side.¹⁸⁹ The triage nurse classified Mrs. Matthews as having a non-life-threatening condition, and she was told to sit in the waiting room.¹⁹⁰ The patient waited over 4 hours in the waiting room and spoke to a social services representative 8 times.¹⁹¹ When Mrs. Matthews was told that she was the next patient, she exclaimed that she had waited too long and was leaving.¹⁹² The social worker pleaded with Williams to stay but the patient said that she would see a doctor the next day.¹⁹³ Instead of visiting a physician, she went to work the next day and died at the office.¹⁹⁴

¹⁸⁴ *Id.* at 43.

¹⁸⁵ *Id.* at 44.

¹⁸⁶ *Id.* at 45.

¹⁸⁷ *Id.*

¹⁸⁸ *Matthews v. DeKalb Cty. Hosp. Auth.*, 440 S.E.2d 743 (Ga. Ct. App. 1994).

¹⁸⁹ *Id.* at 744.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 745.

A malpractice claim was filed and the alleged negligence was that triage misclassified the severity of her condition and that she should have been seen sooner by a doctor.¹⁹⁵ The court disagreed and noted that Mrs. Matthews left the hospital when she ready to be seen under her own power, and in no apparent distress. Instead of visiting her family physician the next day, she went to work.¹⁹⁶ These actions resulted in a voluntary termination of her relationship with the emergency room personnel and severed any causal relationship between their listing Mrs. Matthews as a non-emergency and her death.¹⁹⁷

IV. Conclusion

Medicine has its share of difficult patients. Many reasons exit as to why patients act out. Regardless of the justification, patients are taking out their frustrations on the medical staff with increased frequency. This patient irritation can result in the ignoring of a physician's instructions, leaving a hospital against medical advice, or physically assaulting a member of the medical staff.

Criminal assaults by patients or their family members are not an isolated occurrence. Medical facilities are the most common location for workplace violence and emergency rooms are particularly susceptible. Patient outbursts are usually not intentional and result from a mental illness or impairment. Noncompliant patients are equally troublesome, and the inability by physicians to offer optimal treatment as a result is one of the most important issues in healthcare.

There is no simple explanation as to why patients act out or fail to follow a doctor's instructions but many of the reasons have a psychological foundation. Patients are even leaving hospitals before the treating physician has determined that he or she is ready for discharge. This

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ *Id.*

presents challenges because of the increased risk of litigation and likelihood of an adverse medical event. In most cases, the physician can't stop the patient from leaving, but the doctor must take reasonable steps to ensure the patient understands the consequences of their actions.

These issues have resulted in a number of physicians refusing to treat specific patients. There are multiple reasons for this development, but the major restriction on right to refuse treatment is that it cannot be done on the basis on gender, race, or religion. Ethical considerations also come into play and require physicians to inform patients a sufficient time in advance so they can locate another health care provider.

In an era of physician shortages, increased restrictions on the practice of medicine, and the number of problem patients, it is difficult to find an easy solution to the issues presented in this article. To make matters worse, disruptive physicians have become problematic and their conduct leads to a hostile work environment, morale problems, compromised patient care, and obstruction in the regular running of the organization. This combination of disruptive patient and physician is a toxic mix that only compounds the overall problem. The ultimate solution is hard to visualize but the legislature, medical organizations, and courts will have to play a role.