

The Last Chance: Contemplations on “Firing” a Patient

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I run a clinic designed for “difficult-to-treat” patients. Even by our standards, Mr. S was a tough case. He was transferred from the endocrinologist-run specialty diabetes clinic to our “last chance” clinic because his blood sugars remained poorly controlled despite taking multiple daily injections of insulin. Each month, four of us—a social worker, a dietitian, a psychotherapist, and myself (an endocrinologist)—would sit with him for one hour in a group appointment. We’d been doing this for 13 months. Despite hours of counseling, education, problem-solving, and escalating doses of insulin, his hemoglobin A1C (HbA1C) was 13%. Our interventions appeared to be failing.

It wasn’t just his blood sugars that remained unchanged; his behavior remained the same, too. He was vague, evasive, and inconsistent when questioned about his self-care practices. Rather than engage in solutions, he routinely shifted conversations to the stressors that he held responsible for his lack of improvement: chronic pain, unemployment, a contentious living situation with his in-laws, depression, and more.

Sometimes he seemed to thrive on the attention he received from our team; at other times, frustrated by our interventions, he excused himself from his visit and would not be heard from for days.

We were frustrated. Although sympathetic to his issues, we felt manipulated and impotent. We decided to “fire” him from our clinic and send him back to his primary care physician, as our verbal agreement at treatment initiation had stipulated.

When I gave him the news, he wouldn’t accept it. He insisted that

our clinic had helped him with his stress and his diabetes management. He was ready to try harder and follow through on our advice. He just needed another chance. I explained my concerns. I pointed out that we had agreed that if no improvement was made, he would be discharged. But in the face of his insistence, I hesitated to follow through with my task of firing Mr. S.

I’m left wondering why it is so difficult to fire a patient. I certainly feel that discharging Mr. S from our clinic can be ethically justified. Due to the intensity of our clinic visits, we have a limited panel of patients that we can maintain. Increasing this panel sacrifices a key component of our success: time. By taking up one of these spots, Mr. S was shutting out patients who may have shown greater physiologic and psychological improvements. We were fair with Mr. S. We were transparent about the criteria that we were using to judge success. We used these same criteria for Mr. S and everyone else in our clinic and worked just as hard to help Mr. S achieve these goals as we did for our other patients. Using objective measures of disease control to judge success is a valid (and increasingly common) way to distribute access to scarce resources, like our clinic. Based on all of this, firing Mr. S was just.

Despite the fact that I can rationalize firing Mr. S, I remain uncomfortable with the idea. In part, this is because I believe that Mr. S’s failure to progress truly was outside of his control. Diabetes is a uniquely difficult disease to treat. The cornerstone of successful treatment is self-care; this involves significant disruptions to patients’ lives—

frequent painful injections and blood sugar checks, loss of flexibility and spontaneity, restriction of pleasurable foods, and obtaining supplies and keeping them available. In the best of circumstances, motivation is difficult to maintain—the effort required is unending and the pay off for success is deferred. Behavioral economics tells us that poverty, a common problem in our clinic, further undermines this motivation.¹

The purpose of the “last chance” clinic is to equip our patients to handle these daunting challenges. But when you hear enough stories, you begin to shift your benchmarks for success. What do we tell a patient who won’t take his meter out in his gang-riddled neighborhood because it looks like a thick wallet in his pocket? How about when the patient knows what 60 grams of carbohydrate look like on his plate, but he can’t refuse his sister-in-law’s meal without risking his place to live? How do we counsel the undocumented immigrant who can’t ask for break time during a 12-hour shift so she can check her sugar and inject her insulin? We do our best to be creative when faced with these situations, but it is often not enough. The A1C remains dangerously high like Mr. S’s.

Medical ethics will tell you that, yes, patients have responsibilities and duties in the doctor-patient relationship. They ought to adhere to their treatments, and the implication is that failure to do so is grounds for firing.² But there is a caveat. The stringency of these responsibilities diminishes when keeping the promise is impossible or highly impractical.³ Certainly, Mr. S’s considerable physical, psychological, and social burdens made

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complying with our intensive treatment recommendations highly impractical. What is the role of the health system when we do our best, and it is still not enough?

To take this a step further, what are the objectives of our relationship with Mr. S anyway? Is an improvement in the HbA1C the only goal for the doctor's visit? Simply spending time with a person and demonstrating caring and support can have profound psychological impacts.⁴ The HbA1C provides a narrow perspective on success. Is it possible that, as Mr. S told me on the phone, our clinic was helping him in ways that we couldn't mea-

sure? Might these benefits be worthwhile endpoints of care?

In 1927, Francis Peabody wrote, "[t]he treatment of a disease may be entirely impersonal; the care of a patient must be completely personal."⁵ It is my desire to care for Mr. S, not just his diabetes, which makes me hesitate to fire him from our clinic. Ultimately, we may be forced to make a difficult decision. But, for now, Mr. S will get his final last chance with us.

References

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