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Refusing to treat – is it legal? Is it justifiable? Is it ethical?

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INTRODUCTION

Historically, when clinicians wanted to know if certain conduct was ethical, they would consult the guidelines set out in the Hippocratic oath. While adherence to the oath may "represent an expression of the professions' ethical obligations", and be useful in promoting their commitment to "abide by these norms", this assumption is open to question.[1] Different practitioners may see and interpret the codes in different ways, depending on their personal ethos as well as the specific time and situation under consideration. At the same time, ethical material can and should reform, and when needed, be re written under optimal cool, calm conditions. Changes should be based on "contributions from those with a variety of perspectives who have access to as much available knowledge as possible" and not implemented as a result of immediate pressures where there may be distorting circumstances.[1] Perhaps the best way to judge their value is to debate how well the code addresses the issue at hand in terms of its "comprehensiveness, clarity and consistency".[1] This paper uses an actual patient scenario as a basis on which to pose some clinically and ethically related queries and postulate possible solutions.

CASE SCENARIO

A 20-year-old student had just returned after a 2 year study scholarship in Cuba. During this time she had commenced with specialised orthodontics to correct her bite and improve her aesthetics. Treatment included tooth extraction and full arch banding in both the maxilla and the mandible. However, her study time had ended before her therapy had been completed. Upon her return she began to experience problems with some of the fixed appliances debonding and wanted to have all of the bonded brackets removed as she felt that they were no longer making any difference to her tooth position, and she was satisfied that her teeth had been moved sufficiently. They were also becoming uncomfortable, affecting her speech and an aesthetic concern. She sought help from local orthodontists, who all insisted that she must first get them copies of her dental, and specifically orthodontic history from the treating clinicians in Cuba before they would commit to taking her on as their patient. She had tried for weeks to track down her previous dentists or her record files, but had no success with either. In the interim more of her brackets were starting to become loose and yet no orthodontists would see or treat her. In desperation she turned to the HPCSA for help and guidance.

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LEGAL GUIDELINES REGARDING TERMINATION AND REFUSAL TO TREAT

There is a clear distinction between the situation where a clinician feels it necessary to terminate a doctor-patient relationship and where they refuse to accept a new patient up front. This paper will focus on the latter. However a brief mention of factors that may justify termination will be given initially.

1. Reasons for treatment termination

There are many and various clinical, personal or professional situations that may lead to a breakdown in the doctor-patient relationship and lead a clinician to terminate treatment. For example:

a) Patient non-compliance / adherence. This includes patients who fail to keep scheduled appointments, who do not follow the doctor's advice or instructions, or persist with destructive habits. These patients may also have an increased risk of disease, have poorer treatment outcomes, place a heavier financial, time or psychological burden on themselves and their treating clinicians, and deprive others of much needed care.[2]
b) Patients who don't complete their full treatment, and then frequently re-appear as emergencies and demand to be fitted in. Doctors may also fear that these patients could damage their reputation if seen by other colleagues at a later stage, where their previous history is not known.[2]
c) Patients who are unwilling to accept a proposed treatment, who insist on treatment that goes against the clinical judgement and / or ethics of the doctor, or demand interventions that may be harmful to themselves.
d) Where the doctor-patient relationship has broken down to such an extent that it is better to refer the patient elsewhere.[3,4]
e) Violent or threatening patients.[3]
f) Patients with chronic drug seeking behaviour.[5]

If a clinician does wish to withdraw their services they should first establish the reasons behind the relationship breakdown[4], as well as the level of persistence and extremity of the difficulty.[5] They may initially explore possibilities of reconciliation, such as setting new boundaries, and only withdrawing if the patient does not adhere to these.[4] However if all reasonable attempts fail, they should be aware that "struggling to maintain a chronically stressed doctor-patient relationship may be riskier than a well-timed termination".[5] They should then explain to their patients why they have decided to withdraw from treating them, and

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try arrange for a suitable referral. They should also transfer copies of all the patient's records to the new practitioner as soon as possible.[4] Patients should also be made aware that there are different systems in place for this, and that the transfer of records may require additional fees.[1] In the interim, they have an ethical duty to continue providing basic care, or treat emergencies.[3]

2. Situations that may prompt clinicians to refuse to treat

Most doctors enter the profession in order care for and treat patients in need. This "duty of care" is based on the ethical principle of beneficence, and acting in the best interest of others.[6] They are also obliged to treat any patient who presents with an emergency that needs immediate attention.[5] However, no clinician is legally bound to care for all patients needing their services, or to carry out treatment that makes them uncomfortable. They are free to decide who to accept as a new patients[6], even if no other clinician is available.[1] They may also refuse to commence with more treatment in existing patients. However, legally in the latter case, it is advisable for them to notify the patient "sufficiently long in advance of withdrawal to allow time for another practitioner to be found".[1] Their decision is often based on a personal judgement call, and as such needs to be defensible, legal and ethical.

Reasons for refusing treatment are vast and varied, and may include:

a) Conscious objection where the treatment requested goes against their own professional judgement, beliefs or philosophies. The literature is replete with debates that either support or admonish this stance. Some authors question whether a doctor should be allowed to refuse to treat a patient based on personal values, unless such treatment would cause more harm than good;[7]
b) They feel the work needed is beyond their capabilities or skills, or outside their scope of practice;
c) They wish to avoid inflicting pain on patients due to treatment that they feel has limited benefits;
d) Where they feel there will be a poor outcome[7], or that the patient may end up in a worse state than if no treatment had been done;
e) They calculate that the administration time and effort needed prior to commencing the clinical work (if any) will not justify the amount they can charge for their services. For example, in cases where patients have medico-legal disputes and they need a second opinion or a clinical report. The dentist will have to open a file, examine the patient, try contact previous practitioners to source old records, write medico legal reports, offer an expert opinion, and then may never be the one to carry out further treatment. They may also feel obliged to render emergency care for problems they did not create;[2]
f) They may be reluctant to take over a patient where work was started by a colleague as they could then become accountable for the outcomes, and have to manage any adverse consequences;
g) It is not financially viable for them to complete work that a colleague started, and where the patient has used up all of their funds on the initial stages;
h) They may elicit from the patient's records that other dentists or specialists have refused further treatment and be cautious about becoming involved. This is especially so where patients have moved between many clinicians and bad mouth their previous dentists;
i) When they suspect (or know) that the patient has outstanding debts with colleagues;
j) Where there is an ongoing dispute, grievance or legal case between the patient and another practitioner;
k) They don't trust the information given to them by the patient;
l) The patient is mentally unstable or not able to give true informed consent;
m) Their practice is not equipped with the necessary materials or equipment needed to carry out the work correctly.

Note that the above examples all differ from paternalism. In the latter the clinician agrees to treat the patient, but decides on what work is done based on what they think is in the patient's best interest.[8]

No doctor is forced to take on any new patients against their will. However, refusal to treat must never be a response to a personal bias, or discriminatory opinion.[3,4,7] At the same time, if a clinician decides not to treat, they should consider whether their refusal to act is in the patient's best interest.[4] How they handle the situation thereafter is often more important than the decision itself. They could offer to transfer the patient to someone else. This may be a colleague who is more skilled, has better facilities or has had training in a particular field; to a specialist; to a medical practitioner; or any other person they deem appropriate to manage the patient.[4] Before arranging the referral they should inform the patient clearly and calmly and give the reasons for their decision, so that the "refusal cannot be seen as an act of unlawful discrimination or unprofessional conduct".[3,4,7] Of course the situation becomes more complex if the dentist is unable to find a suitable person who is willing to take on a new patient. Can they ethically "abandon the patient after a reasonable, good-faith effort to find an alternative pracitioner" has failed?[1]

From a legal perspective, section 27 of the constitution of the Republic of South Africa 1996 affords "every patient the right to health care services and guarantees that no one may be refused emergency health care", so they are not only ethically but also legally obliged to deliver this if the patient has a genuine emergency. However, what constitutes an emergency or the need for immediate care varies widely in both medicine and dentistry, and between different organisations, countries, and people. It often relies on the clinician's opinion, based on their training and experience. For example, Canadian legislature defines an emergency as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy; serious impairment of bodily function; or serious dysfunction of any bodily organ or part".[9] The decision may be judged against the "reasonable man" rule of how other practitioners would view the situation.[10] In most instances a basic screening examination should be done on any person who presents as an emergency. This will both safeguard the practitioner and show beneficence towards the patient.

3. Ethical concerns and Patient-related considerations with regards to withholding treatment

A patient who seeks dental treatment does so with a desire and / or need for physical, psychosocial, emotional, comfort,

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functional or aesthetic reasons. Refusing to treat will thus negatively affect them in any number of these domains. In this particular case scenario, the lack of treatment was already causing emotional distress to the young lady, as well as physical discomfort, and psychosocial embarrassment due to the effect the braces had on her speech and aesthetics. From a dental perspective, there was the risk of her oral and dentition condition deteriorating. The occlusion could be affected by non-functional orthodontic appliances if more active movement and /or orthodontic retention treatment was needed. She was also at increased risk of developing tooth demineralisation or caries under the bands or periodontal disease due to her compromised ability to clean. The loose bands had already begun to cause mucosal damage and posed a choking hazard. She suffered further harm in the form of wasted time, frustration, mental anguish, depression and a feeling of complete helplessness.

4. Possible solutions

In this situation if the new dentist / orthodontist agreed to treat, they would still need to see previous records to evaluate her initial condition and compare it with her current situation. This in itself may be problematic. Her previous dentist may be reluctant to release copies of the records if they have not kept adequate documentation, or if there is an outstanding debt. This then deprives the new practitioner of valuable information that could impact on their further management. In any event, the new clinician would still require a new, complete set of records, including radiographs (panoramic and cephalometric), clinical photographs and scans or study models for diagnostic and treatment planning purposes, and to keep in their own files.[10] These documents would allow them to determine if the dental alignment and occlusion had improved and to draw up a new treatment plan if they identified the need for further orthodontic treatment, restorative work, tooth splinting, periodontal therapy or aesthetic procedures such as bleaching and veneers. Comprehensive pre-and post treatment records are crucial in all of dentistry, but even more so if there is a risk that the treatment outcomes may not be ideal or in accordance with the patient's desires or expectations.

Prior to commencing with any clinical procedures, they would have to spend time discussing the situation with the patient to make sure she was aware of why all of the above was necessary, that she may need more treatment for which she would have to pay, and to ensure she provided autonomous, informed consent.[11] They would be justified to bill for their initial consultation, as well as for the extra time spent trying to access old records, and for all subsequent clinical diagnostic aids needed. Should the patient be unable to afford this, they could arrange a referral to a state dental clinic. Considering the ordeal that this lady had already suffered, it would be gratifying if they communicated directly with a practitioners at the referral centre to see if she could be given priority over a less urgent case. However, enabling a patient to "jump a waiting list" is unfair towards those who may have been waiting some time for treatment. Liang has questioned the ethics of weighing up patients and then prioritising treatment for those considered to be the most deserving. He considers this to be tantamount to a clinician becoming the judge over who has the greatest needs, and acting in a manner that is not necessarily in the best interest or fair to all patients. They also run the risk of making decisions that are based on personal opinions and could be subject to bias. For example, a dentist may favour certain types of patient such as those with the best / worst dentitions, or needing the least/ most complex work, depending on how each one suits their practice profile and treatment preferences.[7]

CONCLUSION

This paper highlights the importance of a strong doctor-patient relationship. This is even more crucial in cases where the patient has long-term treatment needs such as fixed orthodontics, or complex restorative or periodontal therapy which can span over months or years. It also cautions practitioners to be aware that their rights to refuse a patient for no reason does not imply a right to refuse them for any reason. That is to say that their arbitrary decision cannot be based on any form of underlying discrimination.[1] Perhaps the final question that must be posed is whether refusal to treat is acting in the patient's best interest, is ethically justifiable and legally defensible? Many times it is "How the refusal to treat is managed, rather than the decision itself that makes the difference" between ethical patient management and unprofessional conduct.[4]

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