Idaho State Board of Medicine

THE REPORT

December 2024

Public Protection through fair and impartial application and enforcement of practice acts

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Message From the Board of Medicine:

The Record

Patient Abandonment: Inconsistent, Paradoxical and Common

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Board Member

Patient abandonment is a type of medical negligence that occurs when a healthcare provider improperly terminates the doctor-patient relationship. Albeit a specific form of medical malpractice, it occurs when a physician or healthcare provider ends a doctor-patient relationship without reasonable notice or discussion and subsequent failing to provide that patient with a qualified replacement. When patient abandonment causes harm, the victim could pursue a medical malpractice claim to recover compensation for damages.[1,2]

The practice of medicine and the physician-patient relationship with its conformation in the clinical encounter, is fundamentally a moral bond that arises from the basic 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.[3]

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Patient abandonment occurs when:

A doctor/patient relationship must have been established. This occurs when a healthcare worker agrees to provide treatment for a patient and begins a course of treatment as per mutual agreement. The caregiver must discontinue the relationship while the patient is in an ongoing stage of the treatment process. Patients are in the *critical stage* when they are still in need of medical attention and/or are still in the process of undergoing a course of care.

The doctor then curtails treatment abruptly either with or without explanation. The medical care provider then disallows the patient from seeking an alternative treatment source.

The patient's abandonment must cause harm. The patient must experience actual, measurable consequences such as higher medical bills or a worse prognosis because of the patient's abandonment.
Patient abandonment can cause serious harm to patients because it can interrupt their treatment and affect their prognosis. Patients who wish to pursue a medical malpractice case based on patient abandonment must be able to prove one or all these elements in a claim to prevail in a civil lawsuit. An experienced medical malpractice attorney can help victims of patient abandonment pursue a claim against a care provider who discontinues medical services inappropriately.

The decision or failure to treat must be one-sided. The patient seeks care from that provider, who either refuses, is unavailable, or negligent in providing timely care. If a patient chooses to leave a provider, the provider is not responsible for harm that may result.

The patient must need ongoing treatment which the provider refuses or fails to provide. ***It is not medical abandonment*** if the provider provides enough notice for the patient to find another provider. However, the provider is not responsible for finding a new provider for the patient.

Any healthcare provider can commit patient abandonment, including doctors, advanced level providers, or other staff members who form a professional relationship with a patient. The medical professional who discontinues treatment can be sued for abandonment.

Although patient abandonment is a serious issue, there are circumstances where doctors and other healthcare providers are allowed to end a relationship. Doctors may stop treatment without it being considered patient abandonment if they meet any of the exceptions noted in Box 1.

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{Considerable Exceptions}

1. They do not have the necessary training or knowledge to continue treatment
2. They do not have the supplies or resources to continue treatment
3. A conflict of interest arises
4. Patients violate the policies of the doctor or behave inappropriately, such as verbally abusing the care provider
5. Patients violate the doctor's policies
6. Patients repeatedly miss or cancel appointments
7. Patients do not comply with care recommendations

(Box 1)

When doctors have a valid reason to discontinue a relationship with a patient, they must ensure they take certain steps to avoid being legally responsible for patient abandonment. They must provide notice, give the patient time to find alternative care, and send patient records to the patient's new physician (Box 2).

Established obligations are therefore:

1. Not terminate the relationship during a time when it is still necessary that care be continuous unless there will be an immediate transition to another physician
2. Give adequate notice (30 days in most states) to the patient of the termination so that they will have the time to set up alternative care
3. Support that transition, including by making records available or being willing to discuss the case with the new physician
4. Provide coverage for emergency treatment during the specified transition period

(Box 2)

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In summary, to effectively terminate your relationship with a patient requires the undoing of each step that formed it:

1. The patient came to you in need of care. They can only be terminated when they are not actively in need of care.

2. The patient sought care with you. They can only be terminated by giving them reasonable time to find care elsewhere.

3. Your conduct allowed the patient to reasonably believe that you were their doctor. They can only be terminated by you laying out clear statements that make such a belief unreasonable.

Further Discussion Points

Failure to initiate treatment that was warranted

In a medical malpractice case, this would be alleged in addition to the negligence claim. The premise being that the patient was internally abandoned within the active doctor-patient relationship because the care that was needed never began, leaving them as though they had no access to the treatment at all.

Refusal to see the patient

This most commonly occurs when the patient has a large outstanding bill they are refusing to address, and the doctor tells them that they will not be scheduled for further appointments until the bill is dealt with. This acts as constructive abandonment because the patient thereby loses substantive access to the doctor while the bill remains unpaid.

Such a situation should instead be dealt with by the formal discharge of the patient from the practice, followed by all appropriate collection procedures. This potential for falling into constructive abandonment in such "self-help" situations is an important reminder as to two points:

There is no such thing as *de facto* ending of the physician-patient relationship due to patient conduct. Even if the patient sues the doctor, that does not, in and of itself, end the relationship. Therefore, any approach to a troublesome patient that begins with the idea that "Well, since the patient did (fill in thing that drives you bonkers) it means that I am no longer bound by my duties as a doctor" should be immediately avoided. Unless the patient says "You're fired," they are still your patient until you formally terminate them.

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The law views the physician-patient relationship as one in which the patient, as the one needing expert services for their health, is in the dependent role. The law is, therefore, protective of the patient. This means that any doctor who finds themselves in opposition to a troublesome patient should make sure to use only clearly sanctioned methods, such as formal discharge, that affords the doctor considerable protection.

Physician/Provider Coverage

Because you are responsible for providing an adequate alternative to your patients when you are unavailable for an extended period, if you do not do so, thereby leaving the patient without needed care, it can give rise to an abandonment claim.

This could occur if you use a covering doctor who is not reasonably equivalent to you (e.g.; not from the same specialty or at least a closely allied specialty, such as Internal Medicine and Surgery covering for each other, or barely out of training when you are very experienced) and so cannot provide a comparable level of expertise. It can also occur if you continue to use an answering service even after it habitually proves unreliable at getting messages from the patient to the covering doctor accurately and promptly.

In both situations the patient really has no meaningful access to appropriate care through the coverage system their doctor has put in place and so they are abandoned.

The final topic to consider is ***inadvertent abandonment***, which occurs when the patient is left without care despite a system to provide care being present. This generally occurs in two settings:

No Coverage

In this situation, unlike the coverage issues that can give rise to constructive abandonment, there is a proper call schedule in place, but the covering doctor becomes unexpectedly unavailable. To the extent that the doctor needing coverage could have then reasonably stepped in (e.g., leaving a movie, as opposed to returning from a vacation out-of-state) to prevent the problem by taking the call personally but did not, they can be deemed to have abandoned their patient.

Office Conduct

In this situation, unlike a refusal to see a patient who is not paying their bill, you are willing to see the patient, but the conduct of your office staff creates the abandonment scenario. This can occur if your staff refuses to let a patient with a real problem talk to you, schedules a necessary appointment too far in the future, or simply files away the chart of a patient who needs to do some important follow-up rather than contacting that patient. In these cases, procedures to track the patient properly

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within the practice are present, but the staff's actions deprive the patient of access to those processes, thereby abandoning them. You, therefore, need to have set clear office policies in place—preferably in writing, since you may have to prove them—to prevent these problems.

References

What Is Patient Abandonment? (2024 Guide) – Forbes Advisor

Abandonment - StatPearls - NCBI Bookshelf (nih.gov)

Patient-Physician Relationships | AMA-Code (ama-assn.org)

Culture of Change

Creating an environment where an entity can view a mistake or error from the lens of opportunity for improvement and not strictly as a reason for discipline is a movement that has been impressed upon various industries, including healthcare. Rather than strictly disciplining and placing blame for errors, the goal is to encourage open and honest reporting of mistakes. The entities investigate the error to benefit internal process improvement. If an employee does not feel comfortable in the environment in which they work to report errors they make or observe others making, the facility does not know errors are being made. Unless, of course, the mistake is egregious enough to incur the attention of many. If an entity doesn't know what errors are made, it cannot make the changes necessary to mitigate those errors.

A concept developed to allow for such change is just culture™. This theory was first developed in 1997 as part of a safety culture (2024). In recent years, several books have been written speaking to just culture ™.

Ideally, utilizing such a concept would create an environment where people are not afraid to share their mistakes, education is increased, and processes are viewed, develop, critiqued, and enhanced from a well-rounded point of view.

As mentioned, concepts such as just culture ™ are utilized in various settings. Some facilities create or use previously vetted algorithms to guide their process, others address specific questions, some utilize a toolkit, and others may use a combination of several tools. The importance of whichever tool is chosen is that it addresses the needs of the environment where it is utilized.

One of the duties of the Idaho Board of Medicine is to address complaints and issue discipline when needed. As Sidney Dekker indicates in his book *Just Culture Balancing Safety and Accountability* (2012, p.141), "Building a just culture starts at home, in your own organization...match your organization's ambitions to the profession's possibilities and constraints, the culture of your country and its legal traditions and imperatives". The Board has implemented a process developed with aspects of a just culture™ in mind to aid in their decision-making when addressing complaints. It is essential to the Board that when a complaint is made due to a mistake or error, the disciplinary decisions help to educate and mitigate the potential for future mistakes primarily for the public's safety but also for best practice of the licensee.

Dekker, S. (2012). Just culture Balancing safety and accountability.(2nd ed.). CRC Press.

Wikipedia contributors. (2024, November 2). Just culture. In *Wikipedia, The Free Encyclopedia*. Retrieved 20:18, December 20, 2024, from https://en.wikipedia.org/w/index.php?title=Just_culture&oldid=1255012736

Compounding Drugs in Shortage

The Board has received many inquiries regarding the compounding of commercially available products while those products' statuses on the FDA's drug shortage list is contested. The Rules of the Board of Pharmacy provide that "[a] drug product that is commercially available may only be compounded if not compounded regularly or in inordinate amounts and if … [t]he commercial product is not reasonably available in the market in time to meet the patient's needs."

The FDA's drug shortage list provides a clear benchmark for when commercially available products are not reasonably available in the supply chain. The Board's rule is not limited to that list. The Board recognizes that commercially available products may not be reasonably available in the supply chain for a host of reasons. So long as the product is not reasonably available in the supply chain to timely meet the patient's need and the pharmacy is not regularly compounding the product as part of its business but rather only in response to the need to make the product reasonably available, compounding the product would not run afoul of the rule.

For further information, please review the Board's pending rule, IDAPA 24.36.01.700.04:

04. Limited Compounding.

a. Triad Relationship. A pharmacist may compound a drug product in the usual course of professional practice for an individual patient pursuant to an established prescriber/patient/pharmacist relationship and a valid prescription drug order.

b. Commercially Available Products. A drug product that is commercially available may only be compounded if not compounded regularly or in inordinate amounts and if:

   i. It is medically warranted to provide an alternate ingredient, dosage form, or strength of significance; or
   ii. The commercial product is not reasonably available in the market in time to meet the patient's needs.

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It is essential for physicians to understand, a provider that is ordering medication for a client that is being sent to their office to be dispensed, requires the physician have a prescriber drug outlet registration with the Idaho Board of Pharmacy. Compounded prescriptions received by a physician's office for a specific patient must be labeled by the compounding pharmacy for that patient if the medication is being dispensed to the patient.

A physician may not dispense medication received from a compounding pharmacy that is not labeled for a specific patient by the compounding pharmacy.

If you have any questions, please feel free to contact the Board of Medicine by phone at (208) 334– 3233 or by email at HP-Licensing@dopl.idaho.gov.

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Tirzepatide Shortage Resolved

On December 19, 2024 a declaratory order was issued by the Food and Drug Administration (FDA).

The shortage of tirzepatide injection products has been resolved. Initially the FDA determined the shortage was resolved in October 2024. The FDA has since re-evaluated and has revoked and replaced the October decision with this current decision.

Information received by the FDA from Eli Lilly indicated that the pharmaceutical company has been able to meet or exceed the demand for Zepbound and Mounjaro with no reason to believe they will not be able to meet projected demand.

The FDA is allowing for time to transition from compounded medication to the FDA-approved

tirzepatide, specifically:

- For state-licensed pharmacists or physicians compounding under section 503A of the FD&C Act, 60 calendar days from the date of this order, until February 18, 2025; and
- For outsourcing facilities under section 503B of the FD&C Act, 90 calendar days from the date of this order, until March 19, 2025. (Cavazzoni-S).

For the complete declaratory order go to https://www.fda.gov/media/184606/download?attachment

References:

Cavazzoni, P., MD . "Declaratory Order: Resolution of Shortages of Tirzepatide Injection Product (Mounjaro and Zepbound)". December 2024. Retrieved from https://www.fda.gov/media/184606/download?attachment

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Health Professionals RECOVERY Program (HPRP)

formerly Physician Recovery Network

The goal of the Health Professionals Recovery Program is to assist health professionals and their families in identifying substance use disorders that may be a potential threat to the individual or their loved ones. The program aims to lessen the negative impacts on the individual and their career.

Research shows that disciplinary actions don't necessarily intervene in the progression of addiction. However, individualized alcohol or substance use disorder treatment can be an effective method for medical professionals and society at large.

Are you ready to make changes?

Do you feel that yourself or someone you know is going down the wrong path?

Do you know someone in the medical community struggling who needs help?

You can choose the direction you are headed and get help addressing substance use or mental health.

For further information about this program contact Katie Stuart.

Katie Stuart, CIP

Website: dopl.idaho.gov/health-professionals-recovery-program

Phone: (208) 577-2489

Email: Katie.Stuart@dopl.idaho.gov

2025 Board Meeting Schedules

Board of Medicine

- 2/27/2025
- 5/22/2025
- 8/28/2025
- 11/13/2025

Physician Assistant Advisory Committee

- 1/22/2025
- 4/15/2025
- 7/23/2025
- 10/21/2025

Allied Health Advisory Board

- 1/08/2025
- 4/16/2025
- 7/30/2025
- 10/08/2025

Committee on Professional Discipline

- 1/09/2025
- 4/24/2025
- 7/31/2025
- 10/16/2025

Maternal Mortality Review Committee

- To Be Determined

All Meetings will be held at:
11341 W Chinden Blvd.
Building 4
Boise, ID 83714
Room: TBD
For meeting updates visit:
Home - DOPL (idaho.gov)

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