ETHICAL ISSUES IN DIALYSIS CENTRES – DIALYSIS PATIENT - PROVIDER CONFLICTS

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Ethical dilemmas of a Medical Director

What should (or can) I do when a near-by dialysis centre starts to solicit patients from my centre?

How should I respond to a request by the dialysis provider to use up ex-stock or lower surface area dialysers?

How do I manage the disruptive, abusive patient?

How do I handle a nephrologist who does not review patients according to the facility schedule ?

How do I manage the uncooperative patient with dementia?

What we'll cover today

- Principles of Medical Ethics
- Overview of ethical issues in dialysis therapy
- Practical tips and resources (using case scenarios)
- (Reading list enclosed)

Shared decision making

Mental capacity

Professional knowledge - provide all information required by patient to make an **informed** decision

Doctor-patient relationship

Medical Ethics

1. Beneficence → Treatment is beneficial and in the patient's best interest
2. Non-maleficence → Treatment does not harm the patient
3. Social (distributive) justice → Treatment is available to all without discrimination
4. Autonomy → Allowing patient to make his own informed decision

Limits to **Extent** of Patient Autonomy

1. When its exercise causes harm to someone else or may harm the patient
2. When its exercise violates the physician's / healthcare team's medical conscience

Fiduciary Relationship

Doctor-patient relationship

Definition of Fiduciary Relationship

- Derived from the Latin word "*fidere*" - to trust
- Legal relationship between a professional and client where the fiduciaries hold something in trust for one another. They must act in the best interests of their clients (patients), subordinating self-interest.
- Higher standard than business people who protect their own self-interest – "let the buyer beware"

Physicians have a fiduciary duty to their patients because the balance of knowledge and information favours the physician; patients are reliant on their physician and may be vulnerable.

The “Others”

HEALTHCARE PROFESSIONALS

DIALYSIS PROVIDERS

DIALYSIS PATIENT

FAMILY AND CAREGIVERS

GOVERNMENT

International Society of Nephrology Ethical Dialysis Task Force

Health Policy

Ethical issues in dialysis therapy

Vivekanand Jha, Dominique E Martin, Joanne M Bargman, Simon Davies, John Feehally, Fred Finkelstein, David Harris, Madhukar Misra, Giuseppe Remuzzi, Adeera Levin, for the International Society of Nephrology Ethical Dialysis Task Force

Financing of dialysis – Financial interests and service delivery

- Pay-for-performance system, cherry-picking
- Nephrologists with financial interests in dialysis centres
- Cutting cost, compromised patient care
- Prioritizing investment in dialysis at the expense of other areas (prevention and management of CKD)

Clinical care and decision making

- Dilemmas for dialysis – When is dialysis in the best interests of the patient?
- Clinical decision making – Physicians have a responsibility to provide sufficient information, be aware of their own potential biases and personal financial interests, be trained in communication and facilitating end-of-life decisions
- Care when renal replacement therapy is not appropriate or available – palliative care programmes

Distributing dialysis resources

- Distributive justice requires the development of a framework to guide allocation of limited resources – eg funding access, dialysis access
- Procedural justice requires that decisions about access policies be made by legitimate authorities who are accountable to those affected by the decisions

Jha V et al. Lancet. 2017 May 6;389(10081):1851-1856

Panel 1: Ethical principles and goals for health authorities and dialysis care providers

***Panel 1*: Ethical principles and goals for health authorities and dialysis care providers**

- Individuals with end-stage kidney disease should have access to the best available care in renal-replacement therapy and supportive and end-of-life care when required[21]
- Health professionals and policy makers should strive to reduce the costs of dialysis, using simple, safe, and affordable modalities without compromising the quality of care provided to patients
- Commercial competing interests on the part of policy makers and health service providers, including nephrologists, should be routinely disclosed to the public and patients
- Where rationing of dialysis resources is necessary and unavoidable, access to dialysis should be equitable
- Physicians have an obligation to provide information about risks and benefits of dialysis and to support patients or their surrogate decision makers in qualitative evaluation of treatment options
- Decisions about initiation or withdrawal of dialysis should not be considered irrevocable; however, decision makers should be informed of the potential limitation of future options that could be the consequence of initial decisions
- Policies and guidelines governing access to dialysis should strive to:
  - Avoid futile treatment
  - Assure a minimum expected benefit threshold, below which the burdens of initiating or continuing dialysis are considered disproportionate and hence unacceptable (within the sociocultural context)
  - Promote equality of opportunity
  - Maximise utility gains from the available resources
  - Exclude criteria that are not morally justifiable with respect to allocation decisions, such as race, sex, religion, or social status
  - Ensure transparency of policies and processes

Panel 2: Practical recommendations regarding dialysis for health authorities

Panel 2*: Practical recommendations regarding dialysis for health authorities

- Efforts to reduce the costs of providing dialysis to those with end-stage kidney disease should occur in conjunction with more cost-effective efforts to prevent development of and to manage end-stage kidney disease within a population—eg, health systems should establish programmes of kidney disease prevention and health promotion, in conjunction with renal-replacement therapy programmes
- Minimum standards of quality and safety should be established for all dialysis units and regulations introduced where necessary to ensure standards are maintained
- Audit systems should be designed to facilitate and encourage documentation of patient care and transparent reporting of costs and outcomes of care to provide an evidence base for decision making and objective evaluation of performance
- Regulatory safeguards should be implemented where necessary to prevent undue commercial influences on clinical decision making
- Locally appropriate policies or guidelines governing access to dialysis should be developed and transparently implemented in accordance with principles of procedural and distributive justice

*National or regional issues might influence specifics of these recommendations, but we recommend transparency in clinical practice.

Panel 3: Practical recommendations for health professionals involved in dialysis care

***Panel 3*: Practice recommendations for health professionals involved in dialysis care**

- Nephrologists and renal care nurses should collaborate with other health professionals, social scientists, and ethicists, in the investigation of specific ethical issues at the local, regional, or international level
- Priorities for research might include assessment of the impact of costs on clinical decision making in different countries and investigation of burdens of care in special populations such as infants and those with complex comorbidities; such research might inform development of evidence-based communication tools and allocation policies respectively
- Professional societies and medical councils should ensure that health-care professionals working with patients with end-stage kidney disease are familiar with their responsibilities for patient care, including their obligations to provide care to those who might be perceived to pose risks to care providers (eg, from infectious disease) and to provide or refer patients to palliative care services
- Supportive care should be made part of end-stage kidney disease management plans, and appropriate facilities should be developed
- Guidelines for clinical decision making, specifically with regard to withdrawal of dialysis, "do not resuscitate" orders, and time-limited trials of dialysis should be developed; where guidelines exist and have been implemented, sharing of best practices and outcomes across jurisdictions is essential
- Nephrologists should refer patients to available services when they are unable to provide such care
- Nephrologists should receive education about shared decision making, advance care planning, and end-of-life counselling, and communication about end-of-life care
- Dialysis providers should be trained in clinical decision making conversations, and develop multidisciplinary teams in collaboration with providers of other treatment options such as transplantation or supportive care
- Dialysis units should institute a process of second conversation, which will prepare the patient for future decline and serve as an optimal time for advance care planning if the conservative care pathway is chosen

Jha V et al. Lancet. 2017 May 6;389(10081):1851-1856

Case 1: Dialysis Patient Solicitation

Dr A & B were physicians in ABC Dialysis Centre.
Dr B left to open her own dialysis centre – DEF Dialysis Centre.

- Some patients transferred to DEF Centre for convenience of location
- Some left despite living closer to ABC Centre
  - ❖ When patients of Dr A were cared for by Dr B while in hospital (where Dr A had no visiting rights), they were told that DEF Centre offered better care than ABC Centre
  - ❖ Some patients reported being called at home by Dr B or her clinical staff with the same message

Is Dr B right in doing what she did?

Ethical considerations

Dr B failed to meet

1) professional ethical standard for informed consent in the physician-patient relationship
2) the stringent duty of physicians to give priority to the patient, even if it is to their financial detriment, and
3) the minimal ethics of the marketplace, because comments that DEF Centre is better is not supported by evidence and in fact, are materially misleading.

DT Ozar et al. Clin J Am Soc Nephrol 8: 840–844, 2013

Position on ESRD Patient Solicitation – Renal Physicians Association

Table 1. Principles of professional conduct and recommendation with regard to dialysis patient solicitation

Principles of professional conduct

1. Notifications by nephrologists other than the treating nephrologists with the intent of soliciting a patient to change physicians, change practices, or change dialysis facilities constitute unethical behavior.
2. If it is the patient's own nephrologist, the nephrologist could recommend transferring from one unit to another if the nephrologist believes it is in the patient's best interest, but the nephrologist must disclose if he/she has a financial interest in either unit and make this recommendation in a transparent and noncoercive manner.
3. Similarly, in both the initial enrollment of a patient and if and when the patient is referred for vascular access services, the nephrologist must disclose if he/she has a financial interest in either the dialysis unit or the vascular access center and should make this recommendation in a transparent and noncoercive manner.
4. Nephrologists, their nursing staff, or other representatives must be as transparent as possible in their interactions with dialysis patients and their families and disclose potential conflicts of interest.

Recommendation

1. Nephrologists must strive to be in compliance with their state's medical practice acts or other relevant state statutes. According to state law, nephrologists' conduct that is not in compliance with these state regulations should (or must, if required by state law) be reported to the appropriate state licensing board.

Renal Physicians Association: Forum of ESRD Networks: Position on ESRD Patient Solicitation, 2011

- It is unethical to approach another nephrologist's patient with the intent to solicit a change in physician, or practice or dialysis facility.
- If it is your own patient, you may recommend transfer from one unit to another if you believe it is in the patient's best interest.
- You, and your staff, must always be transparent and noncoercive, and disclose any financial interest or conflict of interest.

Position on ESRD Patient Solicitation (RPA) – Governing bodies

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Modified from reference 1, with permission.

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- Comply with state's medical practice acts
- Non-compliance should be reported to appropriate state licensing board

Renal Physicians Association: Forum of ESRD Networks: Position on ESRD Patient Solicitation, 2011

Case 2: A Demented Dialysis Patient

Mrs A is 70 years old and has diabetic nephropathy and has been on hemodialysis for 12 months. She is widowed and has dementia and stays with her only son and his family. Prior to the initiation of dialysis, her son was informed of the poor prognosis but he insisted on keeping her "alive at all costs".

During the first 6 months on dialysis, Mrs A was accompanied to the dialysis centre by her maid and she was quiet and cooperative during dialysis. Unfortunately, she later required several admissions to hospital for various problems including sepsis from lower limb infection, hypoglycemia and pneumonia. Over the last 2 months, she has become increasingly uncooperative and agitated during dialysis. She has attempted, unsuccessfully, to remove the dialysis needles on two occasions. She occasionally screams and shouts during dialysis and this results in early termination of the dialysis session.

The son was informed of his mother's distress on dialysis and the need for the constant presence of a caregiver during her dialysis sessions. The nephrologist in charge of Mrs A has had many discussions with the son over the last 2 months and has recommended he consider withdrawal of dialysis.

On the day in question, the patient became agitated during dialysis and the "V" needle became dislodged resulting in a large haematoma. She was sent to hospital for further management.

Case 2: Shared decision making – Real Life

FAMILY AND CAREGIVERS

- DISRUPTIVE
- DEMANDING
- (DISTRAUGHT)

HEALTHCARE PROFESSIONALS

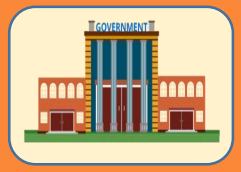
- PATIENT SAFETY
- PERSONAL SAFETY

DEMENTIA UNCOOPERATIVE

DIALYSIS PROVIDERS

- PATIENT SAFETY
- STAFF SAFETY
- POTENTIAL UNHAPPINESS FROM OTHER PATIENTS / CAREGIVERS
- STANDARD PROTOCOLS TO DEAL WITH SPECIAL SITUATIONS

STATE / HEALTH AUTHORITY

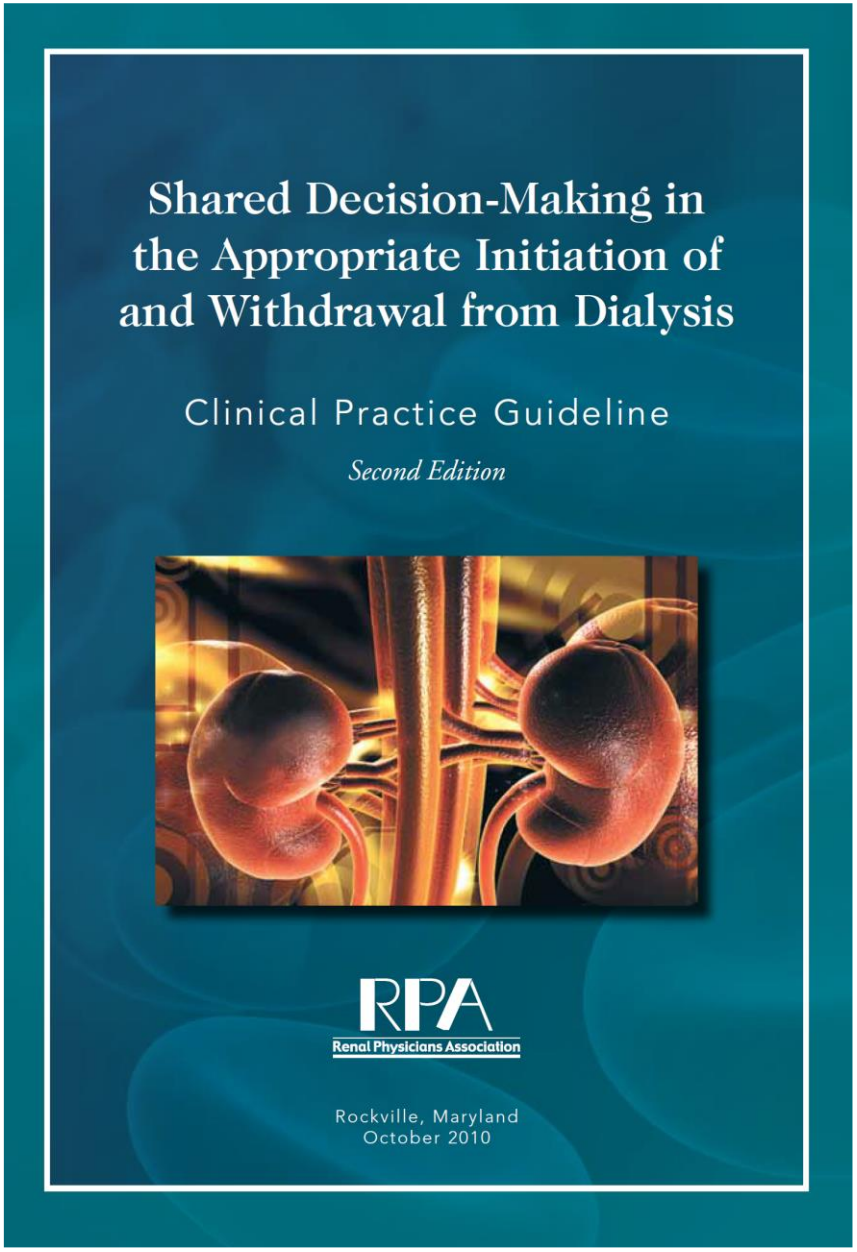


- CODE OF PRACTICE
- LEGISLATIVE LAWS AND ACTS

OUTPATIENT DIALYSIS CENTRES

Table 1. Unique features of outpatient dialysis centers relative to other outpatient medical settings

1	Frequency of contact (three times per week versus typically a few times per year)
2	Duration of each contact (3–4 h versus 10–60 min)
3	Presence of other patients (multiple other patients present versus one-on-one visit)
4	Therapeutic community of patients and caregivers rather than an individual provider–patient interaction
5	Close proximity of patients, which increases the likelihood that one patient's behavior might disturb others and that patients might be exposed to other patients' blood and body fluids
6	Risk of patient exsanguination within minutes from needles dislodged from an arterial circuit and risk of blood-borne pathogen exposure to other patients from exsanguination
7	Life-sustaining treatment required for the remainder of the patient's life with fatal consequences of missing/stopping treatment (life or death versus usually not life or death)
8	Difficulty in discharging patients and finding alternative treatment settings



Establishing a Shared Decision- Making Relationship

1. Develop a physician-patient relationship for shared decision-making

Informing Patients

2. Fully inform AKI, stage 4 and 5 CKD, and ESRD patients about their diagnosis prognosis and all treatment options
3. Give all patients with AKI, stage 5 CKD, or ERSD an estimate of prognosis specific to their overall condition

Facilitating Advance Care Planning

4. Institute advance care planning

Making a Decision to Not Initiate of to Discontinue Dialysis

5. If appropriate, forgo (withhold initiating or withdraw ongoing) dialysis for patients with AKI, CKD or ESRD in certain, well-defined situations
6. Consider forgoing dialysis for AKI, CKD, or ESRD patients who have a very poor prognosis or for whom dialysis cannot be provided safely

Resolving Conflicts about What Dialysis Decisions to Make

7. Consider s time-limited trial of dialysis for patients requiring dialysis, but who have an uncertain prognosis, or for whom a consensus cannot be reached about providing dialysis
8. Establish a systematic due process approach for conflict resolution if there is disagreement about what decision should be made with regards to dialysis

Providing Effective Palliative Care

9. To improve patient-centred outcomes, offer palliative care services and interventions to all AKI, CKD, and ESRD patients who suffer from burdens of their disease
10. Use a systematic approach to communicate diagnosis, prognosis, treatment options, and goals of care

Making a Decision to Not Initiate or to Discontinue Dialysis

Recommendation No. 5*
If appropriate, forgo (withhold initiation or withdraw ongoing) dialysis for patients with AKI, CKD, or ESRD in certain, well-defined situations.

- Patients with decision-making capacity, who being fully informed and making voluntary choices, refuse dialysis or request that dialysis be discontinued.
- Patients who no longer possess decision-making capacity who have previously indicated refusal of dialysis in an oral or written advance directive.
- Patients who no longer possess decision-making capacity and whose properly appointed legal agents/surrogates refuse dialysis or request that it be discontinued.
- Patients with irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.

*Medical management incorporating palliative care is an integral part of the decision to forgo dialysis in AKI, CKD, or ESRD, and attention to patient comfort and quality of life while dying should be addressed directly or managed by palliative care consultation and referral to a hospice program (see **Recommendation No. 9** on palliative care services).

Share decision-making in the appropriate initiation of and withdrawal from dialysis. Clinical Practice Guidelines (2nd Ed). Renal Physicians Association, 2010.

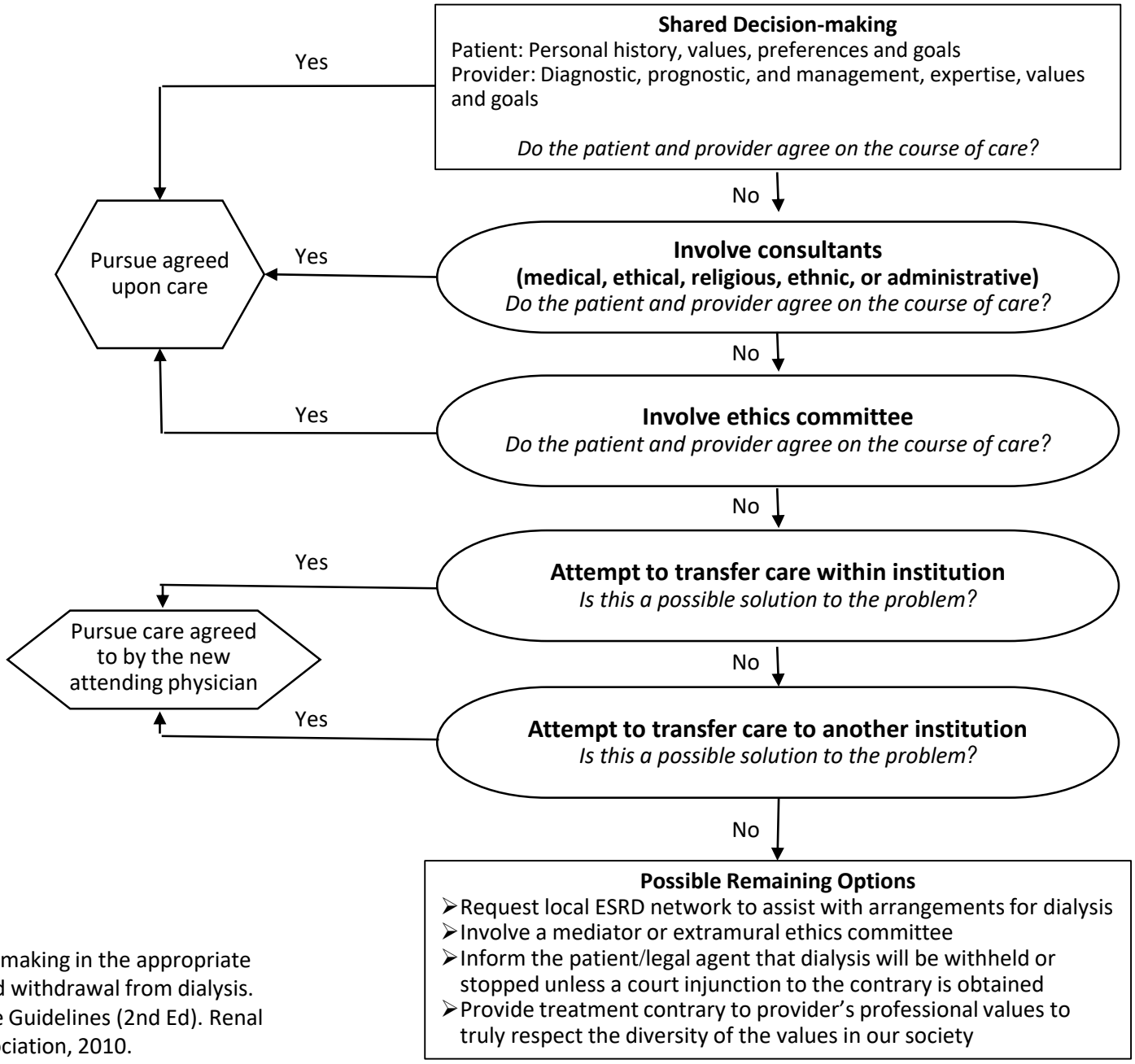
Making a Decision to Not Initiate or to Discontinue Dialysis

Recommendation No. 6
Consider forgoing dialysis for AKI, CKD, or ESRD patients who have a very poor prognosis or for whom dialysis cannot be provided safely.

- Those whose medical condition precludes the technical process of dialysis because the patient is unable to cooperate (e.g., advanced dementia patient who pulls out dialysis needles) or because the patient's condition is too unstable (e.g., profound hypotension).
- Those who have a terminal illness from non-renal causes (acknowledging that some in this condition may perceive benefit from and choose to undergo dialysis).
- Those with stage 5 CKD older than age 75 years who meet two or more of the following statistically significant very poor prognosis criteria (see **Recommendations No. 2 and 3**): 1) clinicians' response of "No, I would not be surprised" to the surprise question; 2) high comorbidity score; 3) significantly impaired functional status (e.g., Karnofsky Performance Status score less than 40); and 4) severe chronic malnutrition (i.e., serum albumin less than 2.5 g/dL using the bromcresol green method.

Share decision-making in the appropriate initiation of and withdrawal from dialysis. Clinical Practice Guidelines (2nd Ed). Renal Physicians Association, 2010.

Systematic Approach to Resolving Conflict between Patient and Kidney Care Team



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Policies and guidelines governing access to dialysis

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A Demented Dialysis Patient

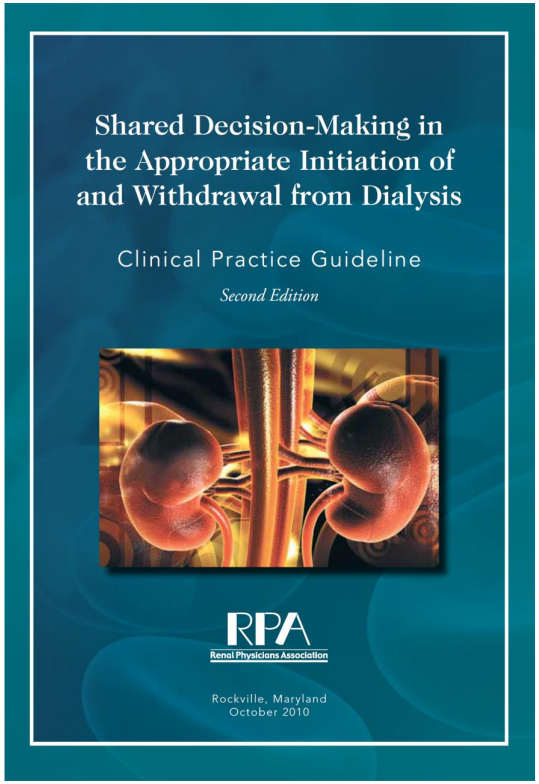
What would you do as a Medical Director?

1. Refuse to accept the patient back into the dialysis centre when she is discharged as she poses a safety risk to herself and others (patients/staff)
2. Accept the patient back into the dialysis centre BUT with a formal understanding with her son/family that she will be involuntarily discharged from the clinic if a similar incident occurs
3. Accept the patient back into the dialysis centre with a time-limited trial that the son/family will consider withdrawal of dialysis if the patient ‘s condition continues to deteriorate
4. Arrange for the patient to be transferred to a high dependency facility under the same dialysis provider

A Demented Dialysis Patient - Outcome

When admitted to hospital, the patient's AV fistula was found to have failed because of a large haematoma. The son and family were counselled on the patient's prognosis and given the options of placement of a temporary catheter for dialysis or withdrawal of dialysis. The son and family decided on withdrawal of dialysis and the patient was discharged with home hospice care. She passed away 5 days after her discharge.

Could we have done better? 🤔



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CJASN Ethics Series

1. Time to Improve Informed Consent for Dialysis: An International Perspective
2. The Evolving Ethics of Dialysis in the United States: A Principlist Bioethics Approach
3. The Ethics of Chronic Dialysis for the Older Patient: Time to Re-evaluate the Norms
4. Should an Elderly Patient with Stage V CKD and Dementia Be Started on Dialysis?
5. The Demented Patient Who Declines to Be Dialyzed and the Unhappy Armed Police Officer Son: What Should Be Done?
6. Ethics and Health Policy of Dialyzing a Patient in a Persistent Vegetative State
7. Dying on Dialysis: The Case for a Dignified Withdrawal
8. Beyond the Futility Argument: The Fair Process Approach and Time-Limited Trials for Managing Dialysis Conflict
9. Considerations in Starting a Patient with Advanced Frailty on Dialysis: Complex Biology Meets Challenging Ethics
10. The Ethics of End-of-Life Care for Patients with ESRD
11. Advance Care Planning in CKD/ESRD: An Evolving Process
12. Ethical Principles and Processes Guiding Dialysis Decision-Making

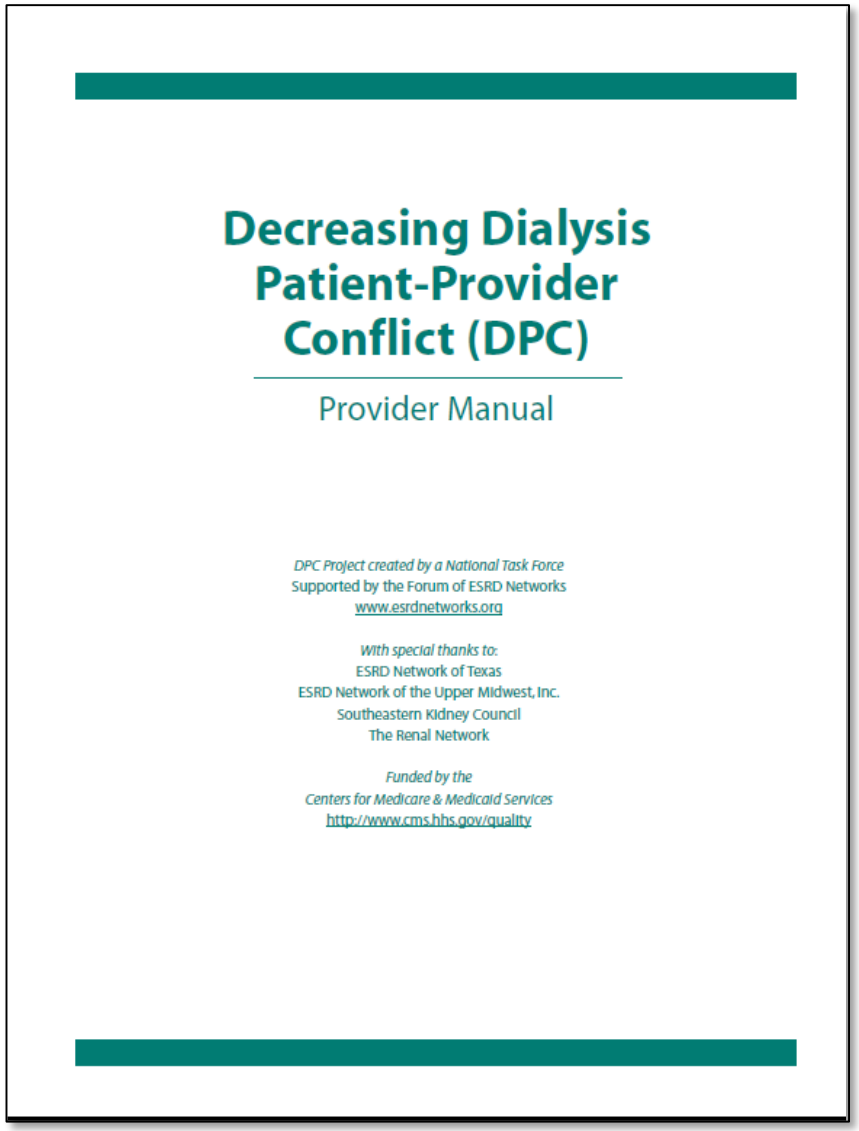
Case 3 - The Disruptive Patient

Mr LFK is 65 years old with presumed chronic glomerulonephritis and gout. He started on hemodialysis 5 years ago. He is a widower with 3 children and he stays with his youngest daughter and her family. He has a history of mild non-adherence to medications and has had occasional “run-ins” with the medical social worker (MSW) on the issue of medical subsidies.
In the dialysis centre, he was a “model” patient – punctual for dialysis, friendly and chatty. He greeted everyone that entered the centre and called the dialysis nurses his “darlings”.

About 1 year ago, he started to default payments for dialysis and accumulated a bad debt of about $7000. The Patient Care Team (PCT) from the dialysis centre helped work out an installment plan with the daughter and patient. The MSW of his referring hospital was also informed of the problem but the patient refused to make an appointment to see her. After discussion with the daughter and the PCT, they agreed to repaying the bad debt through installments while paying on a per dialysis session for subsequent dialysis.

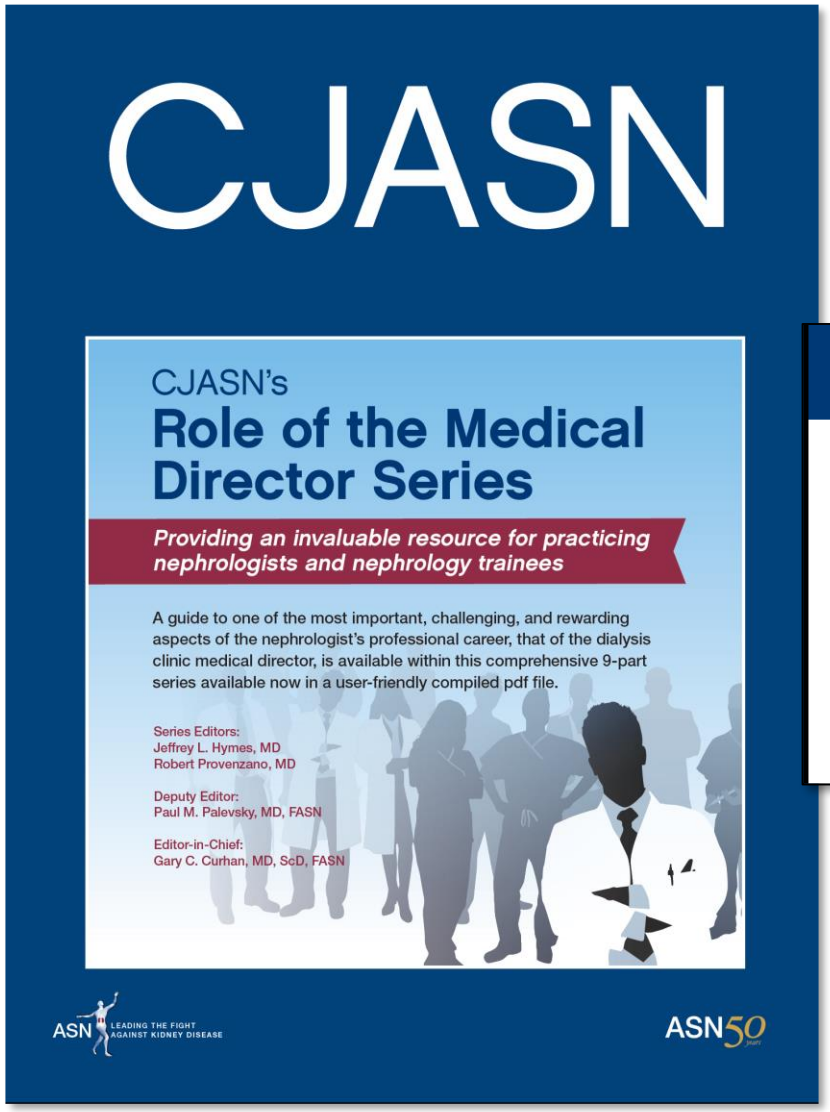
Mr LFK began to criticize and find fault with the dialysis procedure and nurses frequently saying “I don’t see why I need to pay so much for such lousy dialysis”. He had a disagreement with another male patient resulting in the transfer of the patient to another shift. He started to use vulgar language on the nurses and the clerk and received multiple verbal warnings of termination of dialysis from the PCT.

On the day in question, he accused the clerk of cheating him and became verbally abusive in the dialysis centre. He was asked to leave the dialysis centre by the Nurse Manager and to report to his referring hospital for further dialysis. He refused to leave and continued to be verbally abusive. His daughter was called and asked to come in to bring him to hospital. She refused to come down, hoping that he would receive his dialysis. The patient was informed that the police would be called in if he continued to refuse to leave the centre. The patient then called his daughter who came to pick him up.



Create a Calm Environment
Open Yourself to Understanding Others
Need a Nonjudgmental Approach
Focus on the Issue
Look for Solutions
Implement Agreement
Continue to Communicate
Take Another Look

ESRD Network Coordinating Center: Decreasing Dialysis Patient–Provider Conflict, 2013. Available at: http://www.esrdncc.org/index/decreasing-dpc



Role of the Medical Director

Managing Disruptive Behavior by Patients and Physicians: A Responsibility of the Dialysis Facility Medical Director

Edward R. Jones and Richard S. Goldman†*

The Disruptive Patient

It is important to maintain objectivity and to recognize that the difficult behavior or situation is not a characteristic of the patient, but of a specific set of circumstances that may cause these behaviors.

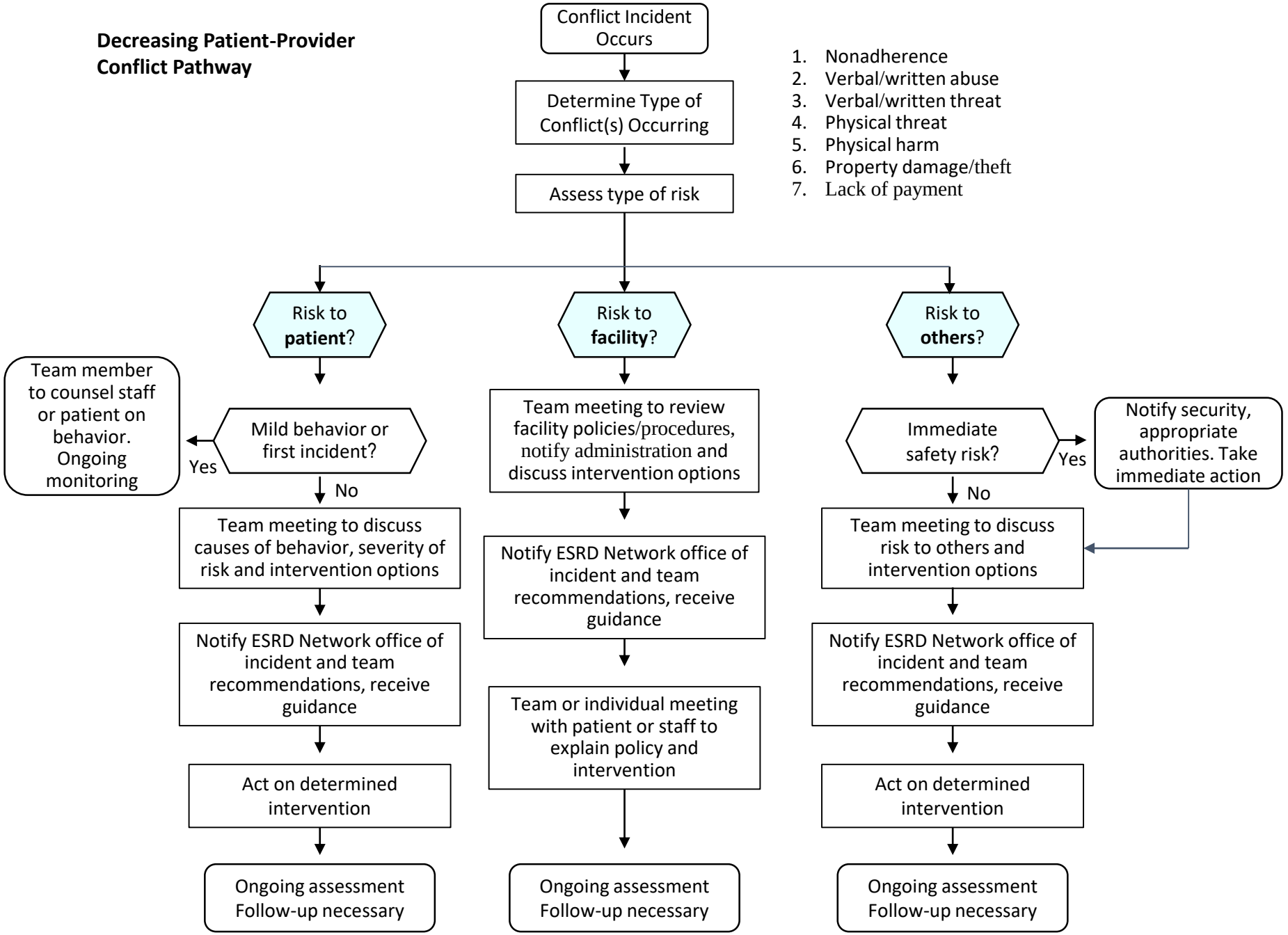
Stratification of Risks

1. **Risk to patient (Low)**
   Behaviors, physical acts, nonphysical acts or omissions by a patient that result in placing his/her own health, safety or well-being at risk (frequently referred to as non-adherence to medical advice).
2. **Risk to facility (Intermediate)**
   Behaviors, actions, or inactions by patients and/or family, friends or visitors perceived to put the safe and efficient operations of the facility at risk (for example frequent "no-show" for treatment or non-payment, frequently referred to as non-adherence to facility policy and procedures).
3. **Risk to others (High)**
   Behaviors, actions or inactions by patients and/or family, friends or visitors that are perceived to place the health, safety or well-being of others at risk (commonly referred to improper behaviors that impinge on the rights of others).

May result in **involuntary discharge** (IVD) or **involuntary transfer** (IVT) of patient

ESRD Network Coordinating Center: Decreasing Dialysis Patient–Provider Conflict, 2013. Available at: http://www.esrdncc.org/index/decreasing-dpc

Decreasing Patient-Provider Conflict Pathway



The Disruptive Patient – How do we manage?

Too little, too late 😬

What could we have done to avoid it? 🤔

DOCUMENT
DOCUMENT
DOCUMENT
💪💪💪

"**Setting the tone**" of the centre (Rules and Regulations)
- Patient-Provider Contract
- Patient Rights and Responsibilities
- Reviewed regularly (annually)

Spotting the problem early
- Staff training
- Protocols & Algorithms
- Timely escalation to appropriate personnel (Team members)
- Meet with patient/family to understand situation

1. Nonadherence
2. Verbal/written abuse
3. Verbal/written threat
4. Physical threat
5. Physical harm
6. Property damage/theft
7. Lack of payment

TEAM MEMBERS
1. Medical Director/Nephrologist
2. Nursing staff
3. Patient Welfare Staff
4. Appropriate staff from referring hospital/institution
5. Ethics Committee

Settling the problem early
- Train **ALL** staff in conflict resolution skills
- Team members meet to plan intervention and <u>specific goals/end points</u>
- Team member(s) meet with patient/family to work out a solution

1. Formal agreements on intervention
2. Verbal warnings
3. Written warnings

The Disruptive Patient – What actually happened

The patient went back to his referring hospital to be admitted for dialysis. His primary nephrologist was informed of the situation. The patient was counselled and his problem referred to the medical social service (whom he originally refused to see) to seek financial assistance for his dialysis fees. On discharge, he was transferred to another dialysis centre under the same provider. His medical records were transferred internally without bias. After a few months, the patient secured a place in a VWO centre and he was transferred.

Table 2. Conclusions of the dialysis provider-patient conflict task-force [7]

Physicians have the right to refuse treatment to a violent/abusive patient
Care contracts to guide appropriate behavior may be constructed to avoid future conflicts
A physician may terminate a patient-physician relationship only after documented conflict resolution has been attempted
The dialysis unit staff must make a reasonable attempt if the patient is terminated to seek other dialysis care for the patient
Termination of a patient from a physician/group or facility on grounds of nonadherence alone is not acceptable and conflict resolution must be attempted in this circumstance

American Kidney Fund: Barriers to Treatment Adherence for Dialysis Patients – American Kidney Fund and Adherence Survey 2018. http:www.kidneyfund.org/assets/pdf/akf-adherence report.pdf

Case 4 - The Disruptive Physician

Role of the Medical Director

Managing Disruptive Behavior by Patients and Physicians: A Responsibility of the Dialysis Facility Medical Director

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Table 3. Examples of disruptive behaviors in nephrologists

Condescending and abusive language	Lack of participation in interdisciplinary rounds
Not returning phone calls in a timely fashion	Noncompliance with patient visits
Not responding to medical director inquiries	Not fulfilling roles and responsibilities
Constantly refusing to follow established protocols	Refusing to participate in facility programs
The medical director is late for QAPI meetings	Cherry-picking patients
Physical abuse	Substance abuse and impairment
Fraudulent billing	Initiating dialysis inappropriately
Solicitation of patients	Bad-mouthing employees and facility
Repetitively not fulfilling attestation issues (*e.g.*, signing of CMS 2728 attestation form)	Insulting, intimidating, or demeaning patients, family members, staff, colleagues or facility
Placing financial needs ahead of patients needs	Throwing objects/anger management

QAPI, Quality Assurance and Performance Improvement; CMS, Centers for Medicare & Medicaid Services.

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The Disruptive Physician

Table 5. Suggested interventions for physicians exhibiting disruptive behavior

1. Engage the physician one-on-one with data and examples of the behavior; keep the discussion focused on the behavior and try to avoid personality conflicts (7)
2. Refer to and make available the credentialing by-laws of the facility, including issues of due process
3. Consider and exclude potential medical reasons, including depression and drug dependence
4. If necessary, engage all who may oversee the functioning of the medical director, such as the governing body, company medical advisory board, chief medical officer and dialysis organization's legal department
5. Suspend or terminate recalcitrant physicians. Dialysis providers must be vigilant and firm in this regard, even if it means the transfer of patients. The facilities' quality of care must take precedence.
6. If necessary, report the disruptive behavior to the state medical society. This allows the medical society to adjudicate the appropriateness of the complaints and to recommend or mandate actions.

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Summary

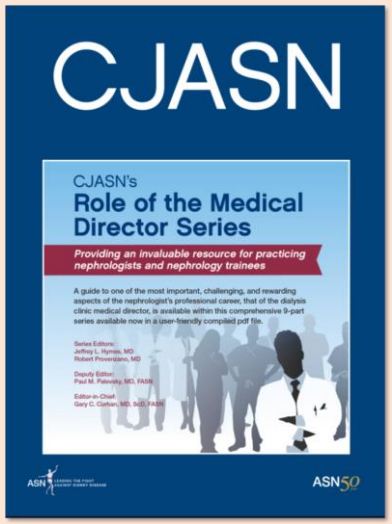
Principles of Medical Ethics

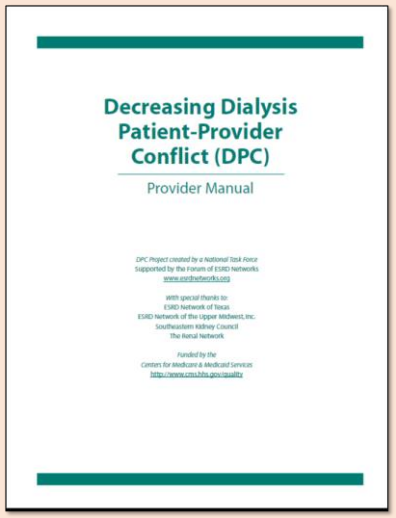
1. Beneficence
2. Non-maleficence
3. Social (distributive) justice
4. Autonomy

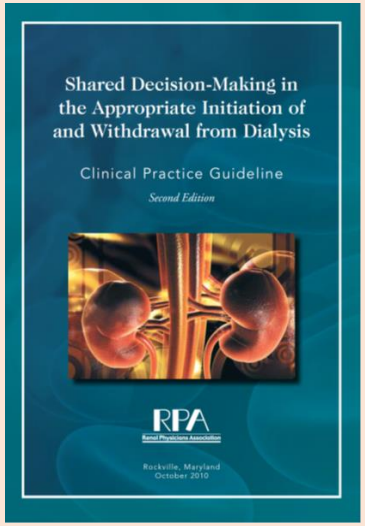
Overview of ethical issues in dialysis therapy

- Financing of dialysis
- Clinical care and decision making
- Distributing dialysis resources

Practical tips and resources (using case scenarios)







(Reading list enclosed)