

Emerging Trends in Discharging Disruptive Dialysis Patients: A Case Study

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At the end of the 2009 calendar year, 399,000 End-Stage Renal Disease (ESRD) patients received dialysis as their treatment method, according to the U.S. Renal Data System. In addition to the consequences of their ESRD, patients on dialysis experience many challenging emotional, physical and financial burdens. Steps need to be taken to ensure safety when a patient is a threat to the rights and safety of other patients and staff. Severe cases of threat and abuse, both verbal and physical, can lead to the offending patient being involuntarily discharged from the dialysis facility. However, the ESRD Networks, as well as the state Departments of Public Health, do not have the authority to mandate that outpatient dialysis facilities accept known disruptive patients. When patients are involuntarily discharged from a dialysis facility, and cannot find another outpatient facility to admit them, they are instructed to go to the nearest emergency room for dialysis care. The Emergency Treatment and Active Labor Act requires hospitals to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay. This case study attempts to explore the emerging trends of discharged, disruptive dialysis patients who are denied dialysis services from outpatient dialysis facilities.

INTRODUCTION

The prevalence of U.S. residents with End Stage Renal Disease (ESRD) receiving treatment at the end of the 2009 calendar year was more than 571,000, which is a rate of 1,738 per million population (United States Renal Data System Annual Report, 2011). The number of incident dialysis patients rose 3.9 percent in 2009, up from 1.2 percent in 2008, to 112,782. In 2009, nearly 399,000 ESRD patients received dialysis as their treatment method. Dialysis therapy allows patients the choice to dialyze at home or in an outpatient clinic. Of the 399,000 patients, 365,566 chose in-center hemodialysis, usually three times a week for a three to four hour treatment (United States Renal Data System Annual Report, 2011). Patients on dialysis experience many emotional, physical and financial challenges. These challenges can cause patients to become angry and disruptive, both in and out of their dialysis facility. With increasing numbers of patients beginning dialysis each year, we can expect increasing numbers of problems with disruptive patients. Dialysis is unique, in that in-center hemodialysis is conducted in an “open treatment setting” where one patient can observe and hear the treatment of other patients, even with the best intentions of facility staff to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. There are no “special care” dialysis units, so all conversations can be heard and staff interactions with a specific patient can be observed.

THE CENTERS FOR MEDICARE & MEDICAID SERVICES CONDITIONS FOR COVERAGE (CFCs)

On April 15 2008, the Centers for Medicare & Medicaid Services (CMS) released a final rule that revised and updated the Medicare CFCs for the nation’s dialysis centers. Outpatient dialysis facilities must meet the CFCs to be certified under the Medicare program. According to the CFC V Tag 501, “the facility’s interdisciplinary team (IDT) consists of, at a minimum, the patient or the patient’s designee (if the patient chooses), a registered nurse, a physician treating the

patient for ESRD, a social worker, and a dietitian. The IDT is responsible for providing each patient with an individualized and comprehensive assessment of his or her needs. The comprehensive assessment must be used to develop the patient’s treatment plan and expectations for care” (ESRD program interpretive guidance, 2008, p. 186). The new CFCs strongly emphasize that the medical director has responsibility for the functions of the IDT. The CFC states, “The medical director is accountable to the governing body for the quality of medical care provided to patients” (ESRD program interpretive guidance, 2008, p. 276).

The definition of medical director sometimes requires the physician to take on dual roles. The role of the medical director, as part of the dialysis organization, requires the nephrologist to comply with the organization’s policy and procedures. The medical director also acts as the attending nephrologist to his/her patients. Sometimes medical directors are encouraged to involuntarily discharge patients by other members of the IDT. Members of the IDT work with disruptive patients on a daily basis, while some medical directors may only see these patient a few times a month. The time and energy that goes into managing disruptive behaviors may make members of the IDT feel “professional burn out”. If the medical director discharges a patient from his/her dialysis clinic, he/she will most likely also discharge that patient from their nephrology practice as well.

THE NEPHROLOGIST AND THE DISRUPTIVE PATIENT

Once a nephrologist establishes a patient-physician relationship, the nephrologist has a continuing legal duty to treat that patient until the need for services is lawfully terminated (Ripley, 2009). ESRD patients will need medical services until the end of their life. According to Goldman (2008), “Medical directors and attending nephrologists must act in the best interests of the patient (‘beneficence’), placing the patient’s interest above their own” (p. 248). An example of unethical behavior would be to involuntarily

discharge a patient for nonadherence to prescribed medical treatment because it lowers the clinic performance of the provider of service (Goldman, 2008).

While a patient may terminate the physician–patient relationship at any time, the nephrologist must take the legal concept of medical abandonment into consideration. A nephrologist can only terminate the relationship after ample warning has been given to the disruptive patient and a reasonable attempt to transfer the patient’s care has been made (Goldman, 2008). “Ultimately, the courts decide what constitutes ‘ample’ and ‘reasonable,’ applying the test of what would be done by a ‘reasonable person’ acting under ‘similar circumstances’ ” (Goldman, 2008, p. 248).

The Hippocratic Oath is an oath historically taken by physicians swearing to practice medicine ethically. The oath includes the statement: “I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.” Most physicians comply or strive to comply with this oath even with the complexities of medicine. According to Ripley (2009), “The obligation to treat a non-compliant, abusive dialysis patient is one area where the struggle continues” (p. 1).

INVOLUNTARY DISCHARGE AND “CHERRY PICKING”

Severe cases of threat and abuse, both verbal and physical, can lead to the patient being involuntarily discharged from their dialysis facility. According to the CfCs, the “medical director must monitor and review each involuntary patient discharge to ensure that the facility interdisciplinary team follows the discharge and transfer policies” (ESRD program interpretive guidance, 2008, p. 280). The CfC interpretive guidance V Tag 766 states that the “medical director ensures that no patient is discharged or transferred from the facility unless –

1. The patient or payer no longer reimburses the facility for the ordered services;
2. The facility ceases to operate;
3. The transfer is necessary for the patient’s welfare because the facility can no longer meet the patient’s documented medical needs; or
4. The facility has reassessed the patient and determined that the patient’s behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired
5. In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure” (ESRD program interpretive guidance, 2008, p. 293 & 294).

Conditions 1–4 require a 30 day notice to the patient as well as a “good faith effort” to place the patient in another outpatient dialysis clinic. A 30-day notice also must be made to the local End Stage Renal Disease Network (ESRD program interpretive guidance, 2008).

The ESRD Network Program, under CMS contract, is a national program of 18 ESRD Networks, responsible for the 50 U.S. states, Puerto Rico, the U.S. Virgin Islands, District of Columbia and several other territories. ESRD Networks service geographic areas based on the number and concentration of ESRD beneficiaries (ESRD Network Organizations, 2012). ESRD Networks assist patients, ESRD facilities and other providers of ESRD services by assuring the effective and efficient administration of benefits, improving the quality of care for ESRD patients, collecting data to measure the quality of care, and evaluating and resolving patient grievances and complaints.

Dialysis facilities are required by the CfCs to report all involuntary discharges to Networks and State Survey Agencies. However, neither the ESRD Networks nor State Survey Agencies have the authority to mandate that outpatient dialysis facilities accept patients. ESRD Networks advocate that dialysis facilities accept patients who are being denied services. For example, patients with mental illness are often requested to obtain psychiatric services prior to admission into a dialysis facility. Mental health professionals can often determine the root cause of the abusive behavior. Often, when dialysis patients are involuntarily discharged and placed at another facility, they no longer display the disruptive behavior they portrayed at the previous facility. In severe cases, Networks have coordinated “sharing” of patients with difficult behaviors between dialysis facilities for a specified length of time so that one facility never “owns” the patient for an extended period of time.

Dialysis facilities have policies and procedures in place outlining their admission criteria for new patients. A dialysis facility cannot admit a patient into its clinic without a nephrologist who has agreed to treat the patient. A growing concern is the unethical “cherry picking” of patients by either nephrologists or dialysis facilities. Cherry picking is actively excluding patients with perceived negative qualities (Parker, 2011). A physician or dialysis facility that becomes focused on the characteristics of the population of patients, instead of the ethical and medical need to treat patients in a specific clinical situation, may be tempted to manipulate the patient population by excluding certain types of patients (Parker, 2011). Patients differ in age, disease burden, mental well-being and willingness to adhere to medical advice. Patients may have psychosocial burdens such as poverty and poor support systems that make them less likely to maintain good clinical outcomes. Finally, some patients are not willing to follow the advice of their physicians (Parker, 2011).

A 2008 national survey was conducted as part of the Identifying Best Practices in Dialysis (IBPiD) study, which

is a multidisciplinary research effort conducted by the University of California–Los Angeles (UCLA) in collaboration with the Renal Physicians Association (RPA) and the American Nephrology Nurses Association (ANNA). The IBPiD aimed to identify best practices that may improve facility-level achievement of clinical performance measures and overall outcomes in dialysis patients. IBPiD's national survey was conducted to elicit caregiver perception regarding the extent and consequences of cherry-picking in dialysis care (Desai et al., 2009). The respondents, a random sample of 250 nurse members of ANNA, 250 nephrologist members of the American Medical Association, 50 key opinion leaders and 2000 physician members of RPA were asked about their perceptions of 1) cherry picking, including the frequency and effect of various 2) cherry-picking strategies on dialysis outcomes. Three-quarters of respondents reported that cherry picking occurred “sometimes” or “frequently.” “There were no differences in perceptions by provider or facility characteristics, insurance status, or health status” (Desai et al., 2009, p. 772).

Physicians can exclude or “fire” their patients by referring them to other providers and practices or by “manipulating the patients into foregoing dialysis” (Parker, 2011). “The nephrologist might simply declare without any explicit rationale that the patient is ‘not a dialysis candidate’ and leave the impression for the patient, as well as the referring physician, that there is some nonvalue laden medical judgment that has been made when in reality the judgment was heavily value laden” (Parker, 2011, p. 6). If society comes to believe that nephrologists are making decisions about whether to recommend dialysis therapy for patients based on how these patients will affect clinical performance outcomes, then it will understandably develop a healthy skepticism whenever a nephrologist recommends against dialysis regardless of the potential burdens to the patient. Trust is built in a therapeutic patient–physician relationship when the physician is not focused on his or her own self-interest but in the interest of the patient (Parker, 2011). Cherry picking weakens this trust.

DECREASING DIALYSIS PATIENT-PROVIDER CONFLICT

When a patient is a threat to the rights and safety of other patients and staff, steps need to be taken to address safety issues. The Occupational Safety and Health Act of 1970 mandates that facilities ensure the safety of their staff and patients. Law enforcement should be contacted when severe threats of harm are made or physical violence occurs. Dialysis organizations have the responsibility to protect facility staff, as well as all patients, including those who are verbally disruptive and abusive, provided those patients are not a threat to the safety of themselves or others. Patients deserve dialysis care in an environment where they are safe.

When patients display abusive behaviors in the clinic, IDT members have policies and procedures in place to

address these behaviors. The policies and procedures usually include plan of care meetings, behavioral agreements and mental health services referrals as effective ways to assist patients in addressing the root cause of their abusive behavior. Occasionally, changing the patient's dialysis time or facility can alter the situation, causing the stress for the patient and the abusive behavior to subside. Lastly, implementing the Decreasing Patient-Provider Conflict (DPC) Toolkit in facilities can help staff understand how to effectively manage behavioral conflict.

The Forum of ESRD Networks is a national membership organization that advocates for national policies relevant to the ESRD Networks. From 2003 to 2005, the Forum of ESRD Networks addressed the increasing national trend to involuntarily dismiss disruptive, noncompliant patients. The Forum partnered with CMS and other stakeholders to create the Decreasing Patient-Provider Conflict Committee, which developed a toolkit for defusing disruptive behavior and resolving dialysis facility-based conflict, consistent with federal regulation, medical ethics, and statute (Goldman, 2008). CMS funded the production of the DPC toolkit to implement the action plan. The Dialysis Patient Provider Conflict Committee developed three categories of disruptive behavior. “The first was disruptive behavior that places the disruptive individual at risk. The second was disruptive behavior that places the facility at risk. And the third was disruptive behavior that places others in the facility at risk” (Goldman, 2008, p. 246).

CASE STUDY

History

Patient K is a 35-year-old female. She developed End Stage Renal Disease (ESRD) in 2009 due to untreated hypertension. Patient K has a reported history of drug and alcohol abuse, as well as aggressive/violent behavior. The patient does not have a family or social support system to assist in meeting her emotional or physical needs. The only person Patient K trusts is her longstanding therapist. Patient K was initially denied outpatient dialysis services by a nephrology group in her state. The patient's nephrologist referred Patient K to a psychiatrist, who reported that Patient K was “not a candidate for outpatient dialysis due to her behavior.” The patient was seen by another nephrology group that started her on hemodialysis at an outpatient facility in August 2009. The patient received hemodialysis at the facility for two years. The nurse manager at the dialysis facility reported that Patient K was verbally abusive but generally not disruptive to facility functions, with the exception of a few incidents. The nurse manager and social worker developed behavioral contracts with the patient; however, she never adhered to them. The social worker tried to refer the patient for psychiatric therapy, which was also denied by the patient. The IDT made several efforts to have a meeting with the patient but she refused. In May 2011, Patient K was involuntarily discharged from her dialysis

facility, with the facility citing “Immediate Severe Threat” according to the Centers for Medicare & Medicaid Services (CMS) Conditions for Coverage (CfCs). The patient had threatened to physically assault the nurse manager. Dialysis facilities are required by the CfCs to inform their ESRD Network as well as the State Survey Agency when a patient is involuntarily discharged from a facility. The nephrologist, and subsequently the nephrology group that was treating the patient, also discharged her from their care. The Patient Services Coordinator (PSC) for Network 1 received a call from the dialysis facility and has been involved in trying to coordinate dialysis services with the patient since the discharge. This work has involved several hours conversing with the State Survey Agency, nephrology practice groups, dialysis facilities, hospital personnel and mental health specialists. The PSC, a licensed clinical social worker, has continued to advocate for Patient K, while remaining cognizant of the safety of other patients and facility staff where the patient received or will receive her future medical care.

Presenting Problem

The patient has been denied services from every outpatient dialysis facility in her state, as well as most of the facilities in a neighboring state. Patient K has only dialyzed at one other outpatient dialysis facility, which is owned by one of the large dialysis organizations (LDOs), but has been denied services from the other LDOs, as well as independent and small dialysis organizations (SDOs). There is no nephrologist who will currently accept the patient for renal care. Since the patient’s involuntary discharge, she has been arrested once for disorderly conduct and resisting arrest. The patient is currently receiving dialysis at an acute hospital that does not provide chronic outpatient dialysis. There are two acute hospitals in the patient’s area, but she only dialyzes at one due to the second hospital’s restraint policy. This policy allows the hospital staff to restrain the patient during dialysis if she presents in their Emergency Department. When Patient K presents at the Emergency Department, and if she meets the Emergency Medical Treatment and Active Labor Act (EMTALA) criteria for clinical emergent need, she is admitted and dialyzed. The hospital is obligated to treat this patient under the requirements of EMTALA. Patient K is not receiving her full prescription for dialysis three times a week.

LEGAL ACTION AND THE NONADHERENT DIALYSIS PATIENT

There are few legal cases documented regarding involuntary discharged dialysis patients. Two frequently-cited cases involve patients who tried to resume their dialysis services after they were discharged from their facilities for nonadherent behavior (Smetanka, 2006). In medicine, adherence (also compliance or capacitance) is defined as the degree to which a patient correctly follows medical advice (Compliance, n.d.). Prior to the 2008 revision, the CfCs did not address nonadherent behavior or involuntary

discharges. In the current CfCs (2008), patients cannot be discharged for “failure to comply with facility policy unless the violation adversely affects clinic operations, shortened or missed treatments unless this behavior has a significant adverse effect on other patients’ treatment schedules or failure to reach facility-set goals for clinical outcomes” (ESRD program interpretive guidance, 2008, p. 294).

In the first case, *Payton v. Weaver* (1982), Brenda Payton, a dialysis patient, had her services terminated by Dr. John C. Weaver, as well as her dialysis facility, after being a patient for three years. According to the physician and facility, the patient displayed persistent uncooperative and antisocial behavior, was nonadherent to the limitations of hemodialysis, dietary restrictions, and medical prescriptions, and was also an illegal drug user. Payton was denied services from two other dialysis facilities and was being treated by Dr. Weaver on an emergent basis. After receiving a second letter from Dr. Weaver stating that he would no longer treat her, Payton retained a lawyer who petitioned to have her dialysis clinic and the physician provide her with outpatient dialysis services (Smetanka, 2006). This lawsuit was resolved with an agreement that the patient, dialysis facility and nephrologist accepted. The agreement addressed that:

The patient would keep all appointments at her scheduled time; that she refrain from use of alcohol and drugs; that she maintain prescribed dietary habits; and that she “in all respects cooperate with those providing her care and abide by her physician’s prescribed medical regimen.” Later, a sixth stipulation was added: that Payton would “enter into and participate in good faith in a program of regular psychotherapy and/or counseling” (Smetanka, 2006 p.72).

Payton failed to comply with the agreement, and was discharged again after 11 months. After Payton petitioned the court a second time, the court found that she knowingly and intentionally violated all the terms of her agreement. The court also found that Payton’s behavior endangered other patients at the facility. The nephrologist and dialysis facility had no legal obligation to provide her with additional services (Smetanka, 2006).

The second case often cited is *Brown v. Bower* (1987). In this case, the patient Michael Brown was “an extraordinarily non-compliant, disruptive, violent, substance-abusing, chronic dialysis patient [who] received dialysis ... and whose body had rejected two renal transplants because he apparently did not take required medications” (Smetanka, 2006, p.74). Brown either missed or was late to dialysis consistently, was rude to patients and staff and had verbally threatened to “kill, shoot or physically attack” his nephrologist, Dr. John Bower, hospital administrators and others (Smetanka, 2006). After being discharged by his dialysis facility, Brown was court ordered to be bound and gagged while receiving dialysis at the hospital. Brown was not able to find treatment at an outpatient dialysis facility

because of his reputation. The court ruled that the hospital, which received federal funds, was required by law to provide dialysis treatment to Brown; however, Dr. Bower was not required by the ruling to resume the physician–patient relationship (Smetanka, 2006).

EMTALA AND “PATIENT DUMPING”

When patients are involuntarily discharged from a dialysis facility and cannot find another outpatient facility to accept them, they are instructed to go to the nearest emergency room for dialysis care. Emergency rooms are not obligated to treat chronic conditions unless that condition becomes emergent. EMTALA, passed in 1986, requires hospitals to provide care to anyone needing emergency healthcare treatment, based on medical examination, regardless of citizenship, legal status or ability to pay. Participating hospitals may only transfer or discharge patients needing emergency treatment under the patient’s informed consent, after stabilization, or when their condition requires transfer to a hospital better-equipped to administer the treatment (The Public Health, 1944). Hospitals must also accept patient transfers if they have the capacity and capability to do so (Hyman, 1998). Physicians who are “on-call” to the emergency room are required to come to the hospital and provide all necessary services. This provision can force the nephrologist to treat a patient in the hospital who has been discharged from his care in the outpatient dialysis setting.

EMTALA applies to hospitals that accept payment from the Department of Health and Human Services under the Medicare program, which includes nearly all hospitals in the U.S. Medicare payment for all medical expenditures in the U.S. was \$491 billion in 2009, an 8.2 percent increase from 2008 (United States Renal Data System Annual Report, 2011). These rising costs make it impractical for hospitals not to participate in EMTALA.

Involuntarily-discharged dialysis patients may not be in emergent need for treatment when they present at the emergency room. Patients may not present with clinical symptoms (e.g., chest pain, shortness of breath) and/or their laboratory values (e.g., high potassium level) may not indicate the need for emergent dialysis. The patients’ regular dialysis time may be shortened or the treatment may be postponed, placing the patients at risk for increased morbidity.

The concern of placing the disruptive discharged dialysis patient is distinct from the problem of a hospital transferring indigent patients to other hospitals without stabilizing them—the original principle rationale behind EMTALA (Smetanka, 2006). The discharged dialysis patient’s circumstance accelerates to a life-and-death situation when there is no other facility that will accept the patient. “At this point, the problem begins to resemble the ‘patient dumping’ situation that is addressed by EMTALA” (Smetanka, 2006 p. 80). Nephrologists, dialysis facilities, patients and CMS all agree that the acute hospital setting is not the ideal place to provide regular dialysis treatments for the patient with ESRD. However, it is very likely that disruptive patients will

continue to be discharged or dumped by outpatient dialysis facilities (Smetanka, 2006).

CONCLUSION

With the increasing number of patients requiring dialysis treatment, it can be expected that the number of patients who present with disruptive, abusive behaviors will also increase. It is important to have resources available at the dialysis provider level to assist these patients in obtaining the help they need to assimilate to their new life with End Stage Renal Disease. ESRD Networks offer a range of instructive material and technical assistance for providers, as well as patients, that can help with these difficult situations.

When a situation arises where a patient is involuntarily discharged from the dialysis clinic it is important that the dialysis facility make a “good faith effort” as stated by the CfCs, and not “blacklist” the patient from other potential facilities.

Nephrologists are the first renal professional patients meet when they are diagnosed with ESRD. Most patients report having a trusting, therapeutic relationship with their nephrologist and rely on the nephrologist as the most important person to help them make informed medical decisions.

Utilizing the services of all members of the IDT, including the nurse manager and the social worker, helps the patient obtain the best medical care possible, as well as offer support to the nephrologist. The role of the social worker is very important in disruptive/abusive patient cases. Many times it is the social worker who is the primary person addressing the patient behavior. They can often spend days, weeks and months assisting the patient with his issues, while also trying to be supportive to the other members of the IDT. Members of the IDT will come to the social worker with complaints about patients, and the social worker will act as a facilitator between the staff and patients. Prior to a patient being involuntarily discharged, it is often the social worker who will work on behavioral contracts and outside referrals with the patient.

A growing problem is the number of patients who utilize hospitals for dialysis services when they should have access to an outpatient dialysis facility. Undocumented patients, patients without health insurance and involuntarily discharged patients with no accepting dialysis facility all become an undue “burden” on the hospital, which has no choice but to treat the patients. These patients can get lost in the system and receive fragmented care; sadly, some of them die because they do not receive the specialized services they need. As social workers we need to do our part to continue advocate for the patients in dialysis facilities who are close to being involuntarily discharged. Offering referrals for counseling, anger managements classes, and group therapy (if appropriate) are strategies to assist patients in getting services before the situation escalates.

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