The article “Look for reasons if patients refuse advice” in the February 2014 ACP Internal raised many interesting points, but I strongly disagree with one of them, that it is unacceptable to dismiss a patient who won’t comply. I’ve always believed that patients should have the right to make medical decisions about their own lives. But 2 major concerns have combined to change my opinion about remaining the doctor for patients who refuse to follow my advice.

First, there is the legal aspect. In our paternalistic legal system, the doctor is at least partly responsible for bad outcomes of patients’ noncompliance. Please note the “Additional reading” section of the article, which referred to an article titled “Documenting noncompliance won’t protect you anymore.” The second aspect is more important from a patient-centered point of view. What if, despite the doctor’s best efforts, there’s a flaw in that doctor’s communication skills? Or what if there’s some sort of interpersonal mismatch between that particular doctor and that particular patient? Isn’t it possible that the patient who doesn’t follow doctor #1’s advice might connect with doctor #2, and then comply? Isn’t it plausible that if doctor #1 doesn’t dismiss the noncompliant patient, the patient will be harmed?

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**Test Yourself**
(Question on page 4)

**Answer and critique**

The correct answer is E: Observation. This question can be found in MKSAP 16 in the Hematology and Oncology section, item 1.

The most appropriate management of this patient now is observation. This patient has primary myelofibrosis, which is a chronic myeloproliferative disorder characterized by overproduction of megakaryocytes and bone marrow stromal cell-mediated collagen deposition. The peripheral blood smear shows marked leukoerythroblastic findings with teardrop-shaped erythrocytes and megathrombocytes. The bone marrow aspirate is often “dry” (unsuccessful aspiration), and bone marrow biopsy shows marked fibrosis. This patient has low-risk primary myelofibrosis (PMF) given the absence of high-risk features such as age older than 65 years; fever, night sweats, and a weight loss of 10% or more; a hemoglobin concentration of less than 10 g/dL (100 g/L); a leukocyte count greater than 25,000/μL (25 x 10^3/L); and circulating blasts of 1% or more. As such, his median overall survival is 135 months or approximately 11 years. Given his favorable prognosis, he requires only observation for now.

Allogeneic hematopoietic stem cell transplantation is potentially curative in patients with PMF but is associated with significant morbidity and mortality and would not be a good choice for a patient with low-risk disease, but it could be considered if the disease progresses. Transplantation is the preferred treatment for younger patients with two or more adverse prognostic features. Danazol is used to treat PMF-related anemia and leads to responses in 37% of patients with transfusion-dependent anemia or a hemoglobin level less than 10 g/dL (100 g/L). This treatment is not indicated in this patient considering his hemoglobin level of 12.5 g/dL (125 g/L).

Hydroxyurea would be a reasonable therapy if the patient had constitutional symptoms such as fever, weight loss, night sweats, symptomatic splenomegaly, or problematic thrombocytosis; however, this treatment is not required now. Imatinib is appropriate therapy in patients with chronic myeloid leukemia, but it is not effective in treating PMF.

**Crossed Words**
(Puzzle on page 4)

**Answer: Kaolin and pectin**

The name “Kaopectate” originally comes from the ingredients kaolin (adsorbent) and pectin (emollient) in its initial formula. Attapulgite, a type of absorbent clay, replaced the kaolinite in the 1980s. Then, the FDA ruled in 2003 that the product had unproven effectiveness, and since 2004, bismuth subsalicylate (Pepto-Bismol’s active ingredient) has been used in the U.S. In 2007, Chattem, a Sanofi company, bought Kaopectate from Johnson & Johnson. In Canada, McNeil Consumer Healthcare continues to market Kaopectate using attapulgite. (Source: Wikipedia and Chattem, Inc. websites.)

Fourth, improve the Medicaid program. The fact that tens of millions of poor people will have access to Medicaid is a good thing. The most important improvement for this population would be for all of the states that have declined to expand the program to get on board. At the same time, Medicaid is by no means a state-of-the-art program. Except for a few pioneering states, Medicaid is not considered to be a haven of innovation in payment and delivery. The program’s rules are cumbersome, and its payments to physicians and hospitals are too low. Yet Medicaid already is the single largest coverage program in the United States, and as more join the program, state governors, legislators, Congress, and the Obama administration should find bipartisan approaches to making it less expensive, more efficient, and more accessible to both patients and physicians.

Such improvements are not conducive to the red-hot politics over the ACA’s fate, where everything is shouted in apocalyptic terms designed to scare and motivate voters. But isn’t the purpose of politics to elect people who will do what is best for their constituents? Wouldn’t constituents benefit by making the ACA work better for them?

Many of the improvements discussed here can be made without Congress’ consent, through administrative rule-making, oversight, and state regulation. Congress and the states, though, can make things worse by denying the funds needed to, say, build a better federal enrollment site or by declining to expand Medicaid, not because this would be in the best interests of constituents, but for partisan, ideological, and political reasons.

We have an opportunity to improve the ACA, and the least we can hope is that politicians don’t get in the way.