

DEALING WITH DIFFICULT, ABUSIVE, AGGRESSIVE OR NON-COMPLIANT PATIENTS

INTRODUCTION

There is growing concern throughout Australia as to how health facilities respond to patients who are considered difficult, abusive or non-compliant. What are their responsibilities to the patient? What are their responsibilities to other patients and staff? Can the patient be removed from treatment? Are these questions influenced by the threat posed by the patient to the safety of staff and other patients?

Drawing on a number of complaints involving decisions by treatment facilities in relation to patients considered difficult, abusive or non-compliant, I examined the competing rights and responsibilities of service users and service providers, drawing on the issues raised by these types of complaints. Consideration was given to a number of factors, including:

- the funding status and geographical location of service providers;
- occupational health and safety requirements; and
- financial considerations.

An important qualification in regard to this subject is that it is intended to relate to circumstances where serious issues arise regarding the behaviour of persons receiving health services in the context where such behaviour is clearly inappropriate, aggressive or violent.

It is recognised that there will be occasions where patient behaviour, whilst being difficult and emotive, is not necessarily wrong or inappropriate in the context of the service being provided and the circumstances relating to their particular health issue.

LEGAL CONSIDERATIONS

I think most people would agree, there is a general right to treatment in an emergency (*Lowns v Woods* 1996). However, it is not so clear, in the Australian and overseas literature, if this duty extends to the ongoing treatment of a chronic illness.

Consider the situation of a patient with a chronic illness, such as renal failure. With regular dialysis, the patient maintains a relatively healthy and independent lifestyle. Without such treatment, the patient could become very ill, and possibly die. Can a treatment facility refuse to dialyse a patient who is violent or abusive, when he or she presents for a regular dialysis session?

Treatment for a chronic illness versus treatment in an emergency

In the United States there have been a number of cases on the issue of refusal or discontinuation of treatment for a chronic illness, for example *Payton v Weaver* (Payton's Case). This case related to the decision of a treatment facility to discharge a patient with end stage renal disease and the Court held that there is no abandonment of patients if they are given sufficient notice of the intention to end the treating relationship, and time to find another service.

Within the American context at least, it would seem that the need for regular and ongoing treatment of a chronic illness has not been equated with the need for emergency treatment, even where that treatment is life sustaining.

Does it make a difference if it is a public treatment facility?

A situation arose for the American courts' consideration where a patient sought an order that a Mississippi Nephrologist and hospital were required to provide ongoing dialysis treatment, after both had refused to treat him. The court refused to order the Nephrologist to provide treatment, both on the grounds set out in Payton's case, and on the basis that the Hill-Burton Act (legislation which provides funding to State based health service providers) does not apply to individuals (*Brown v Bower* 1987).

Does such a situation exist in Australia?

Section 6 of the Commonwealth Health Care (Appropriation Act) 1998 provides that grants of financial assistance to the States will not be payable unless the Minister is satisfied that the State is adhering to the following principles:

Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of the kind or kinds that are currently, or were historically, provided by hospitals.

Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period.

It is therefore arguable that Australian hospitals in receipt of federal funding could be ordered to provide services.

Availability of Alternative Services

What if there are no other services? Consider not only remote area centres, but most major centres in the Northern Territory where, for example, the public hospital provides the only dialysis service, the only access to diagnostic testing, the only emergency medical centre, etc.

Is it possible a situation could evolve whereby these facilities are forced to continue to provide treatment to violent, abusive or aggressive patients?

WHY DO PROVIDERS SEEK TO RESTRICT ACCESS TO SERVICES

When considering the circumstances in which providers might seek to restrict delivery of services, the situation becomes even more complicated.

We need to ask questions about the responsibilities that service providers, as employers, have in relation to staff who might be treating violent or non-compliant patients. We may also need to look at factors external to the treating relationship, such as the availability of health funding, and how these might influence responses?

Staff Safety

Studies of nurses indicate that between 82 and 96 percent of nurses have experienced verbal abuse within their working life, with approximately 45 percent experiencing verbal abuse within the last fifteen working days. These same studies show that nurses only report abuse about 50% of the time.

The Commission's investigation of one complaint raised similar issues.

In an eight month period, nurses at a treatment facility documented 11 incidents within the medical records and completed three incident reports. However, during interviews, staff indicated they were subjected to almost constant abuse. When asked to comment on the disparity between their statements and the relatively small number of incidents recorded, staff indicated that they did not document all the incidents that occurred.

Workplace Safety Requirements

The Commission has found that staff members are often not aware of policies within their workplace, if they indeed exist, relating to difficult or abusive patients or responding to patient incidents.

Work Health legislation imposes a general duty on employers to provide a safe and healthy workplace, free from hazards. The responsibilities are:

- to identify hazards in the workplace;
- to assess the risk posed by each of these hazards; and
- to control the risk.

Where a patient is known to be or has a history of violent and abusive behaviours, treatment of that patient can clearly be characterised as a workplace hazard. An employer who fails to take steps to control the risk posed by such a patient may have breached their obligation to protect the health and safety of their employees.

The Safety of Other Patients

While a number of articles we considered touched upon the need for staff of health facilities to safeguard patients accessing treatment, it is not an issue which appears to be discussed in depth.

It is entirely possible that patients at a treatment facility could be injured by another patient, or even suffer an adverse health outcome as a result of witnessing the behaviour of another patient.

Health services are potentially leaving themselves open to civil suits if they fail to address such situations. I do not think the courts would look favourably upon health service providers who fail to provide a safe environment for those accessing their services. Agencies need to introduce policies and procedures to protect their patients.

Financial Considerations

Alfred Hospital in Victoria recently decided to deny smokers access to potentially lifesaving surgery until they quit smoking. This stance was defended on the grounds of limited public funding.

Arguments related to funding have also been put forward to justify decisions to restrict the access of violent or abusive patients to health services. For example:

- a hospital may be required to hire additional security personnel to protect staff;
- because of the stress involved, employers may experience an increase in sick leave or worker's compensation claims; and
- highly trained and experienced staff may choose to leave, requiring further expenditure on recruitment, training and development.

However, while I acknowledge the reality of the need to develop criteria to prioritise the delivery of health services with an eye to budget restrictions, there are costs associated with refusal of treatment. For example:

- the decision to restrict access to regular treatment of a chronic illness may result in treatment of the patient at the hospital emergency department, following ambulance transfer; or
- the patient may require costly in patient care in a specialist unit of the hospital, and reduce the availability of hospital beds.

THE GENERALLY ACCEPTED STANDARDS OF PRACTICE ELSEWHERE

Of fifteen hospitals and health services approached by the Commission and asked to supply copies of their policies and information relating to the delivery of services to clients they considered difficult, abusive or aggressive, twelve responded.

None of the organisations that replied had specific policies in place but a number stated that they felt their general occupational safety and health policies covered the situation. All confirmed that it was a situation they often faced.

Some organisations identified steps they had taken to deal with difficult clients. These included:

- treating the patient on an individual basis as there is no specific policy;
- developing a "treatment contract";
- developing a more formal contract which the patient signs, setting out the expectations that the patient has to meet to enable him/her to continue to be treated;
- teaching the patient a home based treatment;

- seeking restraining orders;
- referring the patient to another facility for treatment;
- hiring of security guards to be present while treatment is taking place; and
- terminating the treatment.

Although there may be organisations that do have specific policies and procedures in place to handle difficult patients, our research would indicate it is an area where many hospitals and health services make on the spot decisions as the need dictates. These decisions are generally ad hoc and may or may not be successful.

The situation with health facilities throughout the Northern Territory in dealing with difficult, abusive or aggressive patients, is not dissimilar to many similar organisations throughout Australia.

WHAT CAN BE DONE TO RESPOND TO CLIENTS CONSIDERED VIOLENT OR ABUSIVE

Based on our research and consideration of complaints, I would like to offer some suggestions for responding to patients considered abusive or violent.

Difficult patient behaviour can be conceptualised as a hierarchy or continuum of behaviours ranging from non-compliant or self-harming to physical threats and abuse. For example:

What became clear from our research was that:

- the difficult patient's behaviour will, most often, involve a gradual escalation along the continuum;
- the health care providers' responsibility to the patient changes as his or her behaviour moves along the continuum; and
- the action taken by the treatment provider is generally dependant as to where the patient's behaviour fits along the continuum.
- Examples of actions which can be adopted by health care practitioners and facilities to change or modify a patient's behaviour are:

Behavioural Contracts

This is a statement developed by the treatment facility, which is signed by representatives of the facility and the patient. It sets out the basis on which the patient will be treated or continue to receive treatment. It should be sufficiently specific to allow for action taken by the facility or its staff to be clearly supported by reference to the contract.

Mediation

The literature indicates that mediation can be very successful in achieving the resolution of these disputes: it is more likely to lead to the negotiation of a mutually beneficial solution, rather than the imposition of requirements on the patient by the treatment facility. Mediation differs from the introduction of behavioural contracts in that it does not involve language relating to acceptable or unacceptable behaviour, nor a discussion of consequences, but a deeper level of conflict resolution.

Development of an Individual Treatment Plan

While not entirely separate from either behavioural contracts or mediation, individual treatment plans are seen to have a different philosophy. Behavioural contracts require patients to comply with existing requirements or policies, while individual treatment plans are built on identifying the treatment which best meets the patient's needs. An individual treatment plan may involve a departure from or greater flexibility within the agency's policies.

Psychosocial Intervention

Based on techniques such as active listening and teaching consequences, this is a model whereby treatment providers attempt to determine the reasons for the patient's non-compliance or abuse and with this knowledge take appropriate steps to curb or manage the behaviour. Psychosocial interventions fit within a framework of interventions which may

include patient grievance policies and procedures, the use of behavioural contracts, and policies regarding treatment refusal, discontinuation or dismissal.

Rotational or Shared Care

The patient's care is provided by a number of facilities on a rotational basis. This approach is not so much an attempt to prevent or manage the patient's non-compliant behaviour, but to manage the impact of patient non-compliance on staff and other patients.

Refusal or Discontinuation of Treatment

Refusal or discontinuation of treatment becomes an option when a patient, who has been informed about the treatment facility's policies and requirements prior to the incident, breaches these requirements. The patient is either refused treatment at the time, or the treatment is discontinued. If a patient continues to be violent or non-compliant, the facility or individual treating practitioner may formally advise him or her, that treatment will no longer be provided.

It should be remembered that neither discontinuation of treatment, or patient discharge are everyday approaches: they are measures of last resort, and are only recommended where a range of other strategies have been implemented and have been shown to be unsuccessful.

WHAT ARE APPROPRIATE STANDARDS

Whatever action is taken by the facility, clear policies in relation to non-compliant and abusive behaviour are essential. At a minimum, these policies should:

- be written;
- be provided to patients at the time of admission;
- be displayed prominently within the treatment facility; and
- recognise the unique setting within which treatment occurs: whether an emergency department, labour ward or dialysis facility.

Policies should clearly identify, for both patients and staff:

- what types of behaviour are considered unacceptable or inappropriate;
- what will happen when these behaviours occur;
- what will happen if these behaviours continue to occur; and
- the conditions on which treatment is to be provided.

Importantly, the policies must also be known to staff and enforced consistently.

Whenever violence or abuse is threatened, the facility should carry out an assessment of the patient which includes an investigation of his or her:

- previous history of violence;
- access to weapons;
- personal factors i.e. relationship breakdown, death of family member, friend, loss of job; and
- previous suicide attempts.

All incidents should be clearly documented, and detailed notes made on the patient's chart. Documentation should include not only the clinical aspects of the patient's treatment, but all interactions in which verbal or physical abuse occurs. These notes should include the names of witnesses, the content of any threats made, and the steps taken by staff in response to the situation.

All staff should be aware of the agency's policies and procedures. Staff should have access to training to ensure they have the necessary skills and confidence to implement any measures

agreed upon, have strategies to deal with the behaviour that reduce rather than escalate conflict, and reduce stress upon themselves.

An incident monitoring system, which alerts management to the work areas most affected by violent patient incidents, should be implemented, and the importance of reporting such incidents reinforced to all staff.

CONCLUSION

With the apparent increase in violence against health professionals or at least the increased community awareness of this issue, it is likely that complaint resolution agencies like this Commission will have more contact with both the staff and patients involved.

Assessing the reasonableness of the provider's actions requires the Commission to fully understand the context within which these situations occur. It is important also that we are informed about the factors which influence decision making in these situations and can critically assess the responses adopted by provider organisations.

While recognising the fundamental importance of access to treatment facilities, I must also be cognisant of the personal strain placed on staff of health organisations and the financial consequences of treating violent or abusive patients.

There is also a need for the treatment facilities to examine the circumstances that may be contributing to a patient's behaviour, including medical, mental and other factors. Interventions or other strategies should be considered that provide realistic solutions and options for both patients and staff and, if at all possible, reduce the potential for harm to either party. All effort should be made to prevent the escalation of issues to such a level that denial of treatment is the only solution.

While both patients and health facilities may have recourse to legal remedies, a range of other options, aimed at strengthening and continuing the treating relationship, also exist. Facilities which have a number of these options at their disposal, with trained staff, confident in the use of these strategies, will be better placed to respond to violent or abusive incidents, when they occur.