

## **COMMUNICATION IN DIFFICULT SITUATIONS**

**“WHEN ‘GETTING BETTER TOGETHER’  
MAY NOT GET YOU BETTER”**

**A PAPER PRESENTED AT THE  
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### **INTRODUCTION**

How does a Commission or similar bodies respond to a complaint regarding the temporary removal of a person with a chronic illness from life sustaining treatment? Is the question 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 will explore the competing rights and responsibilities of service users and service providers, drawing on the issues raised by these types of complaints. Consideration will be given to a number of factors, including:

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

From our experience of these complaints, and from a review of national and international responses to such issues, I will put forward some suggestions and recommendations responding to these difficult and complex issues.

By way of background, the complaints involve patients with a chronic illness, who are accessing public treatment facilities. All complaints

involved the decision to discharge or transfer the patient, or to restrict their access to a treatment.

An important qualification in regard to this paper 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**

Putting aside all the legal contingencies, I think most people would agree, there is a general right to treatment in an emergency. In *Lowns v Woods* (1996) the NSW Court of Appeal found that a direct request to give assistance in an emergency situation created "*such a relationship of proximity as to give rise to a duty of care.*" In failing to attend, it was held the doctor breached this duty.

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 will 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.

*Payton v Weaver* (Payton's Case) arose from the decision of a treatment facility to discharge a patient with end stage renal disease. The patient applied to the court for an order compelling her nephrologist and the hospital to continue her treatment.

In reaching its decision the Californian Court considered the Common Law principle of abandonment. 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.

In addition, the Court held that a medical practitioner must be permitted to end a treating relationship because it would be akin to slavery to order an individual to provide personal services.

Within the American context at least, 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 similar situation arose for the American courts' consideration in *Brown v Bower* (1987). The patient, Mr Brown, 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 in this case referred to the Hill-Burton Act: Federal legislation which provided funds to State based health service providers. In return for funding, the health care facilities agreed to provide services in accordance with certain guidelines and obligations. These obligations included:

- an undertaking to provide services to people within the vicinity of the hospital; and
- not to discriminate on any ground unrelated to the need for the service.

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 does not apply to individuals.

However, the court held that the receipt of funding under the Hill-Burton Act prevented the hospital from refusing its services, and the hospital was therefore ordered to provide the treatment.

### **Does such a situation exist in Australia?**

Interestingly, the *Commonwealth Health Care (Appropriation Act) 1998* contains analogous provisions. Section six of the Act provides that grants of financial assistance to the States will not be payable unless the Minister is satisfied that the State is adhering to certain principles.

These principles are as follows

*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 certainly arguable that Australian hospitals in receipt of federal funding could be ordered to provide services.

## **Availability of Alternative Services**

Many of the cases refer to the opportunity for patients to access an alternative service for the purpose of obtaining ongoing treatment. Which raises the question: what if there are no other services? Consider not only remote area centres, but most major centres in the Northern Territory where 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 staff of metropolitan health services may sever the relationship with a violent or abusive patient, referring the patient to an alternative treatment provider, but those in rural or remote areas be forced to continue to provide treatment?

## **WHY DO PROVIDERS SEEK TO RESTRICT ACCESS TO SERVICES**

When we start to consider 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. When asked why they did not report abuse, the nurses in these surveys responded:

*verbal abuse is part of the job or it is the patient's usual behaviour.*

Many of you may have seen the recent call by the Australian Nursing Federation for a national summit on violence against nursing staff. The Northern Territory spokesperson for the Australian Nursing Federation, Paul Nieuwenhoven, has urged nurses to speak out against such violence stating:

*We are encouraging nurses to take legal action against the perpetrators and their employers who have failed to provide a safe workplace. I would guarantee every nurse in the Territory has either been assaulted or threatened while working.*

However, even Mr Nieuwenhoven agrees:

*Half of the problem is that it is going unreported, so it is up to nurses to file incident reports.*

Our 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.

As one staff member stated,

*I think a lot of those situations are not documented because we've just come to live with it.*

Despite statements detailing numerous threats of physical violence, none of these threats were reported to the police.

### **Workplace Safety Requirements**

It is our experience 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 set out in the Northern Territory legislation can be broken down into three components:

- 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. For example, a patient interviewed in relation to one of our investigations complained that proximity to a patient who made constant threats of physical violence exacerbated his heart condition, and made him want to skip his own treatments.

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. In the same manner that organisations introduce policies and procedures to reduce the risk of injury through a fall, or faulty equipment, agencies need to consider steps to protect their patients. Risk management exercises adopted by health organisations should, in my view, include an assessment of the financial risk of such an event occurring.

## **Financial Considerations**

Many of you will have seen the recent articles regarding the decision of Alfred Hospital in Victoria to deny smokers access to potentially lifesaving surgery until they quit smoking. This stance has been defended on the grounds of limited public funding:

*There's not enough health dollars to go around.... it is within our mandate to ration services and smoking is one way to define the patient population (Alfred Hospital respiratory physician, Greg Snell).*

Similar arguments have 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 involved in the treatment of potentially violent patients. Even with the best efforts to reduce the incidence and effect of violence in the workplace, employers may still experience an increase in sick leave or worker's compensation claims. Highly trained and experienced staff may choose to leave, creating a gap in knowledge and expertise and 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, careful consideration must be given to the implications of the measures that are adopted. While it might initially appear to be a cheaper option,

there are costs associated with refusal of treatment. 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. 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**

In investigating this series of complaints, we identified and wrote to 15 facilities across Australia which provide services similar to that offered by hospitals within the Northern Territory. Twelve facilities responded to the request.

While all facilities had general policies relating to occupational health and safety and responding to one-off patient incidents, not one facility had policies in place regarding the provision of regular and ongoing treatment to patients considered aggressive or abusive.

However, the majority of facilities indicated that the issue outlined to them was one with which they are often faced, with one facility stating *there have been an increasing number of situations where difficult clients are putting the safety of staff at risk.*

Most of the organisations provided information about how such situations were approached, in the absence of formal policies:

*Patient difficulties are resolved by "treatment contracts" developed at a meeting with the patient, the medical officer, nurse, social worker and the clinical risk manager. The contract is not formal but takes the form of minutes of the meeting.*

*The patient is taught to administer a home-based treatment if that is appropriate.*

*Restraining orders are sought where there are particularly difficult patients who require care but could put staff at risk because of their unacceptable behaviour.*

*The patient is treated on the weekend, and in the interests of staff safety, security guards are hired while this is taking place.*

One staff member, who replied separately to the response from the organisation stated:

*.....when a unit has tried the above strategies it may not be possible to treat the individual causing the trouble as staff safety and the safety of other patients is so important. My own view would be that if a patient violates a contract of behaviour drawn up appropriately and refuses home-based treatment*

*when it is offered and the individual is capable, then one has done all one can.*

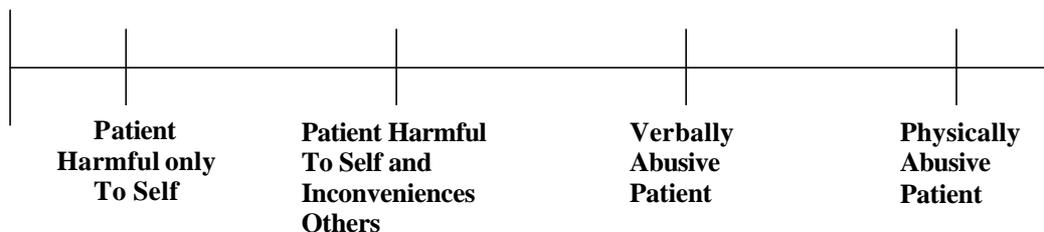
One facility stated that they have only faced one patient considered difficult or aggressive and the approach on that occasion was *to terminate treatment at the first sign of a problem*. However, the agency suggested that this approach is *probably not best practice*.

One service has had no experience of either abusive or aggressive patients.

### **THE COMMISSION'S RECOMMENDATIONS: A TOOLKIT FOR RESPONDING 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. At the outset let me state that my comments are not prescriptive: I am not offering a roadmap for providers or advocating for one particular response or approach to violent patients. I merely wish to draw attention to a number of approaches that are available to service providers, more like a toolkit, from which a strategy can be drawn depending on the nature of the task at hand.

We have adopted a model of difficult patient behaviour, developed by an American organisation, the Mid Atlantic Renal Coalition. We found their model useful, as it conceptualises difficult patient behaviour as a hierarchy or continuum of behaviours ranging from non-compliance or self-harm to physical threats and abuse.



There are a number of points which I think are important to keep in mind when we are talking about violent and abusive patient behaviours:

1. In an ongoing treatment situation, behaviour rarely begins at the far right of the continuum, but involves a gradual escalation of non-compliance and abuse.
2. Health care providers responsibilities change as the behaviour moves along the continuum.

A decision by a patient not to comply with a recommended treatment program, provided he or she is capable, is an expression of patient autonomy and a decision the patient is entitled to make. However, once a

patient's behaviour is impacting negatively on others, the patient's autonomy may be restricted by a treatment provider who has a duty to protect other patients and staff.

3. The action taken by the treatment provider will depend on where the patient's behaviour fits along the continuum. For example: more stringent requirements may be imposed, with more severe consequences for breach of these requirements, once the patient's behaviour moves from inconveniencing others to threatening or harming others.

There are a variety of measures which can be adopted by health care practitioners and facilities, some of which are being used by treatment facilities with great success.

### **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.

For example, a contract might state:

Mrs X will attend for treatment on Monday, Wednesday and Friday at 3pm.

Mrs X will be attended by two nurses, one of whom may be a trainee.

Mrs X will not swear at, or threaten violence against, staff members or other patients.

If Mrs X does threaten violence against staff members or other patients, security staff will be called, and Mrs X will be escorted from the facility.

Obviously, patients may refuse to sign such contracts. If this is the case, staff of the treatment facility should document the patient's refusal. The patient should be provided with a copy of the contract. It is also recommended that patients be given a set time in which to comply with the terms of the contract, to allow both the patient and the staff the opportunity to become acquainted with the obligations imposed on them.

### **Mediation**

More and more health organisations appear to be recognising the benefits of dispute resolution processes facilitated by neutral third parties. The literature indicates that mediation can be very successful in achieving the solution 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*. However, mediation is not suitable to all circumstances: those services which have adopted mediation in working with patients recommend excluding those with a psychiatric illness, current substance abuse or impaired mentation.

### **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;
- 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 are not put forward as the sole strategy to be adopted by the treatment facility; rather, they 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.

### **Physical or Chemical Restraints**

Such methods are usually adopted as temporary measures in situations where there is imminent danger that the patient will self harm or harm others. It is worth noting that we found at least one overseas treatment facility which has adopted chemical restraint as an ongoing control mechanism for the purpose of administering treatment.

### **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. The patient is informed that they may return for their next scheduled treatment, or attend the emergency department for urgent treatment, should that be required.

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. Should this approach be adopted, it is recommended that notification of termination of treatment is accompanied by a list of alternative treatment facilities, and a reiteration of the patient's right to access emergency treatment if required.

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.

We have an example of a treatment plan, which shows how such measures might be used in relation to the continuum of behaviour.

<b>TREATMENT PLAN</b>		
<b>Potential Problems</b>	<b>Behavioural Expectations (unit policy)</b>	<b>Interventions and consequences</b>
1. A patient with a history of missing treatment calls and reschedules a treatment for the next day, then misses that treatment	Patients are scheduled for their treatments by the head nurse. They are not allowed to change their own schedules on a day-to-day basis.	Explain to the patient that the schedule cannot be changed on a daily basis.  If s/he chooses not to have a scheduled treatment, refer the patient to an emergency room if s/he becomes ill.
2. The patient exhibits threatening behaviour prior to or during treatment	Patients are not allowed to display threatening behaviour to staff or other patients.	Inform the patient that the threatening behaviour is inappropriate.  If the behaviour persists, the patient will not be treated, or treatment will be discontinued and security will be called.
3. The patient is verbally abusive during treatment	Patients are not to be verbally abusive toward staff and other patients.	Inform the patient that the behaviour is unacceptable.  After 3 warnings, the treatment will be discontinued: security will be called, if necessary.

Whatever the approach adopted 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.

Wherever 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 will have more contact with both the staff and patients involved.

Assessing the reasonableness of the provider's actions will require Commissions 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, we must also be cognisant of the personal strain placed on staff of health organisations and the financial consequences of treating violent or abusive patients.

While both patients and health facilities may have recourse to legal remedies, let us also remember that a range of other options, aimed at strengthening and continuing the treating relationship, also exist. And 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.

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