Disruptive patient and violence have become more prominent in the healthcare setting and as a result, have received substantial written and media attention. However, the challenges and overall impact on safety created by disruptive patients and families have received significantly less coverage. This article addresses the challenges and provides specific strategies for effectively addressing them without the risk of legal action for patient abandonment.

Disruptive Behavior Defined

The term disruptive implies behaviors that interfere with the caregivers’ ability to provide safe and effective care. Behaviors are also deemed disruptive if they impede effective communication. A few examples of disruptive behavior are abusive or obstructive behavior, providing erroneous or distorted information, screaming and/or acting in a disrespectful or intimidating manner. Interference with the treatment plan ordered by a physician, such as the use of non-prescribed drugs or alcohol while on hospital premises is also viewed as disruptive. Additionally, any interference with the caregivers’ ability to provide timely care due to patients frequently leaving the premises without permission or during times of treatments or testing is disruptive behavior.

This behavior can be harmful in its own right and can also cause a disruption in the patient/provider relationship. This ultimately impacts the patient’s outcomes as well as the therapeutic relationship that is vital to optimal patient care. In addition to the stress and fatigue of a demanding work environment, the behavior can have a long term effect on the staff as many often feel disrespected or fearful and are unable to connect with their patients in a way that is necessary to assure a therapeutic relationship.

Disruptive patients typically:

- Have reckless disregard for their medical needs or the advice of their provider
- Provide distorted or erroneous information
- Engage in abusive, obstructive behavior that undermines their health and the safety of others
- Verbally abusive, disrespectful and confrontational
In a study done by researchers at the VA hospital in Portland, OR, psychiatrists determined 25% of the patients who caused major disruptions of patient care at their hospital were responsible for 38% of the incidents filed. Additionally, behavior which started out as disruptive frequently escalated to more troublesome and violent behavior. Although the study not determine whether or not disruptive patients were more litigious than other patients, they did determine that 30% of disruptive patients filed formal complaints to a third party about their care. Therefore, it is important for organizations to recognize that while dealing with disruptive patients may be seen by some as a part of the job, proactive planning is important in demonstrating the organization recognizes the impact of disruptive behavior and has specific policies to manage and support the staff in handling such behaviors.

Although this article deals specifically with disruptive patients, it should be noted that family members and visitors may also contribute in undermining the culture and safety within an organization. However, as they are on the premises only as guests and have no contract with the facility, they are easier to manage. For example, intoxicated visitors or family members that yell or demean the staff can be asked to leave and when necessary be escorted off the premises by security. Any visiting family member brandishing weapons or threatening the well-being of any staff member or patient should be handled by the local police. The foundation for all management systems set in place should be a zero-tolerance policy for any behavior that undermines the safety of staff, patients or other visitors.

Designing a Comprehensive Program to Manage Disruptive Behavior

The first thing an organization can do to create a culture of support and safety is to implement a program that confirms disruptive behavior will not be tolerated. The process should be focused on three basic principles: communication, assessment as well as consultation and documentation. The first aspect of communication should be a statement defining a zero-tolerance policy. A simple statement can be drafted and placed in prominent spots within the organization where patients and families frequent and are likely to first come in contact with staff. This can be in the Emergency Department, the admitting office, the cafeteria, waiting areas (where family members may congregate) or the lobby. The statement should be concise and clear. For example, “The XXXXX Clinic (or Hospital) has zero tolerance for verbal or physical intimidation of staff. Such threatening behavior will result in a formal warning or immediate notification of law enforcement and termination of any non-emergency patient care from this facility. Please be respectful and recognize that your health depends on the relationships which are established between providers and patients.”

The hospital should also have a policy and procedure that clearly describes the steps to assess and manage this behavior. This might include the option of obtaining consultative support and the need for thorough and accurate documentation of the behavior that problematic. The process should also describe the steps which a provider or provider organization must take prior to terminating the provider/patient relationship.
Assessment: A Critical Step in Identifying an Appropriate Solution

Disruptive behavior exhibited by a patient is often characterized to be a result of a physiologic or psychiatric problem. Clinicians must first rule out the presence of a clinical condition in order to determine how to appropriately manage the disruptive behavior. This is especially true if the patient’s baseline behavior is unknown. When a clinical condition is diagnosed as the cause of the behavior and treated, the behavior typically improves. The following clinical conditions are often associated with disruptive behavior and should be ruled out or treated prior to determining next steps.

Clinical conditions often associated with disruptive behavior:
- Hypoxemia
- Any metabolic or endocrine concerns (renal or liver failure), electrolyte imbalance or abnormal glucose level
- Vascular impairment brought on by stroke or bleed
- Seizures (including post-ictal state)
- Primary psychiatric disorder
- Trauma –concussion or subdural bleed
- Drugs or alcohol ingestion or withdrawal

After the clinical condition of the patient has been stabilized, the provider must then assess the situational factors that might be contributing to or causing the behavior which is being exhibited. Is the patient or family member under significant stress due to the condition of the patient? Are there factors in the environment contributing to the stress and aggressive behavior of the patient or family member?

Is the stress the providers are under likely contributing to erosions in the provider/patient relationship that and to the behavior?

These factors do not justify the behavior, but understanding them may help the provider and the organization establish an appropriate response in order to implement the proper measures to address the situation. Although termination of the provider/patient relationship can be an appropriate response in some circumstances, other interventions should be attempted first.

Under well-established case law, there is no “duty to treat.” However, once care is initiated or a provider/patient relationship is established, there are specific steps which must be taken to terminate that relationship. The first step should be an attempt to alter the behavior whenever possible by discussing how the behavior is impacting the patient’s care.

Communicating Concerns

There are two aspects of communication that are part of the process of managing the disruptive patient or family member. They include:

- **Informal efforts** that allow the provider to describe to the patient or family member how their behavior impacts their care and the outcome they hope to achieve. These discussions should establish clear expectations
and limits and should be clearly and fully documented in the medical record.

- **Formal efforts** that describe a clear and consistent process that the organization has created and which is reflected in a written Provider/Patient Agreement or Contract.

After clearly describing the type of behavior that will not be tolerated, the organizations’ policy should include steps in which caregivers should attempt to remediate the problem. As described in Today’s Hospitalist, the Ochsner Medical Center in New Orleans took a good approach in communicating their concerns.³

This Medical Center instituted a program for addressing disruptive patients through the implementation of a “Code Green” program. The program teaches staff how to identify potentially disruptive patients and family members before behaviors escalate. When a staff member calls a “code green,” a team of individuals specially trained in non-violent crisis intervention techniques respond to the unit. The team meets outside the patients’ room to discuss how to approach the problem and then collectively enter to demonstrate the hospital’s stance on proper behavior. The team members send a clear message that they are willing to help and provide care, but disruption will not be tolerated.

Approximately 50 staff members from various specialties are assembled as team members and serve on a one month rotation as part of the team. By observing how these situations are handled by team members, other staff members also become more adept at managing this behavior.

Organizations may also wish to set up a consultative service where providers can seek advice from a neutral third party about how to manage the behavior and what steps are most appropriate if verbal warnings do not correct the problem. A process for consultation for difficult patients should be created to assure that there is consistency and fairness in the process and a less emotional assessment. The consultation should be considered if the patient’s failure to comply with an assessment or treatment poses a substantially increased risk of mortality, morbidity or both, and/or the patient’s behavior has involved the repeated use of intimidation (which may include verbal abuse or threats of litigation). In addition, the organization should verify that the problem behavior is well-documented in the medical record and that, although unsuccessful, the provider has attempted to resolve the problem.

The consultation process should start with drafting a provider/patient agreement (or contract) which describes the disruptive behavior and its impact on the care being provided. It should also clearly state the provider/patient relationship will be terminated if the behavior continues. After a provider/patient agreement has been executed, all relevant departments (Emergency Department and Pharmacy are typically the most commonly involved) that may be impacted by the agreement should be notified. All staff should be advised that if the patient presents, the risk management or legal department should be notified.
The Position of the AMA on terminating the Patient/Provider Relationship

The AMA Council on Ethical and Judicial Affairs has established ethical guidelines that address termination of the provider/patient relationship.

“The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The patient may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.”

In addition, the AMA guidelines state: “Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently in advance of withdrawal to permit another medical attendant to be secured.”

Both the ethical opinions and legal precedents agree that a physician may not intentionally and unilaterally sever an existing relationship with any patient, unless the physician provides reasonable notice to the patient, in writing, and sufficient time to locate another physician. Failure of the physician to continue to provide care when the patient remains in need of care or failure to provide notice and an adequate opportunity for the patient to find another physician before the relationship is terminated can be construed as the physician’s abandonment of the patient or dereliction of duty if injury results. In addition to being exposed to liability for any damages that are caused by the abandonment or the breach of duty, the physician may be subject to disciplinary action under the state’s medical practice act. In Pennsylvania, a physician’s abandonment of a patient can result in disciplinary action and exposure to civil liability. Even given these limitations, there are some circumstances when a physician can “fire” the patient in non-emergency situations such as the patient’s unwillingness or inability to pay. However, caution must be exercised in this situation. Courts are split on whether a patient’s inability to pay or lack of insurance justifies a physician’s termination of the provider/patient relationship when the patient continues to require medical attention.

Avoiding Allegations of Patient Abandonment

Abandonment is a type of medical malpractice where the plaintiff alleges the provider or provider organization had a duty to provide care to the patient and failed to do so. A duty of care, once it has been established, can be terminated by mutual agreement of the parties, or in some instances, by unilateral action. However, if the patient continues to require care, the physician’s duty continues until the patient is referred or given time to transfer to another provider or provider organization.

In most situations, the establishment of a provider/patient relationship is discretionary for the provider (there is no duty to treat), but once the relationship is established, discontinuing it is not entirely discretionary and specific steps need to be taken. These steps relate to proper notification, and time to identify alternative sources of care. If the patient provider agreement or contract fails to
correct the disruptive behavior, then termination of the relationship may be appropriate. Before initiating this step, advice should be sought from counsel as to the specific state requirements for terminating a patient/provider relationship. Some state courts have determined that abandonment occurs only if the physician leaves the patient at a critical time, without giving reasonable notice or making suitable arrangements for the patient to be cared for by a substitute provider. In other states, providers can be held liable if they excuse themselves from even routine treatment of a patient without giving notice and reasonable opportunity for the patient to acquire other medical care or without obtaining the consent.

The notice requirement is critical and when all other efforts fail, the patient should be advised that the organization and provider are terminating the relationship due to behavior. The patient should be afforded time to find an alternate provider and the organization / provider should be mindful of the need to share medical records and any other information which the patient requests in order to assure continuity of care. Providers should check with health plans to determine if contractual obligations mandate specific obligations which apply to the termination of the relationship. Care should also be taken to assure that there are not unique circumstances that might make the termination of care more likely to give rise to a viable legal cause of action. These might include factors such as difficulty in accessing alternate care without causing extreme financial or personal inconvenience (this could occur if the patient lives in an area where access to care is limited), inability to locate a specialist who can manage the complexities of the patient’s condition, or the likelihood of patient’s condition deteriorating if relationship is terminated.

Supportive Case Law

In Payton vs Weaver, vs. Ms. Payton was a 35-year-old woman with chronic end-stage renal disease. In addition to having kidney disease, she lived alone in a low income housing project, abused alcohol and had been addicted to heroin and barbiturates for more than 15 years. She began outpatient dialysis with Dr. Weaver, a renal specialist, but was disruptive, uncooperative and verbally abusive to staff members. Dr. Weaver sent her a warning letter advising her that he would terminate care if her “persistent uncooperative and antisocial behavior” continued. Upon receipt of the letter, Ms. Payton applied for admission to two different dialysis programs but was refused admittance. Dr. Weaver continued to provide her with care on an emergency basis for an additional year, but her behavior did not improve. He then sent her a second letter terminating their provider/patient relationship. Ms. Payton filed suit seeking a court order to compel continuation of treatment. A settlement was reached, which included a detailed contract under which Payton agreed to improve her conduct by keeping appointments, refraining from alcohol and drug use, and cooperating with those providing her care. When she failed to abide by these terms, Dr. Weaver again notified her in writing that her care would be terminated. Again, Payton instituted legal action seeking continuation of her treatment. This time the court denied her claim concluding that Dr. Weaver had properly discharged his responsibility
to her and that the hospital had not violated her rights by failing to provide her care. Despite Payton’s appeal of the trial court’s decision, the decision was upheld by the appellate court who stated that Dr. Weaver had acted according to the “highest professional standards”.

**Risk Management Considerations**

Managing disruptive behavior is both a risk management and patient safety challenge. However, once a detailed process is in place to manage disruptive patients, the risk of liability is significantly reduced and providers feel supported and patients feel safe. Risk management and legal staff should answer the following questions prior to terminating the patient relationship:

- Was the acute condition manifested by the patient stabilized prior to terminating the provider/patient relationship or transitioning care to another provider?
- Has the physician ruled out any other underlying medical conditions that may be the reason for the disruptive behavior? Has this assessment process been thoroughly documented?
- Was a proper notice period afforded to the patient (this is generally 30 days) to give ample time to seek care from another provider? Be advised that some health plans may have specific requirements for longer notification times such as 45 or 60 days.
- If there is an emergency / urgent situation during the notice period, has the physician been advised that he/she is still obligated to treat the patient?
- Is documentation of all conversations and communications supporting the decision by the provider to terminate the provider/patient relationship included in the medical record? Early communications along with final provider/patient agreement should be included.

Does the entire termination process reflect the organizations’ policies and procedures? Although use of a standardized letter or template may not be appropriate, all correspondence should reflect the organization or group practice’s policies and procedures.

Have all contractual obligations regarding obligations to treat and prohibitions against automatic release from care been met?

Are there geographic limitations that make it difficult for patients to identify alternative sources of care or a specific type of specialty care that may be required? Forcing a patient to seek care which is not local may present both financial and health burdens for the patient. In this situation, the notice period may be insufficient to limit liability for abandonment. Providers in this situation should proceed with caution.

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3. AMA Council on Ethical and Judicial Affairs, Opinion 10.0-1 CPLH 2006; 34:36
4. Ibid
5. Payton vs Weaver, 182 Cal Rptr 225 (Cal App 1st District 1982)
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