ETHICAL MANAGEMENT OF PROVIDER-PATIENT CONFLICTS

ETHICS ISSUE QUICK REFERENCE GUIDE

Updated November 2017

The Issue

Quick summary

There are many considerations when patient-provider relationships break down. Responding ethically is possible when careful thought is given to the many aspects of the situation.

Health care providers are expected to provide ethical care at all times, even when the patient-provider relationship has become dysfunctional. It can be challenging to provide care in situations of conflict between the care team and the patient resulting from challenging patient behaviour. Complex and intractable disputes can involve patient-related and system-related factors. Examples of some of the factors that can result in a dysfunctional clinical encounter are summarized in the table below.

Patient-related Factors	Provider and System-related Factors
Personality conflict Personality pathology Power dynamics Hostility Mistrust of providers or the system Unrealistic expectations Knowledge level and comprehension (high or low)	Inappropriate care setting Lack of alternative care setting Moral distress Perceived or actual powerlessness Risk of legal action against provider or system Resources (shortage of people, time or money)

Ethical Considerations

Some considerations that might help to clearly identify the issue and facilitate a satisfactory resolution include the values of stakeholders:

For more information, see the reference list on page 6.

For the Patient	For Staff
Autonomy Independence Respect Dignity Control Privacy	Respect Empathy Caring Compassion Safety Dignity Justice

Values go some way toward explaining how people (staff and patients) make choices. Recognition of values is important as it demonstrates the respect that is due every human, even when circumstances make it difficult. Acknowledging what is important to an individual is the first step in maintaining open and effective communication.

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Duties and Obligations

Obligations and Duties: Health care providers have an obligation to provide care that meets standards intended to be of benefit to patients. There are corresponding obligations to avoid harming them, and sometimes the harms associated with care can outweigh the benefits. In such cases, there is an over-arching obligation to maintain lines of communication with the patient so that all reasonable options remain available. We must weigh and rank the different duties. For example, it is tempting to consider the obligations we feel as health care providers toward potential or future patients that may be affected by the decisions made in the course of managing the conflict. How do those obligations rank against those we have to current patients (including the one at the centre of the conflict)? Similarly, while there is no obligation for staff to accept abuse, harassment or violence, patients cannot be abandoned on these bases. How can we continue to provide care that meets standards in the face of personal risk? How can we ensure the client continues to receive compassionate, quality care?

Health care providers have obligations to provide care that meets standards. This can be particularly challenging when there are conflicts.

Consequences

Consequences: What are the likely consequences for the patient and for the team? Are these consequences reasonable and ethically acceptable? How should the consequences be weighed and ranked in importance? For example, if there is concern about a lawsuit or bad publicity, are those sufficient reasons not to implement an agreed-upon plan? If so, was the plan ethically acceptable in the first place? An ethical plan that meets the standards of care will be defensible.

Use of an ethical decision-making framework (see page 3) to ensure that all decisions are informed by ethical values and principles and that all relevant ethical theories and considerations have been discussed.

Ethical Principles

For more information, see the reference list on page 6.

Autonomy: Competent patient's choices must be respected, up to the point where they harm others (including staff, other residents and visitors)

Beneficence: Health care mandate is to help and provide benefit for all patients

Non-maleficence: Obligation to avoid harming a patient, prevent harm coming to patient, others, and staff

Justice: Obligation to provide fair care and meet the needs of all patients

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Moral Distress

Moral distress occurs when one is aware that a moral problem exists, acknowledges moral responsibility, makes a moral judgment about the correct action, but is unable to carry out that action due to real or perceived constraints against it. Disagreements among clinicians and families about goals of care are the most troubling situations in patient care settings and are not easily resolved. Assumptions and judgments inform decisions and create division within treatment teams. The American Association of Critical Care Nurses created a framework that can be helpful in transforming moral distress into positive change. It can be found at www.aacn.org/moraldistress4As. Counseling (either in a group or via EAP) may also be of benefit to staff struggling with moral distress.

Legal Considerations

Situations where legal proceedings against staff have been threatened or initiated can be very complex indeed, whether the action is perceived as spurious or justified. A legal opinion should be sought at the earliest possible opportunity in these cases. Although it is always hoped that disputes can be resolved through other means, the only mechanism in Manitoba to resolve a truly intractable ethical conflict is legal.

- Has the behaviour been documented? Has the plan for managing the behaviour and its risks been documented?
- Has all care provided and offered been appropriately and accurately documented?

Check your Respectful Workplace Policy and Procedure Manual for recommended responses to disrespectful behavior. Some examples might include:

Ensure respondent (client) is aware that behavior is unacceptable (if it is reasonable, comfortable and safe)

If this is ineffective or inappropriate, staff may speak to their supervisor, HR, OESH or union representative.

Formal (filing complaint with HR) or informal (discussion with client) resolution processes may be initiated.

Senior Management and management staff will determine what action will be taken

OESH can be involved if there is a safety concern

It is important to ensure all legislative and regulatory requirements are met (e.g. PHIA) so consultation with legal counsel will be essential

Other resources

Engagement of professional conflict resolution services might be appropriate and helpful if there is no ethics consultation service and all parties involved are clearly competent to make decisions and willing to participate in the process.

Using an ethical decision-making guide to work through an ethical issue can be helpful. It guides discussion through relevant ethical considerations. Consult a guide used by your organization, or see the WRHA Patient Care Ethics Decision-Making Guide (http://www.wrha.mb.ca/about/ethics/patient-care.php)

For community-focused issues, consider the Community Ethics Toolkit from the Ontario Community Care Access Centre – a guide to ethical decision-making in the community helps provide insight into the balance of between individual and communal rights and obligations. http://www.jointcentreforbioethics.ca/partners/documents/cen_toolkit2008.pdf

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Resources for Providers

- **Communication** is the most important factor in a difficult situation. Staff may benefit from a safe and open forum to discuss the situation. An opportunity to ensure staff concerns are heard by all levels of the organization and to determine the collective approach will be critical in determining the best approach to providing care and how staff will be supported by the organization.
- **CRNM** provides some guidance through their "Ask a Practice Consultant" series, specifically the documents on Caring for Abusive Patients at http://cms.tng-secure.com/file_download.php?fFile_id=9286 and on Difficult Patients at http://cms.tng-secure.com/file_download.php?fFile_id=392. Essentially, these documents state that there are ethical and legal implications for withdrawing care. CRNM practice consultants are also available to staff for specific questions.
- The CNA Code of Ethics can also provide some guidance (if applicable – unregulated staff will not be subject to or bound by it, but it can provide guidance anyway). In general, the Code discourages abandonment. See:
    - Providing safe, compassionate, competent and ethical care (Responsibilities 2, 3, 4 & 10)
    - Promoting health and well-being (Responsibility 3)
    - Promoting and respecting informed decision-making (Responsibility 4)
    - Preserving dignity (Responsibility 1)
    - Promoting justice (responsibilities 1 & 4)
    - Being accountable (Responsibility 7)
- Other professional **Codes of Ethics** may also be applicable
- **Labour unions** may be able to provide some support for maintaining a safe and respectful workplace. Staff considering this resource is encouraged to follow the recommended process for flagging and escalating concerns.
- The **Canadian Nurses Protective Society** offers a number of resources, including one called vicarious liability. This is a concept that describes the employer's role in ensuring the work environment is set up to facilitate nurses' ability to meet standards of practice. This might be useful in situations where there is a risk or a threat of legal action. The document can be found at http://www.cnps.ca/index.php?page=80.
- Even in situations of conscientious objection, most codes of ethics (including the CNA's) require staff to continue to provide care until an alternative provider is found. When there is no option but to continue to provide care, even at the risk of physical or psychological harm to staff, affected staff may benefit from **Employee Assistance Plan** (EAP) counseling.
- Challenging personalities and conflict are a common occurrence in mental health care, and staff in those areas have experience ensuring that standards of care are met ethically at all times, even in the presence of challenging or dysfunctional relationships. It may be beneficial to **speak with a member of the mental health team** in your area about their practice. If you do not have a mental health program at your site, please contact Ethics Services at 204-926-7124. We can connect you with a resource appropriate to your situation.
- Staff should check and **monitor their own verbal and non-verbal behaviour** when interacting with patients and each other to minimize the risk of misinterpretation and conflict escalation
- It is important for staff to remember that **objectionable behaviour is not usually personal**, and responses to it must not be personal
- Is there a **Clinical Nurse Specialist or psychiatric nurse resource** available to provide ideas and suggestions for ethical and dignity-conserving solutions to the dilemma?

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Questions and Considerations for Discussion

Certain kinds of behaviour can be particularly challenging. Disrespectful behaviour from a health care provider is never acceptable and, if it occurs, must be dealt with promptly as a performance issue. When a patient behaves in an unacceptable way (e.g. abusive, manipulative, demanding, threatening, compromising the safety of others, etc.), it is much harder to formulate an ethical response. Some considerations:

What are most ethically grounded responses? What will demonstrate mutual respect?

- Boundaries: what are the limits of acceptable patient behaviour? How do the patient's capacity, insight and competence affect staff understanding and tolerance of those limits? Does the patient have the insight or capacity to understand the consequences of their behavior? If yes, have the consequences been clearly explained to the patient? If no, are there ethically-grounded ways to modify the patient's behaviour?

- What is the team's plan to respond to the behaviour? Is there consensus among the entire care team as to the plan? If not, have those who disagree been heard and acknowledged? How can the team ensure the client's needs are not overlooked and compassionate, quality care continues to be provided?

- Behaviour contracts may be helpful but must be approached carefully and by a professional with expertise in dealing with the kinds of challenges in question. Have behavior contracts been discussed with the patient? Are the consequences ethical? Are they enforceable? If not, what are the barriers to enforcement? Are the barriers valid reasons to act or not act? (see "Consequences" below for more detail) Have behaviour plans been limited to a manageable number (one or two) of items that are the highest priority to address?

- What power dynamics are at play? Challenging behaviour can be the result of the patient feeling disempowered, leading them to invoke any way possible to express and exert their autonomy. How can the patient be supported in choices within their power, without infringing on the rights or safety of others? In cases of unreasonable power imbalances in either direction, what ethical means are possible to shift that balance so it is more evenly distributed?

For more information, see the reference list on page 6.

- What options are available to shift the focus back to a relationship that reinforces the demonstration of mutual respect?

- Would the team benefit from inservicing on patient-provider conflict? Challenging personalities? Moral Distress? Clinical or professional standards (e.g. the limits on duty to care)?

- Have all plans, interventions, and outcomes been documented appropriately?

References

Many articles have been published on the subject of dealing with a dysfunctional provider-patient relationship. Often the focus is on physician-patient encounters, but each contains learning opportunities for other professions as well. The following is a short list of articles that might provide additional ideas or strategies for providing ethical care during patient-provider conflicts.

Anstey, K. & Wright, L. (2014). Responding to discriminatory requests for a different healthcare provider. *Nursing Ethics*, 21(1), 86-96.

Breen, K. J., & Greenberg, P. B. (2010). Ethics in medicine - A clinical perspective: Difficult physician-patient encounters. *Internal Medicine Journal*, 40(10), 682-688. Retrieved from www.scopus.com

Grossman, V. A. (2012). Hot topics: Do we make the difficult patient, more difficult*? Journal of Radiology Nursing*, 31(1), 27-28. Retrieved from www.scopus.com

Kroenke, K. (2009). Unburdening the difficult clinical encounter. *Archives of Internal Medicine*, 169(4), 333-334. Retrieved from www.scopus.com

Michaelsen, J. J. (2012). Emotional distance to so-called difficult patients. *Scandinavian Journal of Caring Sciences*, 26(1), 90-97. Retrieved from www.scopus.com

Paterniti, D. A., Fancher, T. L., Cipri, C. S., Timmermans, S., Heritage, J., & Kravitz, R. L. (2010). Getting to "no": Strategies primary care physicians use to deny patient requests. *Archives of Internal Medicine*, 170(4), 381-388. Retrieved from www.scopus.com

Teo, A. R., Du, Y. B., & Escobar, J. I. (2013). How can we better manage difficult patient encounters? *Journal of Family Practice*, 62(8), 414-418+421.

For more information on any of the points in this document, please contact us, or talk with your library about the resources on this list.

WRHA ETHICS SERVICES

Phone: 204-926-7124
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http://www.wrha.mb.ca/about/ethics/index.php

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé