Pursuing Criminal Charges Against Patients who are Reported as Having Assaulted Healthcare Professionals: Considerations

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Abstract

In two separate events in early 2014, a nurse was threatened with bodily harm by a patient in an inpatient psychiatry unit in Toronto. The nurses involved pursued criminal charges against the patients who made these threats. In response to questions regarding the procedure of criminally charging patients, and the supports available, a panel presentation was organized and presented for the inter-professional team. The key points from the panel are provided here as a resource for other organizations. This paper provides considerations learned from the Toronto Police Services, a Registered Nurse, a Nurse Manager, a Psychiatrist, a Bioethicist, a Legal representative and from Employee Relations.

Body of Paper

In two separate events in early 2014, a nurse was threatened with bodily harm by a patient in an inpatient psychiatry unit in Toronto. The nurses involved pursued criminal charges against the patients who made these threats. Many questions arose about the efficacy and the procedure of criminally charging patients, and what would happen to the patient after being charged. In response to these questions, and to a request from registered nurses to better understand the process and supports available to charge a patient with assault, a panel presentation was offered to provide discussion and information on the topic. The considerations from the panel are provided as a resource for other organizations that are finding themselves in a similar situation.

This paper outlines a fictional case scenario and is followed by the perspective and considerations learned from a Registered Nurse, a Toronto Police Services representative, the Legal Department, a Bioethicist, a Psychiatrist, a Nurse Manager and from Employee Relations. Although the case involves a psychiatric patient, and some of the considerations result from related complexity (such as the Mental Health Act, Province of Ontario 2014a), these considerations may also apply to a non-psychiatric patient.

Fictional Case Scenario

Tom, a mental health nurse, was caring for Diana, a mental health in-patient, in the psychiatric intensive care unit. Tom has 15 years of experience in psychiatry, and is well trained in all facets of Crisis Prevention and Intervention, including de-escalation. He is knowledgeable about the requirements of the Mental Health Act in Ontario, and with the Least Restraint Legislation, and he applies these principles as an expert mental health nurse. Diana, a 25-year-old woman diagnosed with bipolar disorder, was admitted into the psychiatric intensive care unit in an acute phase of mania. Her thought content included ideas that she was the gold medal winner of the moguls at the Sochi Olympics. Diana was declared incapable of making treatment decisions, offered Rights advice and declined to contest the psychiatrist's declaration. Therefore, treatment was started. Tom brought Diana her afternoon medication. Diana looked at Tom, and responded that she was offended that he would bring

an Olympic athlete drugs. She leaped up, ran at Tom, jumped and kicked him in the chest. A code white was called. Security responded. The patient was safely contained, and Tom's injuries were attended to. The Toronto Police Services were called and enquiries made about charging the patient with assault.

Nurse's Perspective

Charging a patient after being assaulted generates mixed feelings in the nursing staff. The nursing role has traditionally been one of caring for and empowering patients. Charging a patient with assault can seem to go against this role and causes feelings of guilt, anxiety and stress. As each situation will be different, a universal response plan is not possible, making the experience more difficult because it requires working though a full decision-making process. One consideration involves assessing the therapeutic value in charging a patient for a deliberate assault, where s/he was aware of what they were doing and the consequences. The patient would then be held responsible and accountable for their behaviour – a real-life consequence. Charging psychiatric patients is different from charging an emergency room patient for example, because of the common assumption that psychiatric patients cannot be held accountable for their behaviour because of their mental illness. This may serve to perpetuate stigma around our patients.

Another key area of concern is hospital support for the nurse. Although support may be offered in making the actual charge of assault, the aftermath to this also requires support. If a case goes to court, nurses need to be given time and support to attend to this, so there is no impression that they have to "go it alone." Nurses generally do not perceive that this part of the process is well defined and established, which contributes to reluctance to initiate charges. Finally, being assaulted and threatened is not part of the nursing role, and it is never acceptable.

Learning from the Police

When a hospital staff member is assaulted, prompt action must be taken to properly investigate the incident. Patients, including those experiencing a mental health crisis who may have been apprehended under the mental health act and are "formed" in a hospital do not "get a free pass" for criminal conduct against staff. A mental health crisis should not be confused with being "not criminally responsible. " "Not criminally responsible" is a decision only the courts can determine, often with mental health expertise. The person victimized by the assault may lay charges or, if circumstances warrant, the police may lay charges without this person's involvement.

There are three types of assault outlined in the Canadian Criminal Code (Criminal Code RSC 1985): common assault, assault with a weapon or causing bodily harm and aggravated assault. A person commits an assault when, without the consent of another person, s/he applies force intentionally to that other person, directly or indirectly. Assault with a weapon or causing bodily harm involves a person who, in committing an assault, carries, uses or threatens to use a weapon or an imitation thereof or causes bodily harm to the complainant. Aggravated assault involves the commission of an aggravated assault that wounds, maims, disfigures or endangers the life of the complainant. Any of these charges may be laid pending outcome of the investigation by the police.

Legal Considerations in Ontario

A nurse or another healthcare worker, who is the victim of a criminal act relating to the workplace, who wishes to charge the perpetrator, makes the complaint to the police in a personal capacity (as an independent, personal choice). It is important to note that when sharing information with Police Services as a health professional, the Personal Health Information Protection Act (Province of Ontario 2014a) and, as a psychiatry patient, the Mental Health Act (Province of Ontario 2014b), limit what professionals can share without consent or a court order. Unless there is patient consent, a warrant or other court order, the guiding principle is based on the principle of releasing the minimum amount of personal health information possible. Examples of information a healthcare professional can provide to the police, even in the absence of consent or a court order, include job title and professional designation, the name of the person committing the act and direct observations about the criminal act, such as a description of what happened, when and where it happened.

As the victim of a criminal act, a healthcare professional can provide personal information on the experience and impact, such as physical injuries suffered, property damage incurred and emotional impact. A healthcare professional can share the fact that the person is or was a client, but only if that information is relevant to the criminal act. Any information that will eliminate or reduce significant risk of serious bodily harm to others can be shared with the police.

The patient's diagnosis or any information about the kind of treatment or services provided to the person, the names of the person's clinical team members or the program where the person was receiving service, whether the person is on a form or his/her status as a voluntary or involuntary patient, the length of time the person has received care or the person's address are information that the police can obtain through their legal channels.

A court-issued warrant is required for the police to obtain mental health records relating to a patient. When the police obtain a warrant for mental health records, a psychiatrist reviews the matter, and once the psychiatrist assessment concludes that the disclosure is likely to result in harm to the treatment or recovery of the patient, or in injury to a third person, a hearing will be held by the court to consider how to deal with the disclosure.

If a patient has been charged with a criminal offence, and is released on bail, the police will advise the victim of any conditions that are placed on the accused while they are released on bail. Such conditions will likely restrict the accused from contacting the victim and may restrict the accused from being at the hospital, short of a medical emergency. Again, due to privacy laws, the hospital will not receive notice of these conditions. Therefore, the victim is responsible to inform the workplace of any bail conditions, particularly because they relate to the hospital so that the hospital can ensure they are enforced and that the police can be notified if the accused breaches these conditions. A breach of conditions by the accused should be reported to the police and the manager.

Ethical Considerations

Three ethical considerations stand out in the case of Diana and Tom. First, a professional "duty of care" typically means workers have an ongoing obligation to put their patients' well-being first. Yet, this duty is not unlimited. Articles published in the mental health nursing literature routinely reject the still-enduring idea that physical injuries and verbal insults are "part of the job." There is no regulatory or ethical expectation for workers to seriously sacrifice their own physical or mental safety. This is commensurate with the ethical acceptability and public acceptance of emergency service workers (e.g., fire department, police and paramedics) waiting until the likelihood of their own death or serious injury decreases enough before intervening. Admittedly, mainstream media highlights stories of people's actions that are heroic. Yet, they qualify as supererogatory because of the person's decision to exceed applicable norms and expectations for ethical behaviour.

Second, important questions about the interaction between Diana and Tom need answering: "What led to the assault? Who did what, when and why?" Answers help us figure out who to hold responsible and accountable and how to fairly understand and judge their thinking, behaviour and intentions. Are there relevant mitigating factors that alter these judgements? Factors include exacerbation of a psychiatric symptom (e.g., a delusion, paranoia or anxiety), an oppressive environment (e.g., a rule dominated ward) or dismissive staff (e.g. due to counter-transference). Within mental healthcare, punishment, traditionally, has had no clinical place in medication plans, behaviour modification plans or the emergency use of restraints or seclusion. Yet, no patient should be summarily reduced to their mental health condition. It is reasonable to ask whether Diana's actions reflect disproportionate, non-pathological or purposeful choices. Charging is a legal option as well as a safety response. If so, punishment may be justified. This is where the police and courts become involved.

The last key ethical consideration is based on philosopher Margaret Urban Walker's (2006) work on moral repair and restoring an important relationship after one party harms the other party. This work is necessary whether a charge is laid and essential if a charge is pursued. Reflective of the moral complexity of healthcare relationships, if a patient hurts or wrongs her healthcare worker, not only has the professional relationship been harmed but so has the personal or civil relationship. When Diana assaulted Tom, she, in essence, assaulted Tom-the-healthcare professional as well as Tom-the-person. Some healthcare workers find this distinction helpful in understanding their complex responses to being assaulted or threatened. It is appropriate for the unit manager to talk with Tom about what he thinks should happen so he can forgive Diana-the-patient and resume his clinical relationship with her. And what he thinks needs to happen so he can forgive Diana-the-person and resume a basic civil relationship with her. Moreover, if we respect Diana as a person as well as a patient and Tom as a healthcare worker, then a discussion about what she wishes to do to try to restore her clinical relationship and her civic relationship with Tom is ethically meaningful.

Physician Considerations

Physicians may be the targets of patient-initiated violence; however, more frequently, nurses and other unit staff are impacted (Lepping et al. 2013). In the event of an assault, the attending or on-call physician is likely to be contacted. All staff physicians need to familiarize themselves with local policies regarding workplace violence and their roles at their home institutions.

Physicians receive training in acute behavioural disturbance assessment and response during their education and should always assess the clinical status of the patient to rule out common causes of mental status change including: delirium, intoxication (possibly iatrogenic), inadequate sedation or pain management and cognitive impairment. Immediate assessment includes determining if the violent incident represents a marked behaviour change from baseline (Tueth 1995).

From a medico-legal perspective, physicians owe their patient a duty of care to be familiar with the established standards for appropriate care. Standards of care to consider may include medical treatment, documentation, transition of care, communication and confidentiality. Guidance regarding these standards is available from local regulatory bodies (e.g., Colleges or Medical Boards).

In the management of the violent incident and the aftermath, the main role of the physician remains central to ensuring appropriate medical treatment is provided to the ill person, regardless of any act that patient has committed towards a member of

the staff, a student or a community member (Antonius et al. 2010). It is not the role of the physician to determine whether the patient is responsible for a violent act (this is the role of the criminal justice system). While institutions may have policies or guidelines limiting access to hospital services for patients who are violent, the treatment of emergent conditions is typically excluded (Department of Health 2001). It is also important to consider the difference between limiting access to care (i.e., the person is not yet a patient receiving care) and the termination of care for a patient who is currently undergoing treatment (Lepping et al. 2013; American Society for Healthcare Risk Management 2014). In the latter case, the physician has an existing duty of care to the patient.

Where a patient is charged by the police but is not well enough to be discharged from the hospital, the patient cannot be safely removed from the premises. Upon assessing the incident and the impact, the hospital administration may wish to arrange transfer to another facility (American Society for Healthcare Risk Management 2014). The physician should consider the patient care needs, ensure the patient is adequately stable to tolerate a transfer and complete all necessary steps to ensure a safe handover. A transfer is rarely emergent, most violent patients can be managed with adequate support from staff in psychiatry, security and law enforcement officers as required.

Where the attending physician is not a psychiatrist, psychiatric consultation could be considered (Tueth 1995; Antonius et al. 2010). A psychiatrist can provide: (1) recommendations on the assessment and management of the patient and related violence, (2) clarification of hospital policies and procedures around restraint and (3) guidance to the management and team around the application of local legislation governing patient detention or restraint.

When the patient is medically clear to be discharged, the hospital administration may choose to call the police to inform them of discharge and established competency of the patient. A decision to no longer provide treatment to an ill patient requires input from the clinical team, Patient Relations and Ethics and Risk Management (Paniagua et al. 2009; American Society for Healthcare Risk Management 2014). However, there is a complexity to the issues of caring and charging. The duty to care is not limitless. Physicians should consider seeking independent legal advice in these situations, as well as speaking to hospital legal services.

A Nurse Manager's Perspective

The Nurse Manager's role in safety in Ontario is informed by Bill 168 (Province of Ontario 2014c) passed in 2009. This Act amended the Occupational Health and Safety Act with respect to violence and harassment in the workplace. In addition, the Occupational Health and Safety Act, Section 27 (Province of Ontario 2014d), stipulates that the duties of a supervisor include advising workers of potential danger; provide written instructions as to the measures and procedures to be taken for worker protection; and to take every reasonable precaution for the protection of a worker with the duty to advise, train and reduce the risk of harm to the nurse and other team members.

Nurse Managers are called upon to be both leaders and managers (McCallin and Frankson 2010). From a proactive leadership perspective, the "Swiss Cheese Model" of defence methods (Nance 2008: 133) can be used as a model in which multiple layers of 'violence defence' can be built into practice. The National Health Service (n.d.) names three components to security: physical, procedural and relational. Layering these components effectively may serve to minimize the risk of verbal (Stone et al. 2011) and physical aggression. The physical layer includes any environmental components, such as lines of sight, alarms and therapeutic spaces. Procedural layers include organizational and unit policies such as search policies, observation levels, workplace codes of conduct, crisis prevention training and the role of security and/or police. The relational security layer includes assessments to "know" the patient and mechanisms in which information is shared. "Knowing" the patient includes sharing knowledge about past violence (to inform risk) and knowledge of patient triggers and preferences to manage triggers. For nurse leaders seeking to explore the challenges of working in the context of potential violence yet striving to meet least restraint requirements (Province of Ontario 2014e) and a humanized environment, suggested literature includes Bowles et al. (2002) and Horn et al. (2013).

An assault is an acute crisis. In the event that an assault occurs, immediate care must be provided to all involved parties, and the team will need support. The police can be called to investigate and they may lay charges regarding assault or property damage. Internal policies and responsibilities regarding workplace violence involving patients need to be adhered to, and these may include flagging violence in the medical assessment and interprofessional care plan, creating an internal alert for subsequent admissions or appointments, filing incident reports, reporting to Occupational Health and Safety for possible report to the Ministry of Labour, the Joint Health and Safety Committee, the Workers Safety and Insurance Board and appropriate labour unions. A critical incident debrief is advised to support the team, capture and learn from what went well and learn in a non-blaming way from what could have been done differently. Cycle-back debrief findings and recommendations to the entire team to ensure that any changes in practice are completed in a timely way. This adds to the physical and psychological safety of patients and staff, signalling the level of importance that management/leadership places on safety.