



Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

Kelly, AM;Cockburn, T;Madden, B

Title:

When patients behave badly: Consent, breach of the duty of care and the law

Date:

2021-02-01

Citation:

Kelly, A. M., Cockburn, T. & Madden, B. (2021). When patients behave badly: Consent, breach of the duty of care and the law. *EMA Emergency Medicine Australasia*, 33 (1), pp.172-174. <https://doi.org/10.1111/1742-6723.13692>.

Persistent Link:

<https://hdl.handle.net/11343/276691>

When Patients Behave Badly – Consent, Breach of the Duty of Care and the Law

Anne-Maree KELLY MD MCLinEd FACEM

Director, Joseph Epstein Centre for Emergency Medicine Research; Adjunct Professor, Australian Centre for Health Law Research, Queensland University of Technology

Tina COCKBURN BCom LLB (Hons); LLM LLB BCom Grad Cert Ed (Higher Ed); TEP

Associate Professor & Co-Director, Australian Centre for Health Law Research, Queensland University of Technology

Bill MADDEN BA LLB (Hons) FAAL.

Special Counsel, Carroll & O’Dea Lawyers; Adjunct Professor, Australian Centre for Health Law Research, Queensland University of Technology

Address for correspondence:

Professor Anne-Maree Kelly

JECEMR, WHCRE,

Sunshine Hospital, Furlong Road, St Albans 3021

Email: anne-maree.kelly@wh.org.au

Word count: Abstract 105; Main text 1273

References: 16

CONFLICTS OF INTEREST: AMK is a member of the editorial board of EMA

CONTRIBUTION: AMK developed the scenario and drafted the manuscript, all authors revised to and approved the final manuscript.

ACKNOWLEDGEMENT: The authors acknowledge Drs Andy Tagg and Chris Paes for proposing this issue and their insightful questioning of application of duty of care to justify actions.

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: [10.1111/1742-6723.13692](https://doi.org/10.1111/1742-6723.13692)

ABSTRACT

Patients who are abusive or aggressive in Emergency Departments (ED) raise special clinical and legal challenges. These include what steps clinicians should take to exclude serious illness/injury as the cause of the behaviour and when investigations or treatments can be imposed on these patients without their consent.

Using a case illustration, this paper discusses legal issues which arise in this context, including how the standard of care owed by clinicians is determined and what may constitute a breach of duty; such patients' right to consent to (or decline) tests and treatment; and when clinicians may lawfully act without consent and/or control the patient's behaviour.

Key words: negligence, trespass, behavioural disturbance, restraint, medicolegal

HYPOTHETICAL CASE

Jamie, aged 29, was brought to a public hospital Emergency Department (ED) by ambulance after a minor traffic accident. While on a bicycle, he was nudged at very low speed from the side causing him to topple over, landing on his side. Jamie was wearing a helmet. Neither bystanders or paramedics reported a head strike or loss of consciousness. On arrival at the ED, Jamie was alert and talking to a friend on his mobile phone with an apparent leg injury. In the ED, Jamie was uncooperative and threatening towards nurses, demanding immediate medical attention and was abusive and threatening towards doctors who approached him. De-escalation was attempted by several senior clinicians, resulting in more abuse and punches being thrown by Jamie. He demanded to leave 'to go to a proper hospital' but could not walk independently because of his injury.

This situation raises important questions:

1. How is the relevant standard of care owed by doctors determined and what may constitute a breach of duty?
2. Can Jamie decline consent to investigation/treatment and discharge himself?
3. When can Jamie be lawfully treated without his consent?
4. When can Jamie's behaviour be lawfully controlled without his consent?

LEGAL CONCEPTS

Standard of Care and Breach

A public hospital and its health professionals owe a duty to a person who presents to an ED seeking advice or treatment.[1-2] The duty will be breached if reasonable care and skill is not exercised. This requires consideration of all prevailing circumstances, including foreseeability of risk, whether the risk was not insignificant and the precautions a reasonable person would have taken in response to the risk.[3] Whether a clinician is liable for breach of this duty generally requires consideration, in most Australian jurisdictions, of whether the

clinician/s acted in a manner that was widely accepted in Australia at the time as competent professional practice in the circumstances and, if so, whether such actions were irrational/unreasonable.[4-5]

Breach of duty (failure to meet the requisite standard of care by act or omission), causing harm to the person, generally permits a successful claim in negligence for compensation.

Consent

Patients with legal capacity have the right to exercise their autonomy and decide what should or should not be done to them.[6] Capacity is presumed in adults unless the contrary is established, after considering whether they can understand and retain relevant information, weigh up options, reach a decision and communicate this.[7-8] Competent patients may refuse advice or medical treatment, even when this is not in their best interests or risks their death.[8-10] Consulting a doctor (or attending the ED) does not imply consent to the treatment offered.[11] Where a person is treated without consent, a claim in trespass may arise. Trespass protects the right of a competent person to decide whether or not to consent to a course of action, including investigation or treatment, by providing a remedy for infringement of that right. [2 at [14]] By contrast, negligence protects the right to be informed about factors material to the patient in making decisions about investigations or treatment.

An exception to the consent requirement is the emergency/necessity doctrine, which allows provision of treatment to protect against serious harm to the person's health and/or to save their life in an emergency where obtaining consent is not possible.[12] Reasons for inability to obtain consent might include intoxication with drugs or alcohol, psychiatric illness with impairment of decision-making, or cognitive impairment. [13]

BACK TO JAMIE

Can Jamie decline consent to investigation/treatment and discharge himself?

Answering this question hinges on Jamie's decision-making capacity. It cannot be safely assumed that Jamie cannot make decisions simply based on his behaviour. Key questions are whether the demonstrated behaviour is unusual for him or whether there is reasonable evidence that an illness or injury is causing the behaviour, sufficient to overturn the presumption of capacity.

In Jamie's case, there was no evidence of intoxication, cognitive impairment or mental illness. Although he was not cooperating with clinical examination, accounts from paramedics (including details of the incident and examination of Jamie) and an examination of Jamie's bike helmet did not suggest any impact to his head, making the risk of significant head injury very remote. Vital signs and a blood sugar levels taken by paramedics were normal. End-of-the-bed observations found Jamie to be alert, to have normal speech and limb function (other than his injured leg), to be behaving normally when not interacting with hospital staff and to be purposeful in his actions (telephoning friends).

Importantly, a review of Jamie's clinical record found that he had attended the ED on previous occasions. On several of these, he had demonstrated threatening and aggressive behaviour and, on some, had required a security response. Absent evidence of illness, cognitive impairment, intoxication or reasonable suspicion of a significant head injury, it would be reasonable to rely on the presumption of capacity and consider Jamie competent to decline treatment, to discharge himself and possibly to attend another hospital. That does not absolve clinicians of a responsibility to inform Jamie of the risks of this and to try to facilitate this as safely as possible.[1]

When can Jamie be lawfully treated without consent?

If there was evidence that the exhibited behaviour was unusual for Jamie, there were abnormal vital signs, there was significant intoxication with drugs or alcohol, or there was evidence to suggest a significant head injury or a history of significant cognitive impairment, it may have been reasonable to decide that the presumption of capacity was overturned and

Jamie was unable to consent (or validly decline) treatment. If he was at risk of serious harm and treatment was necessary to save his life, the doctrine of emergency/necessity would probably justify treatment without consent.

Mental Health statutory provisions allowing treatment without consent cannot be invoked without reasonable evidence to establish the legislative requirements of the statutes in each jurisdiction. In general, this requires some evidence that the person has a mental illness, that this poses risk of serious deterioration in health, and that no less restrictive means for assessment and treatment regarding their mental health is available. [14]

When can Jamie's behaviour be lawfully controlled?

It is arguable that the possibility of a head injury coupled with the behaviour demonstrated by Jamie justifies chemical/physical restraint without consent. Treating clinicians may be concerned that failing to do so would be a breach of duty because, if present, a head injury could result in significant morbidity or mortality. However, by reference to Jamie's clinical history, this reasoning gives insufficient weight to the issue of autonomous consent. Where a patient has capacity, sidestepping consent requires lawful justification, either by statute or satisfying the emergency/necessity defence, which requires proportionate action.[15] Involuntary sedation and restraint is not without risk – including the risk of death.[16]

On the above facts, whether non-voluntary sedation/restraint is a reasonable response to the remote risk of a serious head injury is doubtful. Arguments that such restraint is for the patient's benefit have been held to be insufficient justification.[11] While preventing injury to staff might be suggested as justification, this is unlikely to be considered sufficient when a less restrictive course of action – letting Jamie leave – is open.

SUMMARY

Issues of consent and non-voluntary treatment for patients behaving badly are challenging. The central issue is the patient's capacity to give or decline valid consent. Assessment of capacity often requires collection and documentation of information from a range of sources.

Treatment of a competent patient without their consent, even when failure to do so poses a risk to their health or life, may be unlawful and may entitle the patient to seek compensation.

REFERENCES

1. *Wang v Central Sydney Area Health Service* [2000] NSWSC 515
2. *Rogers v Whitaker* (1992) 175 CLR 479.
3. Civil Liabilities Acts for example *Civil Law (Wrongs) Act 2002* (ACT) ss43,44; *Civil Liability Act 2002* (NSW) ss5B,5C; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) no equivalent provision; *Civil Liability Act 2003* (Qld) ss9,10; *Civil Liability Act 1936* (SA) s32; *Civil Liability Act 2002* (Tas) ss11,12; *Wrongs Act 1958* (Vic) ss48,49; *Civil Liability Act 2002* (WA) s5B.
4. Civil Liability Act provisions for example *Civil Law (Wrongs) Act 2002* (ACT) no equivalent provision; *Civil Liability Act 2002* (NSW) s5O; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) no equivalent provision; *Civil Liability Act 2003* (Qld) s22; *Civil Liability Act 1936* (SA) s41; *Civil Liability Act 2002* (Tas) s22; *Wrongs Act 1958* (Vic) s59; *Civil Liability Act 2002* (WA) s5PB.
5. Madden B, McIlwraith J, Madden B. *Australian Medical Liability* 3rd ed; Lexis Nexis Butterworths, 2017.
6. *Department of Health and Community Services (NT) v JWB & SMB (Marion's case)* (1992) 175 CLR 218, 234.
7. *Hunter and New England Area Health Service v A* [2009] NSWSC 761
8. *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84.
9. *Airedale NHS Trust v. Bland* [1993] A.C. 789, 864.
10. *Re B (Adult: Refusal of Medical Treatment)* [2002] EWHC 429 (Fam),
11. *Pratt v Davis* 118 Ill. App. 161 (1905), *affd*, 224 Ill. 300, 79 N.E. 562 (1906).
12. *Hunter and New England Area Health Service v A* [2009] NSWSC 761.

13. Bursztajn HJ, Harding HP, Gutheil TG, Brodsky A. Beyond cognition: the role of disordered affective states in impairing competence to consent to treatment *Bull Am Acad Psychiatry Law* 1991;19:383-8.

14. For example, *Mental Health Act 2014* (Vic) s 29

15. *R v Loughnan* [1981] VR 443.

16. *Inquest into the death of Gregory Masters* NSW Cor 2017/67674, findings published 25 September 2020

< https://coroners.nsw.gov.au/documents/findings/2020/Masters_findings.pdf >.