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Mr. Bronwyn Morris Donovan,
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RACGP
1 Palmerston Crescent
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Dear Bronwyn,

RE: Violence toolkit: medicolegal issues

RACGP has asked me to prepare this letter of advice, in connection with a range of legal matters relevant to the recently created draft RACGP document "General practice-a safe place :GP teams preventing patient-initiated violence"(the toolkit)

Background: a range of important legal issues arise when seeking to initiate risk management strategies relevant to the violent/aggressive patient.

Legal issues

While there were many issues potentially raised, here are the key ones:

- clarifying the nature and extent of employer and employee duties under occupational health and safety legislation, and particularly explaining the limitations of those rights and those duties relevant to the toolkit

- providing more information to your members on a range of potentially countervailing issues, which can and sometimes should impinge on or restrict both their willingness or ability to engage in various risk management strategies
- Confidentiality and privacy issues: how risk management activities that involve disclosure of patient-related information can coexist with laws that protect that information and which impose significant limits on the disclosure of it
- discrimination issues, particularly disability discrimination: the violence or aggression can sometimes be linked to underlying mental, cognitive or physical illness. In these situations, what is the likelihood that risk management strategies directed to these people constitute unlawful "direct" or "indirect" discrimination based on disability?
- negligence exposure, particularly the duty of care owed by healthcare professionals to their patients, and also possibly the duty of care that healthcare professionals might also owe to persons other than their patients (including violent/aggressive friends and family of the patient, and other healthcare professionals outside of the practice to whom the member might wish to convey information about the violent/aggressive patient
- Ethical issues, including those surrounding the right to terminate the relationship, and how such termination can properly and lawfully take place
- Emerging human rights issues under Australian law
- Defamation law: disclosure of the violence/abuse reveals to the recipient of that communication information that reflects poorly on the patient. Can the patient sue for defamation?
- The interplay between these varying, and sometimes competing, legal and ethical factors, and their impact on the steps which your members can and should take when seeking to implement risk management strategies relevant to patient-initiated violence/aggression

Specific challenges

In particular, these issues play out in the toolkit with respect to several specific scenarios:

Treating the patient differently: at what point might risk management strategies undertaken during the treating relationship breach the law, particularly discrimination laws? For example, might flagging of patient files constitute an unlawful form of discrimination?

Ending the relationship or refusing to treat: in what circumstances can--and for that matter should -- a doctor end the clinical relationship or refuse to treat an existing or potentially new patient who is violent/aggressive? And when that happens what steps can and should be taken to minimise medicolegal consequences? Among those potential consequences are complaints to disciplinary authorities and, where the patient says they have suffered injury as a result of the failure to treat or the delay in treatment, a possible claim in negligence. And is it discriminatory to end a relationship because of actual or feared violence/aggression, particularly when that behaviour is caused by an underlying illness?

Notifying others about the violence/aggression, either during the clinical relationship or at the point of ending it: to what extent, if at all, do privacy laws or confidentiality laws prevent your members from notifying others about the violence/aggression? In particular, when can--and when should -- your members notify:

- the police
- other healthcare professionals from whom the violent/aggressive patient may later seek treatment, or to whom the member intends to refer that patient? Liaison with this category of persons also raises an additional issue: do your members have either the right or the legal duty to notify that other professional about the violence/aggression, and does their failure to do so potentially expose them to a negligence claim when that other professional, unaware of (and therefore unprepared for) the violence/aggression gets injured by that patient?

And the question relevant to both police and others is whether any such notifications constitutes unlawful discrimination, particularly where the violence/aggression is arguably caused by underlying illness

Legality of certain risk management measures: sometimes, health professionals seek to enter into contracts or agreements, variously titled, to seek to control and modify behaviour by having the patient agree to abide by a set of behavioural standards which form a precondition to ongoing treatment. Are these legal? That is, are they enforceable? And even if they are, is there a risk that professionals who require their patients to enter into such arrangements might themselves confront legal exposure or disciplinary exposure? For example, could it be said that this is a form of unlawful duress, or even discrimination?

Structure of This Advice

I have structured this advice as follows:

Setting the scene: preliminary observations, assumptions and values that inform this advice

Part 1: occupational health and safety

Part 2: Privacy and confidentiality

Part 3: Duty of care issues

Part 4: Discrimination issues

Part 5: Emerging human rights issues

Part 6: Legal risks associated with "acceptable behaviour agreements"

Part 7: Defamation

But first, let me set out my general "philosophical" approach to the issues identified by the toolkit

Setting the scene: preliminary observations, assumptions and values that inform this advice

First, the College should be commended on this excellent initiative. However, and perhaps somewhat surprisingly, the risk management strategies explored by the toolkit have the potential to generate medicolegal problems if handled wrongly.

For better or worse, there does seem to be an inevitable tension between occupational health and safety obligations (for example) on the one hand, and a range of duties the general practitioner owes (where the perpetrator is the patient) under both common and statute law on the other (most notably negligence, confidentiality, privacy and discrimination).

As a result, what at first glance may seem to be ostensibly sensible responses to avoiding or reducing patient-initiated violence can – and sometimes do – generate surprisingly awkward legal questions around duty of care, amongst other issues.

A balanced approach

The toolkit quite understandably focuses on reinforcing the need for vigilance and a proactive approach to risk management.

However, it is important that the College be aware of the risk of potentially over-sensitising some readers to these risks. Members should not overreact to a perceived danger, and (even worse) do so in a way that is heedless of some very legitimate legal, ethical and regulatory issues and (occasionally) impediments. This is particularly so given that the toolkit defines violence and aggression very broadly, so that it covers not only serious criminal offences but also acts that are far more trivial.

Patient rights; doctor duties

Put simply, violent/abusive patients generally (but not always) have the same rights, and are owed the same legal and ethical duties as non-violent patients (and in a healthcare setting, the violence/aggression can sometimes be linked to underlying physical or mental illness). And what might appear to be a commonsense solution can, if wrongly handled, violate those rights and breach those duties.

What we are fundamentally addressing here is a tension between a variety of competing legal, ethical and regulatory factors: part of that tension exists

because on the one hand, there are the rights and obligations imposed by occupational health and safety legislation versus the rights available to and duties owed to citizens (most importantly for present purposes, to patients) under various other laws e.g. privacy, confidentiality, discrimination et cetera.

Challenging the “doctor as hero” model

Perhaps more importantly, the tension arises because the legal compliance models that operate here (particularly OHS) can sometimes rest uneasily with the traditions and cultures of health service delivery, a tradition that has long celebrated heroic interventions, self-sacrifice and putting the patient first.

While these are commendable and admirable values, your members need to understand that they are not mandatory. Not only that, they can sometimes sit uneasily with the current legal and regulatory framework, which recognizes that the health care practitioner is not dealing in isolation with any given patient, but in fact is part of a team. The practitioner therefore needs not only to look after the needs of the patient, but also the legitimate needs, rights and interests of their colleagues – particularly their employees or their fellow employees.

Doctors do not have to “cop it”

And even more importantly, your members are **absolutely entitled** to take care for their **own** safety. While health professionals have long recognized that difficult and challenging patient interactions "come with the territory", it does not follow that your members must in some way assume that they must therefore conduct themselves as if they were operating within a legal and regulatory "parallel universe". The toolkit properly and understandably reinforces that your members cannot and should not make this false assumption.

To that extent, I strongly support the message both implicit and explicit within the toolkit, that requires your members to deal proactively with the challenge of violence/aggression and not to assume that it is something they (or their staff) simply have to "cop' because “that is what health professionals do”.

...And neither do their staff

And even if they were right in forming this assumption (and they are not), not all of your members' colleagues are health professionals e.g.

secretary/receptionist etc. These staff do not confront the same set of ethical and legal obligations that are routinely confronted by and imposed upon health care professionals (though sometimes some or all of those obligations might be imposed contractually, depending upon the terms of their employment).

Risk management, on a medicolegally informed basis

The real challenge however, and therefore the major focus of this advice, is to help ensure that the toolkit not only sensitises your members to their rights, but also helps them identify, understand and navigate through their various duties. In particular, we need to ensure that the many practical and pragmatic solutions proffered by the toolkit are implemented in a way that safely navigates the occasionally very tricky challenges that arise medicolegally.

Medicolegal obstacles usually do not necessarily prevent sensible solutions

And while there are occasionally very significant medicolegal challenges, involving sometimes subtle distinctions, I believe more often than not the legally accurate answer is the same as the commonsense answer.

But sometimes they can pose difficulties...

Having said that, some of the challenges will certainly remain extremely problematic and are probably not susceptible to easy solutions. And for that reason, I do not represent that I provide those solutions in this advice. Instead, what I propose is to help alert your members to those situations. Where things are likely to get particularly tricky, they might want to seek some expert input (at no cost to them) via their medical defence organisation (medical indemnity insurer), who in turn will usually be able to refer them to the medical legal experts who routinely staff those organisations.

Circumstance-specific solutions... and there are lots of different circumstances

The key message here is that while the toolkit should certainly continue to encourage members to proactively embrace violence/abuse-related risk management strategies, they can and must do so only on an informed basis.

And because of the broad spectrum of behaviours covered by the expressions "violence" and "aggression", it must follow that a "one size fits all" or disproportionate response will not only be unjustifiable clinically, but also

medicolegally. As your members are doubtless aware, patients (and others) can display violence/aggression for a whole range of reasons, including:

- In pain
- In need of care/attention
- Desperate for help
- Afraid, anxious
- Expecting early attention
- Confused
- Inarticulate
- On Medication
- Psychotic
- Drunk
- Drugged
- Volatile

And it further follows that at one of the end of the spectrum, legal and regulatory issues may dictate a certain response, whereas at the other end of the spectrum a completely different response may be required. In this advice, I will seek to highlight how that works.

The focus of this advice, therefore, is to set the scene to help your members get a better feel for the potential problem areas they need to navigate, and be seen to have navigated, in order to make sure that their risk management activities properly reflect an understanding of and compliance with their obligations... and not just their rights.

Keeping the length of this document under control

Finally, many of the legal issues under consideration raise quite complex issues, sometimes linked to a long line of case law, for example:

- duty of care to third persons other than patients
- the public interest exception justifying breach of confidentiality
- discrimination issues arising from differential treatment of people whose disabilities cause them be violent/aggressive (there is a long line of case law dealing with violent students in the school system, but not so much on violent patients)

While I have reviewed the relevant statutes and the relevant cases, I have sought to avoid drafting a detailed, written exploration and recitation of all those laws and relevant cases, for fear that to do so would generate a report that is substantially longer than this one (and I appreciate that in its current form, this is no short report).

Instead, I have tried to focus on the key legal issues, on my interpretation and understanding of the key legal issues arising from the relevant statutory and case law, and on their implications for the toolkit.

Part 1:Occupational health and safety

The potential problem

It is important that your members do not focus disproportionately on the obligations imposed, both upon employers and employees, under OHS legislation and as a result ignore or underplay the importance of a range of countervailing medicolegal issues.

Here is why.

First, let me emphasise that it is critically important that your members understand their relevant OHS obligations. This is particularly so where, as here, many have perhaps assumed that they and their colleagues must be seen to subscribe to a range of heroic acts of self-sacrifice, consistent with a long and glorious tradition of such behaviour in the health-care professions.

Your members need to understand that, for better or worse, neither they nor for that matter any other professional group in Australia operates in a vacuum, or in isolation from the laws of the land. Acts of self-sacrifice may well be laudable, but they are not required by law. And sometimes, a culture that encourages such behaviour may well breach that law.

OHS at a glance

The Australian Institute of Criminology described OHS laws as follows, in its publication "Preventing Client-Initiated Violence: a Practical Handbook":

"Statutory law in Australia states that employers have a primary duty to ensure, so far as is practicable, the health and safety of all people on a worksite all performing work. This requirement is detailed under the OHS legislation in each Australian State and Territory. The OHS duty of care provisions include protecting people from violence. The preventive thrust of the OHS legislation requires the prevention of "foreseeable risk". The process of risk identification, risk assessment, and risk control is explicit under the OHS Act or subsidiary legislation in most Australian states and territories. This process requires identification of the extent and nature of risks, the factors that contribute to risks, the changes necessary to eliminate or control the risks, and the monitoring and evaluation of the risk control process. Violence should be treated in a similar way to other OHS risks. Where an employer is aware of the potential for occupational violence, a court could interpret the risks as foreseeable, and it would be expected that prevention program had

been implemented. In such a case where an employer fails to take preventive action, the offence/breach of the OHS legislation occurs in a timeframe prior to an actual incident. All employees also have a duty to comply with organisational policy and procedures, to report incidents, and to support arrangements to control risk..."

These statutory laws operate in all Australian jurisdictions.

Balancing OHS duties against other duties

Much of the toolkit echoes these principles, and does so accurately. In doing so it reinforces the message that the member, particularly as an employer, is duty-bound to recognize that some patients can pose a threat which by law they must guard against.

However, as a health-care professional the member needs to temper that response to recognize the very special relationship that exists, or is meant to exist, between doctor and patient, and the legal and regulatory duties arising from that relationship. There can sometimes be a tension between these forces.

Further, the Institute's description of OHS laws contains a key qualification: OHS duties are not absolute. The employer need not and must not do everything possible, but must do everything "practicable" (or words to that effect).

What is "practicable"?

Although there are some differences in approach, all OHS laws recognize that the duty is limited in the sense that persons affected by the act must do what is practical or reasonable. Among the themes guiding principles have come out of the cases are the following:

- The phrase "reasonably practicable" (and associated phrases in relevant statutes) means something narrower than "physically possible" or "feasible";
- What is "reasonably practicable" is to be judged on the basis of what was known at the relevant time;
- To determine what is "reasonably practicable" it is necessary to balance the likelihood of the risk occurring against the cost, time and trouble necessary to avert that risk.

This balancing test, which has been looked at extensively by the courts, was described in one case as follows:

"It is now established that, in cases concerning the statutory duty which is qualified by those words, the risk of the accident has to be weighed against the measures necessary to eliminate the risk, including the costs involved. If, for example, the defendant establishes that the risk is small, but that the measures necessary to eliminate it great, and may be held to be exonerated

from taking steps to eliminate the risk on the ground that it was not reasonably practicable for him to do so... (the effect of the previously decided cases) is to bring into play foreseeability in the sense of likelihood of the incidences of the relevant risk, and that the likelihood of such risk eventuating has to be weighed against the means, including the cost, necessary to eliminate it" (Austin Rover Ltd v Inspector of Factories (1989) 1 WLR 520).

The case law also reveals and confirms that the employer is under a duty to undertake this balancing approach proactively.

Part 2: Privacy and confidentiality

The problem

Several of the strategies outlined in the toolkit involve, require or necessitate the sharing of information about the patient with others who are not in a treating relationship.

Patient information

Patient information is confidential. Patient information is also protected under privacy law. There are now several different privacy statutes throughout Australia (although the recent – August 2008 – release of a major report from the Australian Law Reform Commission, there should be added and renewed impetus for harmonising and simplifying these laws). The one that applies to all general practitioners is the Commonwealth Privacy Act. In some jurisdictions (Victoria and New South Wales for example) there is also the "dedicated" health privacy legislation which also covers your members practising in those jurisdictions.

Non-patient information

Occasionally, the person about whom the member wants to disclose information is not a patient, but rather a friend or relative of the patient. In that situation, there is no relationship of confidentiality. There may, however, be obligations under privacy law (but probably not the "dedicated" health privacy law... unless even the "non-patient" information falls within the sometimes very broad definition of "health information" appearing within the statutes).

The challenge

How then do these confidentiality and privacy issues affect the ability of your members to undertake the following risk management initiatives:

- notifying the police
- notifying other health care practitioners outside of the practice, particularly
 - those to whom the member proposes to transfer care, or (even more challengingly)
 - a range of local practitioners in order to put them on notice of the patient "just in case" they need to treat that person

(Note: there might be other medicolegal issues associated with the proposed communication, including

- understanding when and how the member is lawfully entitled to terminate the relationship
- managing potential negligence exposure arising from the failure to provide or the delay in providing required care
- managing potential negligence exposure arising from the failure to notify others about the patient's violence/aggression, particularly (but not only) the failure to notify the other doctor to whom care is transferred
- potential exposure for unlawful discrimination, where the patient's behaviour is or is said to arise from a disability

I discuss these issues elsewhere in the advice.

RACGP draft "Handbook for the Management of Health Information in Private Medical Practice" ("the draft privacy text")

To some extent, these privacy/confidentiality questions have been answered in the draft privacy text prepared by the College and the Committee of Presidents of Medical Colleges, where it states:

Lessening or preventing a threat to life or public health and safety

The consent of the patient is not required where the use or disclosure of the personal health information is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety, or a serious threat to public health or safety. This exception might apply in the case of mental illness, where the patient is threatening to harm other people, or where a person has an infectious disease that is likely to be transmitted to others. It has also been applied where a patient is "doctor shopping" (i.e. moving between doctors seeking drugs of dependence), and is the basis of the use of the "doctor shopping hotline." If this exception is to be relied upon, medical practitioners must satisfy themselves that the disclosure of the information is the only effective way of averting the risk, and the consent of the patient should still be sought if it is appropriate and feasible to do so.

Disclosure required or authorised by law

There are not many instances where medical practitioners will be required or authorised by law to disclose personal health information to a third party without the patient's consent. Some examples of this would be producing records in answer to a subpoena, giving evidence under oath in court, statutory disease notification, or reporting suspected child abuse or domestic violence. The specific legal obligations governing these situations vary from State to State. *[See Appendix 1]* Even where a medical practitioner is compelled by law to make the disclosure, it will usually be appropriate for the patient to be informed that the information has been disclosed (e.g. in the case of disease notification to public health authorities or complying with a subpoena) but this is a matter for the judgment of the medical practitioner based on the circumstances of each case. As a general rule, patients should be made aware of how their information is to be disclosed. However, there are clearly some cases (e.g. reporting suspected child abuse) where it would not be appropriate to tell the patient of the disclosure

Warning other medical practitioners about dangerous patients

Medical practitioners occasionally face risks to their own safety from disturbed or violent patients. These risks are particularly high in small general practices where medical practitioners may be alone for much of the time. There have been instances where a dangerous or violent patient, having been refused treatment at one practice, goes to another medical practitioner who may be unaware of the risk to his or her own safety.

Medical practitioners have a number of options in these circumstances. If they believe the patient presents a serious and imminent threat to the safety of other medical practitioners in the area, it would be permissible under relevant privacy legislation to warn other medical practitioners about the patient in question. The information disclosed should be factual and limited to the minimum necessary to convey an appropriate warning. In some cases, it may be appropriate to inform the police of the risk, particularly if the safety of the general public is threatened, and request their assistance in warning other medical practitioners. The disclosure to police would be justifiable under privacy legislation as being necessary for law enforcement. Finally, if the patient is mentally ill, there are of course procedures for involuntary detention and treatment under State mental health legislation

Competence to give consent

There are some patients who, because of illness or disability, are not competent to give consent for the collection, use or disclosure of their

personal health information. In some States and Territories, the relevant privacy legislation authorises specific people, such as a legally appointed guardian or “authorised representative”, to consent to the collection, use or disclosure of personal health information on behalf of an incompetent patient. Other States have legislation appointing certain people as substitute decision-makers for medical treatment decisions for incompetent patients [*see Appendix 1*], and it would be reasonable to look to these people for consent in relation to the patient’s personal health information. In other cases, where there is no legally authorised decision-maker, medical practitioners should speak to the patient's relatives or carers to obtain their agreement to the proposed use or disclosure of the personal health information.

Care should be taken not to assume too readily that a patient is unable to make his or her own decisions about personal health information, by reason of illness or disability. Even where there is some impairment of understanding or communication, such that a substitute decision-maker is necessary, the patient should still be allowed to participate in the decision-making process to the greatest extent possible.

The draft privacy text, with modifications, should be adopted in the toolkit

In many respects, that text accurately states the law and answers many of the questions listed above. And for that reason, I recommend that a version of it should either be introduced into the toolkit or referred to in it (with a hypertext link). In this advice, I discuss some additional issues that arise specifically from the toolkit.

The text also contains some useful and important scene-setting materials, including definitions. While most of those definitions simply repeat the statutory language, one is a little more "creative" and seeks to guide members through the practical privacy challenges that arise in the following two discrete situations

- sharing information within a practice (recognizing that practices are increasingly formed through a variety of legal structure is) on the one hand, and
- sharing information with members outside of the practice

Given that the text already addresses many of the necessary issues, I will not in this advice embark on a detailed review or explanation of privacy and confidentiality laws. Instead, I will focus on those most relevant to the toolkit.

Confidentiality and privacy, and their exceptions

While often used interchangeably, confidentiality and privacy are in fact quite different things. Confidentiality is a long-standing ethical and legal obligation. Privacy is a more recent invention, and is based on several statutes that impose a range of obligations in relation to the information life cycle.

Most confidentiality and privacy law impose stringent protection on sensitive information.

Getting consent should, where practicable, always be the first option

Wherever practicable, your members should first seek the patient's consent before disclosing information about them to others. This is particularly relevant to situations where the member want to transfer care to another doctor. In those circumstances, there should already have been some form of dialogue in order to set the scene for the transfer. And as part of that dialogue, the doctor should indicate their desire to give information to the new doctor in order to help them take over the care. If and when the patient consents to that disclosure, it would in my view be reasonable and lawful to include within those disclosures the information about the violence/aggression, **so long as** the disclosing member has formed a reasonable view that that violence/aggression is likely to be a relevant factor in the ongoing relationship with the new doctor. It follows that where, upon proper consideration, the violence/aggression is in fact entirely **irrelevant** to any future relationship, then it should not be mentioned to the next doctor even where the patient has in general terms consented to the disclosure of information to the next doctor.

It will obviously be impracticable (and not particularly sensible) to seek patient consent where the member decides that the violence/aggression justifies notification to the police, or notification to other doctors in the community who may at some future time encounter the particular patient.

Options for disclosure where there is no consent: operation of law

Fortunately, both privacy and confidentiality laws recognize numerous lawful exceptions which permit disclosure of confidential/sensitive information, even without patient consent.

So far as privacy laws are concerned, the Office of the Federal Privacy Commissioner acknowledged (in one of its Issues Papers prepared in connection with the recent review of the private sector provisions of the CW Privacy Act) that important limitations exist in relation to privacy:

"The private sector provisions of the Privacy Act reflect the premise that privacy is not an absolute right and must be balanced against other important social interests that compete with privacy. The objects clause spells this out. It states that a national privacy scheme was to be established in a way that 'recognises important human rights and social interests that compete with privacy'".

Limited operation of these exceptions

Some of these exceptions will permit notification to the police but to no one else.

Others may permit notification to the colleague to whom care will be transferred.

In my view, it is far less certain that they will permit notification to colleagues in the general community to "put them on notice" about the risk posed by the patient. I explain why below

And even when disclosure is lawful, it still needs to be privacy-respectful: the Caldecott Guidelines

Where disclosure can be justified, it needs to involve the minimum necessary amount of information to the fewest number of people.

These principles were recognized in a Handbook prepared by the South Wales (UK) Working Group on Violence in General Practice. The handbook, entitled "Preventing violence in general practice: a Handbook for professionals" (available at www.south-wales.police.uk) sought to reinforce that general practitioners need to embrace the privacy values which, in the UK, have come to be known as the Caldecott Guidelines (arising from a 1997 report that made a series of recommendations aimed at improving the way in which the NHS handled information which identify patients).

In my view, those guidelines reflect the principles underpinning Australian law (which I briefly outline below) and should for that reason apply with equal force to general practitioners in Australia.

Here I what they say:

- Principle 1. Justify the purpose: Every proposed transfer of patient identifiable information should be clearly defined and scrutinised.
- Principle 2. Don't use patient identifiable information unless it is absolutely necessary.
- Principle 3. Use the minimum necessary patient identifiable information.
- Principle 4. Access to patient identifiable information should be on a strict need to know basis.
- Principle 5. Everyone should be aware of their responsibilities.
- Principle 6. Understand and comply with the law.

Australian Privacy Law

While there are multiple privacy statutes throughout Australia, happily they adopt very similar (but not identical) approaches to data protection, and use very similar concepts.

In the language of privacy law, a member who wants to disclose to another doctor in another practice their concerns about a patient's violent/aggressive tendencies will in effect be involved in a "disclosure" of "personal information" (or in some jurisdictions "sensitive" or "health" information) to another "organisation". Under most privacy models, this can be done, but only if it can be justified under any of the provisions of the relevant privacy legislation, and the statutorily articulated exceptions to the preservation of privacy.

And it also needs to be recognized that whenever one organisation discloses information, the receiving organisation (another one of your members in a different practice, for example) is in effect "collecting" that information. When that happens, the "collector" again owes certain disclosure duties to the data subject (the patient). I will deal with those duties separately, but first let me deal with the obligations of the discloser.

Lawful disclosure under privacy legislation

The Privacy Act recognises that disclosure is lawful even without patient consent in several circumstances, all spelled out in the National Privacy Principles (**NPPs**), specifically NPP 2 (reproduced at the end of this Part).

Here are the main grounds available under Commonwealth privacy law.

Patient consent (or non-patient consent)

If it is practicable to obtain that consent, then that should always be the first port of call. I discussed this earlier.

Where it is practicable, the member should, for example, seek to explain to the patient that in order to effectively transfer care to the next doctor, they need to speak with that doctor about the patient's health and the issues that have led to the decision to transfer care. Once the patient consents to disclosure, it is in my view lawful for your member to tell the new doctor about the problems with the violence/aggression, so long as the member reasonably believes that those issues are relevant and necessary for the next doctor to know about in order for them to provide ongoing management.

A directly related secondary purpose within the reasonable expectation of the patient?

Under NPP 2.1, disclosure without consent is justifiable where it is done for a directly related, secondary purpose that is within the reasonable expectation of the patient.

This exception recognizes that while your members collect information about patients for the "primary purpose"(usually) of providing care to them, they also collect, use and disclose it for several legitimate secondary purposes.

This exception provides that so long as that secondary purpose disclosure is directly related to the primary purpose and within the reasonable expectation of the patient, the information can be disclosed even without patient consent.

I doubt this can be used to justify disclosure of a patient's violent/aggressive propensities. I suspect most patients would assume that information about their less appealing personality traits would, like all other information, about them, remain protected by doctor-patient confidentiality.

And while some patients would or should recognize that there are limits on this, and that your members may well notify the police if, for example, the patient criminally assaults the doctor or a member of their staff, there would be other NPPS justifying police notification.

For these reasons, it would in my opinion be difficult to argue that this exception justifies the member discussing the violence/aggression with the next doctor.

The "serious and imminent harm" exception

This is the most potentially useful statutory exception, particularly in respect of disclosures to people other than the police. However, for it to be lawfully relied upon, the danger must meet the rather high thresholds set out in this exception, namely that

“...the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent:

- (i) a serious and imminent threat to an individual's life, health or safety; or
- (ii) a serious threat to public health or public safety”

Let me now address each limb in turn.

A. to Individual life, health or safety

The threat to an individual's life, health or safety must be both **serious and imminent**.

The mere fact that your member has had a difficult relationship with a violent patient does not, in my view, automatically mean that that patient's future interactions with the medical profession will likewise pose a risk to the next doctor, let alone a risk that is either "serious" or "imminent". Of course, sometimes it does. And on those occasions the statutory exception is available to your members.

Importantly, the exception is available where your member has "a reasonable belief" that disclosure is necessary to lessen or prevent the threat. In other words, your member does not have to be right about this, but simply has to have formed a reasonable view.

It is also noteworthy that the serious and imminent threat need not be to a third person, but rather could be to the patient themselves. On this basis, disclosure to a third party might be justifiable on the grounds that without that disclosure, the **patient** (as opposed to the third-party) will come to harm e.g. through exposing themselves to a situation of danger or exposing themselves to criminal sanction for their further improper acts. However, for disclosure to be lawful in these circumstances, it must be given to someone who can act to prevent or lessen the harm.

Lessons from New Zealand?

A very similar exception exists in New Zealand privacy legislation, and was examined in a recent publication there:

"The rule in 11(2)(d) of the HIP Code (the equivalent New Zealand provision) provides a discretion to disclose information if it is necessary to prevent or lessen a serious and imminent threat to public health or public safety, or the life or health of any individual, including the patient. The rule is based on the common law principle that:

...although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure... It is this binding principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining the confidence against a countervailing public interest favouring disclosure.

The key aspects are thus:

- The risk of harm is serious.
- The risk of harm is imminent.
- The nature of the harm may be either to the ... person themselves or to the health or safety of the public.
- The information must be given to someone who can act to prevent or lessen the harm.
- Only the information necessary to prevent the (harm) should be given which may not involve disclosing all information.

But the danger is that the unchecked professional could justify all disclosures based on their intuitive and subjective assessment. Furthermore, it is difficult to determine exactly who will qualify as a party able to prevent or lessen the harm It is also difficult to delineate between information that is necessary ...and information that is irrelevant to that process..."

(Stewart: "Taking youth suicide seriously: disclosure of information between school, family and health professionals in New Zealand"
<http://www.austlii.edu.au/nz/journals/VUWLRev/2001/16.html>)

b. To public health or public safety

Similarly, the second exception here also permits disclosure by members when they have a reasonable view about certain threats. The threat in the second situation is where there is a serious (but not necessarily "imminent") threat to public health or public safety.

The two key elements here are that:

- the threat is serious ,and that
- it is a threat not necessarily to an identified individual or group of individuals, but to "public health or public safety".

An untested question is whether the expression "public" can be interpreted to mean discreet groups within that public, including for present purposes healthcare professionals. If in fact the public threat is wider than simply the healthcare professionals, then in my view the correct course of action (assuming **any** disclosure is justified) is to notify the police at first instance.

Telling relevant persons or authorities when you suspect unlawful activity

At first blush, this exception might permit notification not only when the member or their staff has been the victim of unlawful violence/aggression, but also when they have reason to suspect that it will happen again (even if it involves other victims).

The uncertainty surrounds the identification of "relevant" persons or authorities. Clearly, the police are one such authority. But when, if ever, might other medical practitioners be treated as "relevant persons"? The answer in part probably depends on whether the purpose of this exception was to allow disclosures to address and prevent the unlawful activity. If that was its purpose, then it is not likely that disclosures to other doctors would satisfy this requirement.

The other exceptions

Although there are additional exceptions permitting disclosure, most of these probably give no help to members who want to notify other doctors. They do, however, help members to lawfully notify the police.

For that reason, I will not deal in detail with those exceptions. Instead, I have set them out, together with a relevant analysis, in the table below.

At a glance: Privacy law, and permitted disclosures of violence/aggression to third persons

| NPP | | Police ? | New doctor? | Doctors in the area? |
|-------------------|--|---------------------|--------------------|-----------------------------|
| 2.1.a | Directly related secondary purpose within reasonable expectation of the person | No | No | No |
| 2.1.b | With consent | Yes* | Yes | Yes* |
| 2.1.e(i) | Necessary to lessen or prevent serious and imminent threat to an individual's life, health or safety | Yes | Maybe | Maybe |
| 2.1.e.(ii) | Necessary to lessen or prevent serious threat to public health or public safety | Yes | No | Maybe |
| 2.1.f | Has reason to suspect that unlawful activity has been, is being or may be engaged in, and discloses the information in reporting its concerns to relevant persons or authorities; | Yes | Unlikely | No |
| 2.1.g | Required or authorised by or under law | Yes | No** | No** |
| 2.1.h.(i) | Reasonably believing the information is necessary for law enforcement body to prevent, detect, investigate or prosecute criminal offences or breaches of law imposing a penalty | Yes*** | No | No |
| 2.1.h.(iv) | Investigate etc seriously improper conduct | Yes*** * | No | No |

*but unlikely to happen in the real world

**even if the "law" purportedly relied upon is the "overriding public interest" confidentiality exception, then I would argue the appropriate contact is usually the police rather than any individual or group of doctors

***so long as the violence/aggression would expose the perpetrator to a penalty under law. And if your member uses this exception, it must make a written note of the use or disclosure.

****only when the violence/aggression forms "seriously improper conduct"

I need to emphasise that even if the privacy laws permit the disclosures, members must always first satisfy themselves that disclosure is a proper and responsible option, not just legally but clinically as well.

And for reasons explored elsewhere in this advice, the mere fact that the patient has been violent/aggressive does not necessarily and invariably mean that your member should avail themselves of the recognized exceptions outlined above.

But sometimes, clearly they should.

Dealing with the hard cases: getting advice

And sometimes, it will be difficult for them to work out whether the law permits them to disclose information or not (as the above table demonstrates). For this reason, and in the circumstances, members should always consider getting expert advice before making the disclosure. One way they can get this advice, and for free, is by calling their medical defence organisation (medical indemnity insurer), many of whom will be able to refer them to their medical legal advisers.

Collecting the information (the new doctor)

Assuming your member can lawfully disclose the information to another doctor in another practice, that other doctor **also** has obligations under privacy law. This is because that other doctor has "collected" information about the patient. Whenever that happens, the privacy laws impose certain obligations

on the "collecting" doctor, which requires them to give certain information to the patient at the first reasonably practicable opportunity.

This would not pose a problem where the collecting professional is in fact the patient's new doctor. In that situation, the new doctor can simply tell the patient that they already received information about the patient via the previous doctor. And this should not come as a surprise to the patient, as they should have already discussed this with their old doctor.

More problematic is the situation where a member has lawfully disclosed information to other doctors, none of whom are the patient's new doctor. Strictly, they too confront the same disclosure obligations that any "collecting" doctor does. However, I would argue that their obligations only arise whenever it is practicable to do so, and that there is no point at which this will occur. As a result, there is no need to notify. (However, the key – and threshold – privacy issue in this situation was whether the disclosing doctor acted lawfully giving the information in the first place. See discussion above.)

Confidentiality law

So far as confidentiality laws concerned, the main exceptions of relevance to the toolkit (apart from consent) are

- the iniquity exception
- the public interest exception

The first of these corresponds to the legal principle that one cannot benefit from being involved in a crime.

The second is very controversial, and while recognized as an available option, is rarely invoked.

One of the rare occasions on which it was used was when the authorities were seeking the assistance of the medical profession to identify the person known as "Mr Cruel", the person responsible for the abduction of several young children. The police and a number of medical defence organisations jointly signed a letter seeking the assistance of doctors. However, even that letter did not go so far as to suggest that doctors had a legal duty to breach confidentiality. Rather, it was suggested that upon due consideration of their ethical responsibilities and a range of competing public interest considerations, doctors may decide to notify.

This issue of "overriding public interest" also arises in the context of negligence law, and determining whether your members might owe a duty not just to their patients but also to third persons who might be at risk because of the patient's violent/aggressive tendencies. I discuss this in the Part dealing with negligence and duty of care.

Extracts from RACGP/CPMC draft "Handbook for the Management of Health Information in Private Medical Practice"

"PERSONAL HEALTH INFORMATION"

In this Handbook, "personal health information" means:

- *health information about a patient or a third party obtained by a health service provider from a patient or a third party in the course of providing a health service; or*
- *An opinion formed by a health service provider about a patient (whether true or not) which is in a form where the identity of the person is apparent, or can reasonably be ascertained.*

This includes information on the person's

- *name, address and contact details;*
- *medical history;*
- *Medicare number or Centrelink/social security details;*
- *other patient identifier, if any;*
- *social circumstances;*
- *health services requested or provided;*
- *Expressed wishes about the future provision of health services.*
-

"PRACTICE"

In this Handbook, the term "practice" refers only to medical practices that operate as a single functional unit for the purposes of patient care, practice management and accreditation, and not to groupings of individual medical practitioners. The practice may operate under one of a range of different business structures, including a company, unit trust or partnership. The practice should have a single privacy policy, one person within the practice who is responsible for overseeing the implementation and effective operation of the privacy policy, and a single point of contact for privacy issues.

Medical practitioners who work within practices that do not meet these criteria must each take individual responsibility for meeting the minimum privacy standards required by law, and implement an appropriate privacy policy for their individual medical practice

For the purposes of this guideline:

- *“Use” means the use of personal health information by the medical practitioner who collected the information or, in the case of a practice operating as a single professional unit, by the practice; and*

- *“Disclosure” means the release of the information to a third party.*

Subject to certain limited exceptions, personal health information held by medical practitioners can only be used or disclosed

- *for the purpose for which it was collected; or*

- *For another directly-related purpose that is within the reasonable expectations of the patient.*

Personal health information can be used or disclosed to others for some other purpose if:

- *the patient concerned has consented to the use or disclosure: or*

- *the medical practitioner reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual’s life, health or safety, or a serious threat to public health or public safety; or*

- *the use or disclosure is required or authorised by law;*

- *the use or disclosure is necessary for law enforcement or to report actual or suspected unlawful activity to relevant authorities;*

- *the use or disclosure is necessary for medical research and is carried out in accordance with applicable guidelines and with the approval of a Human Research Ethics Committee (see section 8)*

Any disclosure should be limited to that which is authorised or required in order to achieve the desired objective.

The general principle governing the use or disclosure of all personal health information is that the patient must understand what the medical practitioner proposes to do with the information and must agree with this proposed use. Only in certain very limited circumstances does applicable privacy legislation permit the use or disclosure of personal information without the consent of the individual concerned. The exceptions most relevant to private medical practice are listed above

“Lessening or preventing a threat to life or public health and safety

The consent of the patient is not required where the use or disclosure of the personal health information is necessary to lessen or prevent a serious and imminent threat to an individual’s life, health or safety, or a serious threat to public health or safety. This exception might apply in the case of mental illness, where the patient is threatening to harm other people, or where a person has an infectious disease that is likely to be transmitted to others. It has also been applied where a patient is “doctor shopping” (i.e. moving between doctors seeking drugs of dependence), and is the basis of the use of the “doctor shopping hotline.” If this exception is to be relied upon, medical practitioners must satisfy themselves that the disclosure of the information is the only effective way of averting the risk, and the consent of the patient should still be sought if it is appropriate and feasible to do so.

Disclosure required or authorised by law

There are not many instances where medical practitioners will be required or authorised by law to disclose personal health information to a third party without the patient’s consent. Some examples of this would be producing records in answer to a subpoena, giving evidence under oath in court, statutory disease notification, or reporting suspected child abuse or domestic violence. The specific legal obligations governing these situations vary from State to State. *[See Appendix 1]* Even where a medical practitioner is compelled by law to make the disclosure, it will usually be appropriate for the patient to be informed that the information has been disclosed (e.g. in the case of disease notification to public health authorities or complying with a subpoena) but this is a matter for the judgment of the medical practitioner based on the circumstances of each case. As a general rule, patients should be made aware of how their information is to be disclosed. However, there are clearly some cases (e.g. reporting suspected child abuse) where it would not be appropriate to tell the patient of the disclosure

Warning other medical practitioners about dangerous patients

Medical practitioners occasionally face risks to their own safety from disturbed or violent patients. These risks are particularly high in small general practices where medical practitioners may be alone for much of the time. There have been instances where a dangerous or violent patient, having been refused treatment at one practice, goes to another medical practitioner who may be unaware of the risk to his or her own safety.

Medical practitioners have a number of options in these circumstances. If they believe the patient presents a serious and imminent threat to the safety of other medical practitioners in the area, it would be permissible under relevant privacy legislation to warn other medical practitioners about the patient in question. The information disclosed should be factual and limited to the minimum necessary to convey an appropriate warning. In some cases, it may be appropriate to inform the police of the risk, particularly if the safety of the general public is threatened, and request their assistance in warning other medical practitioners. The disclosure to police would be justifiable under privacy legislation as being necessary for law enforcement. Finally, if the patient is mentally ill, there are of course procedures for involuntary detention and treatment under State mental health legislation

Competence to give consent

There are some patients who, because of illness or disability, are not competent to give consent for the collection, use or disclosure of their personal health information. In some States and Territories, the relevant privacy legislation authorises specific people, such as a legally appointed guardian or “authorised representative”, to consent to the collection, use or disclosure of personal health information on behalf of an incompetent patient. Other States have legislation appointing certain people as substitute decision-makers for medical treatment decisions for incompetent patients [*see Appendix 1*], and it would be reasonable to look to these people for consent in relation to the patient’s personal health information. In other cases, where there is no legally authorised decision-maker, medical practitioners should speak to the patient's relatives or carers to obtain their agreement to the proposed use or disclosure of the personal health information.

Care should be taken not to assume too readily that a patient is unable to make his or her own decisions about personal health information, by reason of illness or disability. Even where there is some impairment of understanding or communication, such that a substitute decision-maker is necessary, the patient should still be allowed to participate in the decision-making process to the greatest extent possible.”

Commonwealth Privacy Act

National Privacy Principle 2

2. Use and disclosure

2.1 An organisation must not use or disclose personal information about an individual for a purpose (the ***secondary purpose***) other than the primary purpose of collection unless:

(a) Both of the following apply:

(i) the secondary purpose am related to the primary purpose of collection and, if the personal information is sensitive information, directly related to the primary purpose of collection;

(ii) The individual would reasonably expect the organisation to use or disclose the information for the secondary purpose; or

(b) The individual has consented to the use or disclosure; or

(e) The organisation reasonably believes that the use or disclosure is necessary to lessen or prevent:

(i) a serious and imminent threat to an individual's life, health or safety; or

(ii) A serious threat to public health or public safety; or

(f) the organisation has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities; or

(g) The use or disclosure is required or authorised by or under law; or

(h) The organisation reasonably believes that the use or disclosure is reasonably necessary for one or more of the following by or on behalf of an enforcement body:

(l) the prevention, detection, investigation, prosecution or punishment of criminal offences, breaches of a law imposing a penalty or sanction or breaches of a prescribed law;

(iv) The prevention, detection, investigation or remedying of seriously improper conduct or prescribed conduct;

Note 1: It is not intended to deter organisations from lawfully co-operating with agencies performing law enforcement functions in the performance of their functions.

Note 2: Subclause 2.1 does not override any existing legal obligations not to disclose personal information. Nothing in subclause 2.1 requires an organisation to disclose personal information; an organisation is always entitled not to disclose personal information in the absence of a legal obligation to disclose it.

2.2 If an organisation uses or discloses personal information under paragraph 2.1(h), it must make a written note of the use or disclosure.

Part 3: Duty of care issues

Case law has long recognized that:

- a doctor owes a duty of care to the patient
- a doctor can also owe a duty of care to persons **other than** the patient and that
- the doctor can be legally liable for injuries suffered by those persons as a result of acts and omissions of **the patient**

At the same time, case law also recognized that no one (including) doctors owes a duty to the world at large. Nor (with limited statutory exceptions) do doctors have a duty to come to the rescue of “strangers” in actual or potential peril.

So where does that put us when seeking to identify the nature and scope of the member's duty when managing the violent/aggressive patient? The duty, for present purposes, is potentially owed to the following categories of persons in the following settings:

- **the patient.** Because of the delay arising from the refusal to treat, the patient suffers harm. Sometimes, the patient will allege that the violence/aggression was itself caused by underlying, undiagnosed or under-treated illness. At other times, the violence/aggression might be entirely unrelated to the presenting physical condition, but the patient will allege that the presenting illness was mismanaged by the doctor. And very occasionally, the patient may allege that because the doctor failed to recognize and manage the underlying mental problem that caused the violence/aggression, the patient was involved in later violent conduct (and subsequent prosecution under the criminal law) for which the negligent doctor (rather than the ill patient) should be responsible.
- **employees or fellow members of staff.** The most usual scenario is that the doctor-employer fails to have in place reasonable systems to prevent or minimise injury to staff caused by violent/aggressive patients. An alternative scenario is that the employee alleges that they were injured by the violent/aggressive patient because the doctor negligently failed to properly manage that patient.
- **health care professionals to whom the member proposes to transfer care, once they end the relationship.** The duty of care question is

whether the referring doctor owes the new doctor a duty to warn about the patient's violence/aggression. And a related issue is whether the new doctor can sue the referring doctor for breach of that duty if in fact they are injured by that violent/aggressive patient in circumstances where the referring doctor failed to put the new one on notice of that risk.

- **other healthcare professionals who, in the member's opinion, are or may be at risk.** This could be both the other healthcare professionals involved in current or future treatment, or other general practitioners from whom treatment might be sought once the member ends the relationship. That latter category is particularly problematic, as it is not necessarily confined to general practitioners in the immediate vicinity (whatever "immediate" might mean).

Duty of care issues relevant to the patient

Putting the patient first?

Peak bodies have issued numerous ethical guidelines emphasising, in short, that the patient comes first.

But in doing so, they also recognize that this has limits, and that the doctor must also look after themselves—and their staff.

Example: "Good Medical Practice: Guidelines on Professional Conduct"

For example, the publication "Good Medical Practice: Guidelines on Professional Conduct" (December 2006) contains the following:

"b. Putting patients first:

- taking reasonable steps to protect yourself before investigating the patient's condition or
- providing treatment, if they pose a risk to your health or safety
- acting in your patient's best interests when making referrals and providing or arranging treatment or care

g. If the doctor/patient relationship deteriorates:

- do your best to maintain a relationship of trust with your patient
- ensure that arrangements are made quickly for the continuing care of the patient, if you decide it is no longer appropriate to continue the doctor/patient relationship
- transfer relevant medical information to the patient's new doctor on request"

Duty to patient

a. Terminating the encounter because of the violence/aggression

Consistent with the Good Medical Practice Guide, your member is entitled to end a clinical encounter because of patient violence/aggression.

However, in doing so, the member needs to bear in mind several matters:

- it is desirable that they ensure the patient understands why the encounter is being ended, and in particular that the patient's behaviour is unacceptable, and detrimental to management of their health (though of course sometimes it will be obvious to the patient why the encounter has come to an end)
- the member should also seek to ensure any resulting delay in treatment /investigation will not harm the patient
- and if they do have concerns about the potentially harmful effects of the delay, they need to explain that to the patient, if practicable (and document that discussion).

In this way, the member will be seen to discharge their duty of care to the patient. (And it must not be forgotten that the patient **also** should exercise reasonable care for their own health, and in my view this extends to allowing their treating health professionals to do their job properly).

b. terminating the relationship because of the violence/aggression

i. When can the member terminate the relationship?

It is clear that your members are entitled to end a clinical relationship, but only in appropriate circumstances.

For example, The Medical Practitioners Board of Victoria (MPBV) says the following, in relation to terminating long term patient-doctor relationships (presumably, the MPBV considered termination of “short-term” relationships less problematic):

“...Early warning

There may be circumstances in which it is appropriate for the doctor to inform the patient that they are considering terminating the therapeutic relationship and to explain the reasons for this. This is particularly relevant when the patient's behaviour has been unacceptable, but can be changed. For example, in the case of abusive behaviour, or failure to attend booked consultations, a warning might alert the patient that such behaviour is not acceptable.

Non-compliance

A patient's failure to comply with recommended treatment, particularly when that treatment is considered to be necessary for the patient's well-being, may cause a doctor to feel compromised. An open discussion about the patient's condition, the reasons for the treatment and the likely outcomes of non-treatment will inform the patient so that he or she can reach a decision about treatment on the basis of full information. Such a discussion should be carefully documented. If the doctor feels that the patient's non-compliance compromises them to the extent that they cannot provide ongoing care, it is important that they communicate this to the patient so the patient can consider their options.

Relationship breakdown

Sometimes, the relationship between the doctor and the patient breaks down. Regardless of why this has happened, it is acceptable – and sometimes advisable – for the doctor to end the therapeutic relationship, provided the patient is referred for alternative care if this is required.

...

Communicating the decision

As with all aspects of clinical care, a thoughtful and considered approach, including clear communication, will help minimise any potential harm to the patient and negative impact on the doctor.

In communicating the decision to terminate a therapeutic relationship, the doctor needs to make every effort to ensure the patient

understands what is being said. It is usually better if the decision is communicated face-to-face, even if this is difficult.

If the reasons for terminating the relationship are sensitive, it might be appropriate to have another person present at the meeting. In some cases it might be best for another doctor in the practice to talk the patient through the treating doctor's decision. If telling the patient face-to-face is not possible, doctors should at least inform the patient of their decision in a sensitively written letter that explains that it is no longer constructive for the doctor to treat the patient. Patients should not be informed of the doctor's decision at the reception desk next to a crowded waiting room.

Referral

If the patient requires ongoing medical care, the doctor should offer them a referral to another treating doctor. The patient's new doctor should be provided with enough information from the patient's medical file to enable ongoing care and to prevent the patient needing to submit to further tests and investigations unnecessarily. This might require photocopying the entire file or, if confidentiality is an issue (for example as a result of information contained in third party reports), providing a summary of the file may be appropriate.

Terminating an established therapeutic relationship can be difficult. It is important that communication is clear and unambiguous, the process is documented and the patient's long-term medical needs are not compromised.”

Your members should ensure that they take the MPBV’s advice.

ii Duty of care issues when terminating the relationship

As the MPBV publication observes, a critical question is whether the patient will or may suffer harm as a result of the transfer or any resulting delay in investigation, treatment etc .

For this reason, it is clear that not all ostensibly identical episodes of violence/aggression justify or require the same approach. Sometimes, the violence/aggression reflects an underlying clinical problem or clinical need. The member either needs to address that need or ensure that it can be addressed in a timely way by others.

For example, the NHS in its publication "Policy for Withholding Treatment from Violent and Abusive Patients in NHS Trusts" outlined the circumstances in which it felt it was inappropriate to an end clinical relationship (admittedly in a public hospital setting, which often raises quite different issues than general practice):

"There will be circumstances where withholding treatment will be inappropriate...

3.1 Those patients who, in the expert judgement of the relevant clinician, are not competent to take responsibility for their actions, will not be subject to this procedure, e.g. an individual who becomes abusive as a result of an injury or illness. In situations where clinicians are not involved in the delivery of a particular service, for example, the Safe Project, then a manager who is expert in that specialty will be responsible for providing expert judgement.

3.2 Patients / clients who are mentally ill and, as a feature of their illness, may be under the influence of drugs or alcohol.

3.3 Patients who, in the expert opinion of the relevant clinician require urgent emergency treatment

3.4 Patients who are aged 16 years or under, other than in exceptional circumstances.

3.5 Patients / clients where behavioural problems (which may include violent, aggressive and abusive behaviour) are a product of their medical or psychological condition, requiring support from clinical services in this Trust. Each of these patients will have a management plan in place, based on a risk assessment.

NB. Violence and abuse which is detrimental to the patient / client's care and prevents either the individual themselves, or other patients, from deriving benefit from the service, should be considered as a reason for transferring the patient to another health service which may meet the patient / client's needs more effectively.

A decision to transfer or refer a patient / client to another health service will be made on clinical need...."

Duty of care issues relevant to staff and colleagues within the practice

The toolkit already addresses these issues, in the context of occupational health and safety obligations

Duty of care issues relevant to healthcare professionals outside of the practice

i. The threshold questions

The College (and for that matter members) may feel particularly apprehensive about this issue, particularly in light of the long history of case law (mainly American) which has found healthcare professionals guilty of negligence where they fail to notify other people about their patient's violent propensities. The most famous of these cases is *Tarasoff (Tarasoff v Regents of University of California 551 P 2d 334 (1976))*, which I discuss later.

However, before we look at this line of authorities (which in my view are of only limited relevance for current purposes), we first need to address some threshold factual, practical and legal concepts which must inform your members' decision-making processes in this area

I previously noted the broad spectrum of behaviours covered under the concept of violence and aggression. For this reason, it seems to me that before we even get into analysing the difficult issues of duty, your members on each occasion must first work through several threshold questions:

- What was the nature of the violent/aggression?
- What was the harm suffered, or the harm that could have been suffered?
- What is the likelihood that it will happen again with this patient?
- And what is the likelihood that it what will happen again with this patient in other healthcare settings, with other healthcare professionals?

If the episode was isolated and was in the reasonable view of your member not the sort of thing that would happen again, then it seems to me they need not and should not notify anyone else.

Similarly, even if the incident is likely to happen again but there is a low risk of harm, then it is unlikely in my view that the members' failure to notify

constitutes a breach of the duty. However, if that low risk relates to a significant harm, the answer may be different.

ii Duty of care to third-party issues

While there certainly are situations where a negligent general practitioner can be found to have owed (and breached) a duty to prevent a patient from harming a third person, they are rare. And, for the reasons I outlined below, they will very rarely if ever impose upon your members a duty of care to notify other doctors about the patient's propensities.

The case law reveals many situations in which this duty arises, only some of which are relevant to the toolkit. However, the most common scenario (for current purposes) is where, through negligent misdiagnosis or negligent late diagnosis, the doctor fails to diagnose an illness/disease etc, and as a result the patient harms a third person (for example, through transmission of an undiagnosed infectious disease, or through violence occasioned by an undiagnosed or mismanaged mental illness).

In these sorts of cases, the duty has been imposed because the doctor was negligent in failing to properly manage, treat, diagnose or control the patient, with the result that the patient later caused harm to other people.

This is different to the situation where your member manages, in a **non-negligent way**, the patient interaction (during which the patient was violent/aggressive) but where the member has concerns that that patient's behaviour could harm other people (doctors) later.

Tarasoff does not represent Australian law

Although there have been overseas cases (most notably Tarasoff) where the healthcare professional has been found to have owed and breached a duty to third persons in relation to the known violent propensities of their patient, Australia law has tended not to adopt this position.

And critically, the authorities and commentaries (both local and overseas) which have reviewed Tarasoff and similar cases have generally only imposed a duty where there was a known, imminent risk to an identifiable person (as opposed to a theoretical, possible risk to a range of persons simply because

the patient displayed violence/aggression in their interactions with your member).

Impact of tort law reforms

Of course, these authorities now need to be seen in light of the recent wave of Australian tort law reforms. While those reforms are not absolutely consistent nationally, they do have in common the fact that they in practice mean that it is now harder for patients to start legal proceedings against their doctors; it is harder for them to win those proceedings; and when they do when, they probably don't receive as much as they used to.

The most potentially relevant of the tort law reforms deals with the statutory formulation of the duty of care. Most jurisdictions have now adopted the position that a person is not negligent for failing to take precautions against a foreseeable risk unless that risk is "not insignificant" and a reasonable person in the same position would have taken precautions (taking into account the probability, likely seriousness, the burden of taking risks and the social utility of the risk-creating activity).

Importantly, this new position largely reflects the circumstance-specific approach of the previous common law.

Duty to third persons: conclusions

For these reasons, unless and until your members have reason to believe that their patient has "targeted" a specific doctor or group of doctors, there is in my view little basis upon which your member could face negligence exposure in the unhappy event that that violent/aggressive patient actually did harm another doctor.

As I mentioned above, however, the situation would be different if your member negligently mismanaged the case by, for example, failing to arrange for the police to apprehend and transfer the patient to a psychiatric ward (assuming the underlying mental illness justified that action) or is some other way negligently misdiagnosed or mismanaged the clinical aspects of the encounter.

And where your members do have reason to believe that a colleague is at risk of serious and imminent harm, the appropriate step is **not** for your members

to work out which of their colleagues they need to notify, but rather to notify the police and, if necessary, to expressly ask the police to help in notifying the other doctors.

And where the violence/aggression is caused by psychiatric illness which justifies involuntary detention under local mental health laws, then the police can again be asked to assist.

The more difficult arise issue arises where the violence/aggression is caused by psychiatric illness but that illness does not justify involuntary detention and treatment. In these circumstances, there is certainly a threat that the patient could harm, among others, the doctor to whom care is transferred ...or for that matter any other doctor with whom they engage. I previously discussed, in the setting of privacy, the options open to a doctor who wants to disclose information to a colleague who is about to take over care.

To conclude, it will only be in very rare situations that your member may truly be under a legal duty of care to notify other doctors (either the new treating doctors or any others) about a violent/aggressive patient. First, Australian case law generally tends not to impose such duties, and when they are imposed it is only likely to be when the threat is real, immediate and to an identifiable person. Secondly, when the stakes are high, the appropriate response more often than not is to liaise with and through the proper authorities (the police) and let them intervene as and when appropriate.

Part 4: Discrimination Issues

The toolkit advocates a range of risk management initiatives to control or minimise patient violence/aggression.

Some of those initiatives involve the identification of "problem patients" and the introduction of a range of strategies to deal with them.

Patients can be violent and aggressive for a range of reasons, some of which relate to underlying illness and disability. Indeed, among the most challenging patients are those suffering from delusions brought about by their psychiatric illness or the medication to treat that illness.

In these circumstances (**but only** in the circumstances... and **not** where, for example, the violence/aggression is unrelated to an underlying disability), the potential legal issues that arises is whether the proposed risk management initiatives are unlawfully discriminatory against people suffering from those underlying disabilities.

Discrimination and ethics

The AMA Code of conduct states, at clause 1.1(j) that doctor's must:

"... refrain from denying treatment your patience because of the judgement based on discrimination. "

Discrimination and the law

State and federal anti-discrimination legislation prohibits behaviour that amounts to discrimination. While that legislation deals were several forms of discrimination, the most relevant for current purposes is disability discrimination. At Federal level, this is governed by the Disability Discrimination Act 1992 (**DDA**)

The definition of "disability" in the DDA includes:

- Physical
- Intellectual
- Psychiatric
- Sensory
- Neurological, and
- Learning disabilities, as well as
- Physical disfigurement, and
- The presence in the body of disease-causing organisms.

This broad definition is meant to ensure that everyone with a disability is protected. Obviously, many of your members' patients suffer from these disabilities. And sometimes, those disabilities will in turn cause or contribute towards patients' violence/aggression. (Importantly, sometimes the violence/aggression will be quite **unrelated** to those disabilities. In those cases, the discrimination laws are not triggered).

The DDA makes it against the law for providers of goods, services and facilities to discriminate against a person because of his or her disability. Your members provide "services" within the meaning of this definition.

This means that your members cannot:

- Refuse to provide a person with a disability with services and facilities.
- Provide services on "less favourable" terms and conditions.
- Provide the services "in an unfair manner".

It also means that a person with a disability has a right to enter your members' premises if people without a disability can do so.

These laws must inform and be reflected in the violence/aggression-related risk management practices of your members.

The toolkit

It follows from these definitions that the "toolkit topics" that could potentially generate difficulties under discrimination law include the following:

- refusing to treat, or ending the relationship
- agreeing to treat, but imposing discriminatory conditions as a precondition of such treatment

However, the "flagging" of patient files does not of itself constitute an unlawfully discriminatory practice under these laws.

Two types of discrimination

There are two types of discrimination under the DDA, both of which are potentially relevant to current purposes.

1. Direct discrimination It is discrimination under the DDA to treat a person less favourably, because of his or her disability, than a person without that

disability would be treated in the same or similar circumstances. The offence is described in section 5 of the DDA, as follows:

“5. (1) For the purposes of this Act, a person ('discriminator') discriminates against another person ('aggrieved person') on the ground of a disability of the aggrieved person if, because of the aggrieved person's disability, the discriminator treats or proposes to treat the aggrieved person less favourably than, in circumstances that are the same or are not materially different, the discriminator treats or would treat a person without the disability.

(2) For the purposes of subsection (1), circumstances in which a person treats or would treat another person with a disability are not materially different because of the fact that different accommodation or services may be required by the person with a disability. “

2. Indirect discrimination –this happens where the same treatment applies to people with and without a disability but the impact is to disadvantage or exclude people with a disability in a way which is not reasonable. The offence is described in section 6 of the DDA, as follows:

“6. For the purposes of this Act, a person ('discriminator') discriminates against another person ('aggrieved person') on the ground of a disability of the aggrieved person if the discriminator requires the aggrieved person to comply with a requirement or condition:

(a) with which a substantially higher proportion of persons without the disability comply or are able to comply; and

(b) which is not reasonable having regard to the circumstances of the case; and

(c) with which the aggrieved person does not or is not able to comply”

Indirect discrimination includes:

- where there is a condition or requirement imposed before the member is willing to treat which may be the same for everyone, but which unfairly excludes or disadvantages people with disabilities in a manner that is unreasonable

- when a person treats another unfavourably on the basis of a characteristic that applies generally to people who have such an impairment (e.g. a member refuses to treat a patient presenting with a history of paranoid schizophrenia)

Management of the violent/aggressive patient, and direct discrimination

If your members' risk management activities were unlawfully discriminatory, most of them would probably constitute direct rather than indirect discrimination.

The key elements of this are as follows

- your member treats or proposes to treat the patient less favourably than they would , in circumstances that are the same or not materially different, patients without that disability
- your members do so because of the patient's disability

It would be tempting for your members to assume that this has no relevance to the way they manage violent/aggressive patients, for the following reasons:

- Some less obvious forms of risk management may in fact not result in the patient being treated "less favourably" (this is probably correct, but it does not apply to, for example, refusal to treat)
- All other patients are not violent/aggressive. Therefore, and by definition, the problems posed by violent/aggressive patients are never "circumstances that are the same or not materially different". In fact, they are **critically** different, and therefore the provision is not breached
- If there is differential treatment, that is not because of the disability, but in fact because of the violence/aggression. In other words, the member would argue that they are not discriminating on the grounds of disability, but rather simply responding to an actual or perceived threat of violence/aggression.

Unfortunately, the case law, and for that matter the statutory wording, makes it difficult to sustain these arguments. I discuss these below.

But first, some good news:

These issues do not arise where the violent/aggression is unrelated to a patient's disability

As discussed earlier, patients can be violent/aggressive for a range of reasons, many of which are entirely unrelated to any underlying or related disability.

When no such link exists, these discrimination laws have no operation so far as your members' management of violent/aggressive patients is concerned.

And even where they operate, these discrimination laws do not require your member to accept or abide by patients' criminal acts

The case law makes it clear that discrimination laws do not mean that your members need to accept criminal conduct.

Purvis

The leading case in this area is *Purvis v NSW* (2003) HCA 62, a decision of the High Court of Australia.

Purvis involves a State school's decision to expel a violent/aggressive student whose behaviour arose because of his disability. Among the grounds relied on by the school to expel the student (and your members could adopt similar grounds to refuse to treat some violent/aggressive patients) was the fact that it had duty of care and occupational health and safety obligations to its staff and other students (i.e. patients).

The case came to the High Court on appeal, after the Human Rights and Equal Opportunity Commission found that the school had discriminated against the student by failing to accommodate his disability and that this failure led to his suspensions and ultimate exclusion from the school. The Commissioner held that the student's behaviour was so closely connected to his disability that less favourable treatment on the ground of his behaviour was discrimination on the ground of his disability. The Commissioner also held that, to determine the discrimination issue, the student's treatment by the school had to be compared to that of a student without his disability and therefore without his disturbed behaviour. The Commissioner found that the school had failed to accommodate the student's disability in 3 ways.

- Failing to adjust its draft welfare and discipline policy
- failing to provide teachers with training all an awareness programme

- failing to obtain the help of experts

The High Court

Fortunately, the High Court judges recognized that these discrimination laws do **not** require your members (among others) to tolerate or accept criminal acts.

For example, the Chief Justice recognized that:

“The law does not regard all bad behaviour as disturbed behaviour; and it does not regard all violent people as disabled.”

In their joint judgments, Gummo, Hayne and Heydon JJ stated:

“...there will be cases where criminal conduct for which the perpetrator would be held criminally responsible could be seen to have occurred as a result of some disorder, illness or disease. It follows that there can be cases in which the perpetrator could be said to suffer a disability within the meaning of the Act. It would be a startling result if the Act, on its proper construction, did not permit an employer, educational authority, or other person subject to the Act to require, as a universal rule, that employees and pupils comply with the criminal law. Yet if the appellant's submission is right, the "circumstances" to which s 5(1) refers can include no reference to disturbed behaviour (even disturbed criminal behaviour) if that behaviour is a characteristic of, or consequence of, the actor's disability. Understanding the operation of the Act in this way would leave employers, educational authorities, and others subject to the Act, unable to insist upon compliance with the criminal law without in some cases contravening the Act...”

Similarly, Callinan J observed:

“Let me assume for present purposes that the appellant's argument that a person's behaviour in consequence of that person's disorder falls within the definition of disability, or, more specifically, that the behaviour is itself a malfunctioning of part of the body, the brain, within the meaning of par (e) of the definition of disability. Even on that assumption, the Act cannot be sensibly read, in my opinion, as extending to behaviour which constitutes criminal or quasi-criminal conduct. If it were intended to include, as a disability behaviour which was criminal,

itself a startling proposition, then the legislation would surely have said so in clear terms, if of course constitutionally it could operate to impose toleration of criminal conduct on a State educational authority. The conduct in question here was of a criminal or quasi-criminal kind, including as it did, offensive language and assaults. The definition of disability is not to be read as covering criminal or quasi-criminal behaviour. And by criminal behaviour I do not mean only behaviour not excusable by reason of an absence of mens rea (necessary intent to commit a crime). Whether there may or may not be such a defence available is a different matter from the nature of the physical acts which, on their face, involve unlawful behaviour. If it were otherwise, behaviour with a capacity to injure, indeed even kill someone, or to damage property (by, for example, burning a school down) could be excused, and the first respondent bound to tolerate it, or seek to abate it, no matter how difficult, disruptive, expensive, or ineffectual measures for abatement might be. It is impossible to believe that the legislature intended such a result, particularly as it has acknowledged in s 3 of the Act that its objectives are to achieve what is practicable and possible..."

The potential challenge, where the violence/aggression relates to a disability

A key complicating factor is that importantly (and somewhat confusingly) the statutory definition of disability extends not just to the condition itself but **also** to the **consequences** of that condition. In particular, s 5(g) of the DDA includes within the definition of "disability":

"... the disorder, illness or disease that affect a person's thought processes, perception of reality, emotions or judgment **or that results in disturbed behaviour**" (emphases added)

So on that basis, the patient could argue that the violence/aggression is itself part of the disability, because the definition above captures not only the disability's cause but also its consequence ("... that results in disturbed behaviour").

In addition to this complicating factor, the cases that have considered the provision have also struggled to settle on several other threshold matters which are relevant to the operation of these laws with respect to violent/aggressive patients.

For example, the statute in effect provides that a member (the discriminator) discriminates against an aggrieved patient on the ground of a disability if, because of the aggrieved patient's disability, the discriminator treats the patient less favourably than the discriminator would treat a person without the disability in the same circumstances.

Two related questions arise.

1. First, in comparing the treatment of the patient with the treatment that would be given to a person (another patient) without the disability in the same circumstances, what if anything is the other patient to be assumed to have done? In other words, is the comparison to be undertaken with:

- another patient who is not violent, or in fact with
- another patient who **is** violent, but where their violence has nothing to do with their disability?

2. Secondly, was the supposedly less favourable treatment of the patient because of (on the ground of) the disability?

The relationship between those two questions exists because the patient's disability is not merely a physical condition, but a physical condition that results in disturbed behaviour.

The good news for your members is that it does seem that the answer to the first question requires a comparison between a violent/aggressive patient on the one hand, and a **non**-violent/aggressive patient on the other. (as opposed to comparison with patient without disability but who also happens to be violent/aggressive).

Defences

Importantly, even if a member's practice is found to be unlawfully discriminatory, the member may still be able to rely on one of two defences:

1. Unjustifiable hardship A defence of "unjustifiable hardship" may be available with respect to both forms of discrimination. The DDA does not define unjustifiable hardship but rather states (section 11) that:

“...in determining what constitutes unjustifiable hardship, all relevant circumstances of the particular case are to be taken into account”, including

- the nature of the benefit or detriment likely to accrue or be suffered by any persons concerned
- the effect of the disability of a person concerned
- the financial circumstances and the estimated amount of expenditure required to be made by the person claiming unjustifiable hardship
- in the case of the provision of services, or the making available of facilities - an action plan given to the Commission under section 64.”

2. (Indirect discrimination) reasonable in the circumstances In addition, a defence to indirect discrimination, as noted above, is available where the differential treatment is "reasonable".

The case law establishes that the following principles are relevant to determining what is reasonable in the circumstances:

- The test of reasonableness is an objective one, which requires the Court to weigh the nature and extent of the discriminatory effect, on the one hand, against the reasons advanced in favour of the condition or requirement, on the other. Since the test is objective, the subjective preferences of the aggrieved person are not determinative, but may be relevant in assessing whether the requirement or condition is unreasonable: The test of reasonableness is less demanding than one of necessity, but more demanding than a test of convenience. It follows that the question is not whether the decision to impose the requirement or condition was correct, but whether it has been shown not to be objectively reasonable having regard to the circumstances of the case:
- The Court must weigh all relevant factors. While these may differ according to the circumstances of each case, they will usually include the reasons advanced in favour of the requirement or condition, the nature and effect of the requirement or condition, the financial burden on the alleged discrimination of accommodating the needs of the aggrieved person and the availability of alternative methods of achieving the alleged discriminator’s objectives without recourse to the requirement condition: However, the fact that there is a reasonable alternative that might accommodate the interests of the aggrieved person does not of itself establish that a requirement or condition is

unreasonable: *State of Victoria v Schou* [2004] VSCA 71, at [26], per Phillips JA. (approved in *Catholic Education Office v Clarke* [2004] FCAFC 197 (6 August 2004)).

The toolkit and discrimination issues: conclusion

The key discrimination issues your members need is that occasionally, the violence/aggression arises from an underlying illness or disorder. Where that happens, not only the disorder but also its behavioral consequences constitute a disability at law, which in turn imposes certain obligations upon your members.

Happily, your members can comply with those laws through undertaking practices which display a commonsense and proportionate response to the perceived or actual threat. It follows from this that an inappropriate or disproportionate response is not only (and again) clinically inappropriate but is also legally dangerous.

Part 5: Emerging human rights issues

In addition to longstanding discrimination laws (which on one view constitute one form of human rights protection), there has been a very recent trend in Australia to formally embrace and recognize human rights laws. These laws will have only limited relevance to the toolkit. But they will become more important over time.

For example, Victoria is the first Australian state to enact a Bill of Rights, via the Charter of Human Rights and Responsibilities Act 2006. Earlier, the ACPT released The Human Rights Act 2004. It is likely that other States will also enact bills of rights in the future.

The rights in these documents are mainly derived from the International Covenant on Civil and Political Rights 1966, which Australia ratified in 1980. So far as the toolkit is concerned, the most relevant human rights endorsed in these new laws are:

- privacy and reputation
- freedom of expression

These new laws are likely to have wide-ranging and major effects on the laws of the jurisdictions in which they are proclaimed.

However, in my view they have only limited relevance to the toolkit at this stage. This is because the current models do not directly affect either the College or its members, but will certainly do so indirectly over time by, for example:

- requiring all statutes to be interpreted in light of these human rights principles;
- imposing, in the case of Victoria, special responsibilities on public authorities;
- requiring statements of compatibility with human rights to be prepared for Bills before Parliament.

To use the words of the Victorian Equal Opportunity Commission:

“The Charter is an agreed set of human rights, freedoms and responsibilities protected by law. Government departments and

public bodies must observe these rights when they create laws, set policies and provide services.

This means that Government, public servants, local councils, Victoria Police and others are required to act in a way that is consistent with the human rights protected under the Charter. These bodies will have to comply with the Charter and take human rights into account in their day-to-day operations”

(<http://www.equalopportunitycommission.vic.gov.au/human%20rights/the%20victorian%20charter%20of%20human%20rights%20and%20responsibilities/#Human%20Rights>)

So future laws, including those affecting the rights and obligations of doctors and patients, will undergo the scrutiny required by the new human rights laws. In that way, but **only** in that way, they will affect your members. It is therefore possible that in time, those human rights principles will affect laws that are relevant to the toolkit. But at this stage, that is not the case.

For these reasons, this is an emerging area of law, but not one which has a direct bearing (at least not yet) on the toolkit.

Part 6: Legal risks associated with "acceptable behaviour agreements"

Among the risk management initiatives recommended by the toolkit was the entering into of written agreements with the patient recording their commitment to abide by a set of behavioural standards.

Two questions arise in terms of legal risk:

1 Is it enforceable?

2. Might the use of such materials expose the member to censure, for example on the basis that there is some form of coercion, duress or undue influence involved in getting patients to enter into the arrangement?

I have been unable to find any legal authority examining the status, enforceability all propriety of these arrangements, which have been called many things, including acceptable behaviour contracts/agreements etc.

However, I have noted in the clinical literature numerous references to these sorts of arrangements, both locally and internationally.

Australian examples, OHS

For example, the Australian Institute of Criminology report "Preventing Client-Initiated Violence: a Practical Handbook" observes that:

"In Australia, a number of the OHS authorities have developed advice on to reduce the risks of client-initiated violence in the health-care industry. One recommendation from WorkCover New South Wales is that on admission, a code of behaviour should be made clear to all patients. This code should include curfew, visitors, drug and alcohol use, security and general conduct expectations. That is, clear messages must be given to clients about non-violence and any warning about the possibility of charges being laid may need to be repeated"

While this was a "hospital" rather than a "private practice" publication, that distinction seems not to be relevant in this particular setting. In other words, if it is legitimate and lawful in a hospital setting a New South Wales, it is equally legitimate and lawful elsewhere and in other settings.

International examples

Similarly, the UK Home Office has published a document on "Acceptable Behaviour Contracts or Agreements", describing them as follows:

"An acceptable behaviour contract (ABC) or Agreement (ABA) is an intervention designed to engage an individual in acknowledging their anti-social behaviour and its effect on others, with the aim of stopping that behaviour.

An ABC is a written agreement made between a person who has been involved in anti-social behaviour and their;

- local authority
- youth inclusion support panel (YISP)
- landlord
- local police force

ABCs are not set out in law, which is why they are usually referred to as 'agreements'. The two terms – Agreement and Contract - are interchangeable and practitioners should use whichever term they feel will achieve the desired outcome with the perpetrator."

(<http://www.respect.gov.uk/members/article.aspx?id=7820>)

Notably, the Home Office seeks to emphasise that these arrangements "are not set out in law". By this, I gather they are seeking to emphasise – and concede – that these are not legal agreements, and are therefore not legally enforceable.

Despite this, it is noteworthy that the Home office was happy to be seen to encourage the use of the expression "contract"... so long as it achieved the desired outcome. In other words, the Home Office was focused on achieving a practical risk management solution.

While the Home Office did not deal specifically with health care, others in the UK have: in its report "Preventing violence in general practice: a Handbook for professionals" (www.south-wales.police.uk), the South Wales Working Group on Violence in General Practice deal with these agreements in the following way:

"An Acceptable Behaviour Contract should be considered:

1. Where a patient shows early signs of inappropriate attitude or behaviour

2. As an alternative to removal of the patient from the GPs Medical List in the case of a less serious incident

3. When any patient who has been attending an Alternative Primary Care Facility is discharged to register with a GP in the normal way

Sample contract

The report then provided a sample contract, in which the patient is required to sign a document stating that:

“1. I will not threaten or abuse doctors and other surgery staff (this includes swearing).

2. I will not threaten or abuse other patients (this includes swearing).

3. I will not damage any property or write graffiti in and around the surgery / medical centre.

4. I will not act in a manner that causes or is likely to cause harassment, alarm or distress to doctors, surgery staff and other patients.

Breach of this Contract:

If(the Patient) does anything which he / she has agreed not to do under this contract the with Practice, he / she can expect to be:

1. Removed from the above doctor’s list.

2. Reported to the police with view to charges being brought against him / her.

3. Considered by the Health body for listing under the Violent Patients regulations which could mean that he / she will be allocated to a surgery / alternative primary care scheme at which he will only be seen by a doctor when the police are in attendance...”

Having advocated this robust position, the report did concede also that:

"Legal advice should also be sought during the development of local violence prevention and management policies and procedures to ensure that they comply with all relevant legislation."

Conclusions

In my view, the position adopted by these UK publications is precisely the position the toolkit is taking, and should continue to take. These strategies do not necessarily form (and should not seek to form) formal legal contracts, but rather form one of many of risk management strategies aimed to bring about cooperation and acceptable behaviour.

And it is also important to emphasise the non-contractual nature of these arrangements given the various clinical settings in which violent/abusive behaviour might happen. Included among these are situations where the perpetrator may well lack relevant capacity, either permanently or temporarily, to enter into a contract.

In short:

- These initiatives do not form legally binding contracts, and may therefore be unenforceable if tested in court
- Regardless of how your members title or characterise the arrangement, the key message is that the behavioural demands imposed by the arrangement need to be reasonable, rather than unfair, disproportionate or onerous (which would run the risk of, among other things, constituting indirect discrimination where the behavioural challenges arose from patient disability). Clearly, therefore, this particular risk management intervention, like many others, needs to be circumstance-specific. Having said that, the terms identified in the sample contract above seem to me to be entirely reasonable and appropriate in the vast majority of circumstances

Part 7: Defamation issues

Another risk is that the patient might argue that the disclosure of information about their violent/abusive behaviour has unlawfully defamed them.

Here I am dealing specifically with the risks arising from disclosure to fellow healthcare professionals. The issues are different when it comes to notification to the police: in the latter situation, a crime is being reported to the relevant and responsible authorities (though it does raise privacy and confidentiality issues, discussed elsewhere in this advice). In the former situation, the member is not notifying authorities but is simply seeking to give colleagues, either internally or externally, a “heads-up” about the risk of similar behaviour occurring in their possible future interactions with the patient.

Before going any further, your members will need to understand that an absolute defence to defamation is truth (other defences are available as well, which I discuss below). In other words, if your member tells a colleague that the patient is vicious and dangerous; the patient cannot sue for defamation if that patient is in fact vicious and dangerous.

I have no doubt that your members will be able to capably and responsibly identify when there has been an episode of violence/abuse perpetrated by a patient.

That, however, is not the key legal risk from a defamation perspective.

Rather, the risk arises where the disclosure of the episode to a third person (called "publication" under defamation law) does more than simply recite the facts but conveys further certain additional imputations and inferences which, so the patient would argue, were wrong and unjustifiable.

For example, the patient may argue (and may well argue correctly) that the violence/aggression was an isolated episode or was prompted by acts or omissions of the member or by certain personality difficulties between the member and the patient. They could argue that the member's decision to notify others, either the authorities or other health care professionals, carried with it an imputation that the violence/aggression was in fact not an isolated incident but was just as likely to occur with others and in other circumstances... and indeed, justified notification to other persons to put them on notice. In these circumstances, the imputation is that the patient, far from being involved in an isolated incident, has or might have a propensity towards violence/aggression, particularly towards healthcare professionals.

And given the very broad definition of "violence/aggression" adopted in the College toolkit, it is clear that we are dealing here with a very wide spectrum of behaviours. In that situation, a "one size fits all" approach to disclosure is clearly inappropriate but instead needs to be circumstance-specific.

Your members need to understand that before they notify other healthcare professionals, they need to have satisfied themselves that the episode may well not simply constitute an isolated, one-off event.

Once again, they need to exercise caution and commonsense, and to do so with at least a basic understanding of the legal framework within which the laws of defamation now function.

For that reason, I set out below a brief description of the way the laws operate and the defences that might be available to members where the patient alleges that the disclosed information about their alleged violence/aggression was defamatory of them.

New defamation laws

Defamation law is now uniform throughout each State and Territory in Australia. Material (both written and oral) is defamatory if it is likely to –

- injure a person's reputation, or
- Injure a person in their profession or trade

Whether material is defamatory involves determining what is meant by the material. Another way of putting this is to ask what "imputation" the material conveys. Having identified those imputations, the next task is to assess whether the meaning satisfies the definition of what is defamatory. In determining these issues, a court examines the natural and ordinary meaning of the words – how an ordinary person would interpret the material unaided by special knowledge.

Possible defences to defamation

The laws recognise that the need to protect reputation may sometimes be overridden by the public interest in freedom of speech and the availability of accurate information regarding public affairs. For these reasons, several defences are available to your members even if they do publish defamatory material about a patient.

For current purposes, the most relevant statutory defences are:

- a. Justification (truth),
- b. Contextual truth,
- c. Qualified privilege,
- d. Honest opinion,

These are in addition to any other defence or exclusion of liability available at common law (unless modified by the Acts) or under statute (unless repealed by the Acts).

Let me address briefly some of the most relevant defences to this particular matter.

a. Truth

One defence is that the defamatory imputations carried by a statement are substantially true. 'Substantially true' means true in substance or not materially different from the truth. A mere inaccuracy in detail which does not go to the substance of the imputation will not stop it from being substantially true.

b. Contextual truth

Contextual truth is now available to defendants both for contextual imputations that are separate and distinct, as well as those which are substantially similar to, the defamatory imputations the plaintiff complains about. The new defence is wider than was previously available. There is no public interest requirement.

c. Defence of honest opinion

These new laws do **not** prevent people from expressing honestly held (but wrong) opinions, **so long as** they can demonstrate that it was in the public interest for them to express that opinion. In order to rely on this defence, the member must prove that:

- The published matter was an expression of opinion rather than a statement of fact; and
- The opinion relates to a matter of public interest; and
- The opinion is based on proper material.

The Act does not define what ‘public interest’ means, so this defence will rely on the court’s interpretation of what is a matter of public interest. The common law has previously interpreted this as requiring a matter to relate to people in public office or within the public arena, performing public duties. In my view, this will probably:

- extend to discussions with the police, but
- not extend to discussions with other healthcare professionals

However, for this particular defence to apply, the member's statement must be an honest statement of opinion or comment, **not** a statement of fact. The test is: would an ordinary reader consider the statement to be one of opinion or of fact. This can be a surprisingly complex analytical area, involving the making of the most subtle and tortured intellectual distinctions.

Under the new laws, an opinion is based on “proper material” if the material in question:

- is substantially true; or
- was published on an occasion of absolute or qualified privilege (either under the Act or at common law);

d. Qualified privilege

For current purposes, this privilege protects the publication of material in the performance of a duty or to protect an interest. However, it only exists where there is a reciprocity of duty and interest between the publisher and those to whom the material is published. In my view, that reciprocity exists in member dealings with police, but not necessarily with respect to discussions between healthcare professionals in private practice.

Summary, recommendations and next steps

In this advice, I have sought to highlight and address the medicolegal issues and risks associated with the various risk management strategies explored in the toolkit.

If there is one unifying theme here, it is that your members absolutely should take steps to avoid and minimise the risk of violence/aggression from patients, but need to do so by exercising a proportionate, commonsense approach

which continues to respect privacy and confidentiality and which recognizes relevant member duties and relevant patient rights.

More often than not, through the implementation of commonsense risk management initiatives your members should be able to protect themselves and their staff without breaching any laws. But some risk management strategies can be more problematic than others. And when they arise, your members should seek help and advice from their medical defence insurer. As with any medical legal (and, I suspect, clinical) issues, it all comes down to a circumstance-specific solution.

With thanks,

Bob Milstein

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