

## Medical Director Responsibilities Regarding Disruptive Behavior in the Dialysis Center—Leading Effective Conflict Resolution

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### ABSTRACT

Medical directors are directly or indirectly responsible for everything that occurs in a dialysis facility. The proposed Conditions of Coverage require medical directors to oversee the process resulting in involuntary discharges from the facility. Involuntary discharges result in high costs to the patient, family, facility and payers. Consequently, End Stage Renal Disease (ESRD) Networks oversee individual facility involuntary discharge rates. A large national survey found that involuntary discharges were due to disruptive behaviors, most commonly nonadherence to medical advice. Medical directors should create an environment designed to assure that disruptive behavior

and conflict can be resolved. This is best done by using positive interventions before involuntary discharge, by developing policies and procedures that are implemented continuously and by continually teaching these principles. There are two excellent references about dialysis-related disruptive behavior and conflict resolution: (1) the Renal Physician Association's second guideline, "Shared Decision Making in the Appropriate Initiation and Withdrawal from Dialysis," and (2) The Dialysis Patient Provider Conflict Project. Both will aid medical directors meet their conflict-resolving responsibilities under the proposed, federal regulations.

Conflict between hemodialysis patients and dialysis healthcare professionals is inevitable given their chronic, recurrent, proximate, mutually dependent, and emotionally charged relationship. Increasing numbers of patient grievances submitted to ESRD Networks and increasing frequency of involuntary discharges suggest that dialysis-related conflict is escalating (1,2). In 2002, twelve ESRD Networks performed a survey about involuntary discharges from hemodialysis facilities. The survey provided information from 2889 facilities caring for 211,433 chronically hemodialyzed patients. The response rate was 94%. The three most common disruptive behaviors resulting in involuntary discharges in decreasing order of occurrence were: (i) "noncompliance" (26%), (ii) verbal or physical threat (19%), and (iii) lack of payment (8%). The survey found 22% of involuntarily dismissed patients used emergency rooms for their dialysis and 8% died. Twenty percent were lost to follow-up, so the survey probably underestimated morbidity and mortality. Experienced medical directors

know that dialysis-based conflict is costly in terms of time spent, rounding efficiency, patient-staff rapport, clinical performance measures, potential litigation, staff turnover, and patient satisfaction. Disruptive behavior resulting in involuntary discharge is a significant problem for patients, healthcare professionals, dialysis facilities, and payers. Successful conflict management is a quality of care issue.

The Proposed Federal Conditions for Coverage (pCoC) (3) make the dialysis center medical director responsible for nearly everything that occurs in the facility (4). The proposed regulations explicitly make the medical director responsible for the center's "discharge and transfer policies" (5). The Conditions propose "the medical director *monitor and review* (italics added) each involuntary patient discharge to ensure the patient's interdisciplinary team has performed the tasks required in CFR § 494.180(f)" (see Table 1) (6). ESRD Networks survey facility-specific involuntary discharge rates and provide technical assistance to centers with high rates.

As noted by the Network Survey, involuntary discharges result from disruptive behavior and unresolved conflict. The costs of involuntary discharges are high. If involuntary discharges are consequent to disruptive behavior and medical directors are responsible for involuntary discharges, then medical directors are indirectly responsible for managing disruptive behavior,

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**TABLE 1. Proposed requirements for the dialysis interdisciplinary team before involuntary discharge**

Proposed Conditions of Coverage requirements
Reassess the patient and document the ongoing problem(s) and effort(s) to resolve the problem(s)
Obtain a written physician's discharge order, which must be signed by the medical director and (if applicable) the patient's attending physician
Give the patient 30-day notice
Document that an attempt has been made to place the patient in another facility
Notify The State Survey Agency and the ESRD Network of the involuntary discharge of any patient

preferably with productive interventions as well as involuntary dismissal. How should medical directors meet those responsibilities? The pCoC requires the medical director to “assure the development of a patient care policy and procedures manual and its implementation” and to “assure adequate training of nurses and technicians in dialysis techniques” (Table 2) (7). Therefore, the medical director, and The Governing Body of the facility, should develop and impose policies and procedures for effectively dealing with disruptive behavior and conflict.

There are two excellent references describing dialysis-based disruptive behavior management and conflict resolution. The first is The Renal Physicians Association's second clinical practice guideline entitled, “Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis” (8). RPA members can obtain this guideline online. Nonmembers can buy the guideline for a nominal fee. The ESRD Networks have previously distributed this guideline to all of their regional dialysis facilities. Many Networks may have more copies available. The second resource is The Dialysis Patient Provider Conflict Resolution Project (DPC) (9).

**The Dialysis Patient Provider Conflict Project and Tool Kit**

Between 2003 and 2005, the DPC developed a tool kit for defusing disruptive behavior and resolving dialysis facility-based conflict, consistent with federal regulation, medical ethics, and statute. The project was created by The Forum of ESRD Networks to address the increasing national trend to involuntarily dismiss disruptive, mostly “noncompliant,” patients. The Forum of ESRD

**TABLE 2. Medical director responsibilities for managing disruptive behavior**

Medical director responsibilities
Adopt and utilize an accurate taxonomy and glossary for documenting and communicating episodes of facility-based conflict
Assure that policies and procedures concerning facility conflict resolution exist and are ethical, legal, and regulatory-compliant
Assure adequate staff training and maintenance of staff proficiency in effective, safe, timely, and patient-centered conflict resolution
Monitor and review adherence to proper procedure prior to involuntary discharge

Networks (<http://www.esrdnetworks.org>) is an independent, national membership organization helping ESRD Networks in their efforts to improve ESRD quality outcomes.

Project coordinators felt a continuum of aberrant behavior existed from mild to severe with each behavior requiring suitably matched, measured responses. In other words, involuntary discharge should not be the only solution for all disruptive behavior. ESRD Network #12 funded a collaborative stakeholder action plan. Stakeholders included patient advocates, medical ethicists, attorneys, practicing nephrologists, nephrology nurses, dialysis technicians, large dialysis organizations, a psychologist, a State Agency representative, and members of The Centers for Medicare and Medicaid Services (CMS). CMS funded production of a tool kit to implement the action plan. The project included a white paper containing 450 references, entitled “The Law and Ethics of Entitlement in End Stage Renal Disease.” DPC developed and included a taxonomy and glossary to enable effective communication about disruptive behavior.

The tool kit contains an interactive video instructional program on CD-ROM for continual professional staff education. Posters and pocket cards remind trained staff of suitable responses to conflict. DPC provides an algorithm for responses to various disruptive behaviors. The free tool kit is available from each of the 18 ESRD Networks' by request (10,11).

**Taxonomy and Glossary**

The first step towards resolving disruptive behavior is being able to describe it. Accurate, reproducible descriptors are needed to document the disruptive behavior, describe it to the involved parties, and develop a plan of care to successfully resolve the conflict. The DPC taxonomy separated disruptive behavior into categories according to who was placed at risk by the aberrant behavior. DPC developed three categories of disruptive behavior (see Table 3). The first was disruptive behavior that places the disruptive individual himself at risk. The second was disruptive behavior that places the facility at risk. And the third was disruptive behavior that places others in the facility at risk. Based on dialysis-related ethical, legal and regulatory policies, DPC determined a categorical hierarchy of conflict—with risk to others being highest, risk to the facility second, and risk to self third.

The DPC then developed a glossary of terms used to describe an episode of conflict within each category (see Table 3). For example, DPC stakeholders considered written or verbal abuse a lower risk in the “risk to others” category than physical threat or harm. Property damage, theft, and lack of payment were considered “risks to the facility,” an intermediate risk. Nonadherence to medical

**TABLE 3. Taxonomy for describing disruptive behavior**

Categories of disruptive behavior (descending order of severity)
Risk to others
Risk to the facility
Risk to self

advice fell into the “risk to self” category, and was considered the lowest risk. Consequently, responses (see Fig. 1) to the disruptive behaviors were stratified according to who was placed at risk, as well as the severity and the immediacy of the risk.

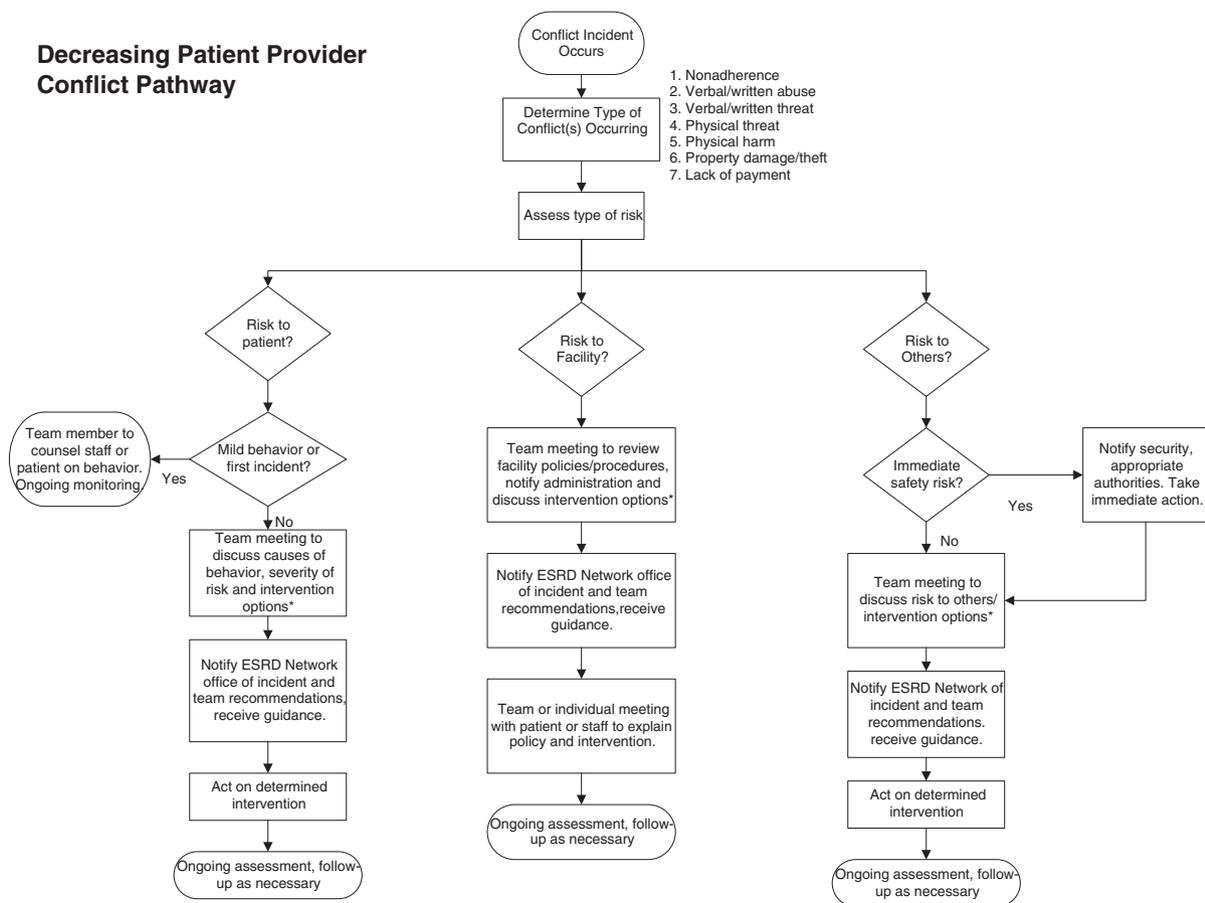
The Dialysis Patient Provider Conflict Resolution Project stakeholders delayed developing responses to disruptive behavior until the ESRD community reviewed and accepted relevant regulatory, legal and ethical ideas about conflict in a dialysis facility. The DPC stakeholders felt the most misunderstood regulatory issue was “entitlement to dialysis treatment.” The most important legal issue was “medical abandonment.” And the most important medical-ethical issues were patient autonomy, physician beneficence, and physician nonmaleficence.

### Entitlement, Medical Ethics, and Medical Abandonment

Unlike dialysis patients in the early 1970s, few people in need of dialysis are rejected today. Many people with

end stage renal disease believe they are “entitled” to renal replacement therapy by federal law and regulation. However, The Social Security Act and The Federal Register defines “entitlement” as “dialysis providers (italics added) who are entitled to receive payment for goods and services that they provide to [eligible] recipients” rather than eligibility for receipt of a medical service, specifically dialysis (12). In other words, Congress and CMS defined ESRD entitlement as an economic benefit paid to providers in the name of qualified beneficiaries (i.e., those who have paid at least ten quarters into SSI).

Although the term entitlement is often misunderstood, all patients deserve high-quality, ethical medical care. A DPC workgroup addressed ethical responses to disruptive behavior and conflict. Their recommendations are as follows. Medical directors and attending nephrologists should always share the selection of medical options with informed patients (“autonomy”), including the right to refuse medical advice. The appropriate response to patients who refuse advice is to educate the patient and family about the risks and probabilities of impact on the quality of life, hospitalization, and survival. This information is best conveyed in a



\* Intervention options: Rule out any metabolic causes for behavior, then consider patient/staff counseling, patient/staff education, patient/family meetings including review of care plan, review of policies/procedures, ethics committee review, patient psychiatric evaluation referral and treatment, patient behavior contract, patient dismissal/discharge or staff suspension or termination only if all other interventions have failed or there is an immediate safety risk or harmful environment (no patient dismissal if the risk of the behavior does not affect others and is only a risk to the patient).

FIG. 1. Algorithm for controlling disruptive behavior.

calm, nonjudgmental manner. Medical directors and attending nephrologists must act in the best interests of the patient (“beneficence”), placing the patient’s interests above their own. For example, it is unethical to involuntarily dismiss patients because their behavior lowers clinical performance measures.

Obviously, physicians must avoid doing harm to the patient (“nonmaleficence”). As noted in the survey, involuntary discharge can cause harm to the patient. In other words, even if patients are not “entitled” to renal replacement treatment by law and regulation, they have a right to expect ethical, safe, effective, equitable, and timely treatment from their physicians. Finally, as pointed out by Winslade and Rose (“The Law and Ethics of Entitlement in End Stage Renal Disease”) “people and their life situations are complex, and the way in which they choose to handle certain circumstances, such as treatment of chronic and terminal illness, are complicated and varied ... and § 1881 of Medicare made no judgments based on patients’ background or on their current behavior” (13).

In serious cases of risk to others, involuntary discharge may be the only responsible solution. When a medical director considers involuntary discharge, he or she must comply with the legal concept of avoiding “medical abandonment.” A patient may end the physician–patient relationship at any time. But a doctor may only terminate the relationship after “ample” warning has been given to the patient and a “reasonable” attempt to transfer the patient’s care to another provider has been made. The new Conditions of Coverage propose “an advance notice of 30 days, provided there is no imminent danger to others” (14).

Ultimately, the courts decide what constitutes “ample” and “reasonable,” applying the test of what would be done by a “reasonable person” acting under “similar circumstances.” For example, the DPC stakeholders and legal experts did not consider “blacklisting” patients by biasing other neighboring facilities against accepting them in transfer to be “reasonable.” Admittedly, there is a gray zone balancing the need to transfer appropriate medical records while avoiding blacklisting. The DPC felt it was “reasonable,” ethical, and consistent with federal regulations to transfer medical records of involuntarily discharged patients. These transferred records should include a problem list, social history, and patient profile. Clearly, any of these records might allude to the disruptive behavior. However, the intent of the transferred medical records should be to optimize patient care, not result in blacklisting the patient. In addition, the DPC did not consider it reasonable to involuntarily dismiss a patient who is nonadherent to medical advice because the “punishment” exceeds the “crime.”

### Defusing Disruptive Behavior

All staff, including dialysis administrators, should learn how to defuse disruptive behavior safely and effectively. Medical directors should assure that specific procedures for resolving conflict are continually taught and

implemented in the dialysis facility. The DPC tool kit includes techniques and teaching tools for diffusing conflict (15). The best environment for resolving conflict is private and calm, with enough time available to adequately understand everyone’s perceptions of the issues. Moving from angry confrontation to calm, nonjudgmental listening is challenging but not impossible. If the staff member involved in the confrontation is unable to calm himself, he should be trained to remove himself from the situation by “handing off” the confrontation to someone else not immediately involved. If there is no time to talk about the issues, a meeting time acceptable to all involved parties should be selected.

Another useful technique for de-escalating conflict is called “effective or active listening.” This is a technique for listening to another’s opinions without judging them. Listeners assure speakers that they understand the speakers’ opinions by “feeding-back” what the listeners understand the speakers are saying, often recognizing the associated emotion. For example, “If I understand you correctly, your arm hurts when your needles haven’t been inserted easily and you have run out of patience. You’ve had enough! Is that right?” Active listeners do not judge, debate, argue, or threaten. He listens until he understands the speaker’s point of view, regardless of whether he agrees or not. The focus is on the issues, not the people involved. Usually when a speaker believes his concerns are understood, the intensity of the conflict decreases. Then good-faith, win-win negotiation can proceed.

If agreement cannot be reached, “timed trials” can be attempted (16). A timed trial is doing something the way one party wants for a specified period of time and then returning to assess the impact of the trial after that period has expired. Prior to a timed trial, the medical director or attending nephrologist should inform patients, family, and staff about the possible risks of the trial. Besides a more detailed description of timed trials, other backstops to failed negotiations are described in the RPA’s second practice guideline, “Shared Decision Making in The Initiation and Withdrawal from Dialysis.”

### Interventions

Every facility should have its own grievance process and every patient should know how to use it. Often, resolving a grievance can prevent conflict from escalating. Medical directors and attending nephrologists should always consider treatable medical and psychological causes for disruptive behavior (Table 4). Psychological referral for evaluation and cognitive behavioral therapy should also be considered concomitant with other interventions. Careful screening, referral and/or treatment for unrecognized depression and poor social support are often appropriate in cases of nonadherence to medical advice (17).

During or after medical and psychological evaluation is the time to initiate good faith negotiations (Table 5). It is helpful to have family members or community members present to avoid the appearance of ganging-up on

**TABLE 4. Glossary for describing disruptive behavior**

Term	Definition	Category by at risk	Relative significance
			1 = significant 2 = more significant 3 = most significant
Nonadherence	Ignoring medical instructions and advice	Self	1
Theft	The stealing of property	Facility, others	2
Property damage	Physical harm or injury that makes something less useful, valuable, or able to function	Facility, others	2
Nonpayment	A refusal or failure to pay money owed	Facility	2
Abuse	Any words (written or spoken) with an "intent to" demean, insult, belittle, or degrade	Others	2
Threat	Any words (written or spoken) expressing an "intent to" harm, or commit violence	Others	3
Physical threat	Gestures or actions expressing "intent to" harm, abuse or commit violence	Others	3+
Physical harm	Any bodily harm or injury, or attack	Others	3++

**TABLE 5. Possible medical causes for aberrant behavior**

Medical causes for aberrant behavior
Drug and alcohol abuse
Preexisting, undiagnosed, untreated, or uncontrolled psychological disorders (e.g., depression)
Adverse drug reactions or interactions
Inadequate dialysis
Hypercalcemia
Subdural hematoma or other dialysis-related intracranial events
Occult sepsis

the disruptive individual. Medical directors should document meeting occurrences and proposed solutions. All parties should agree to a time and date for a return meeting to follow up on the progress of the solutions. All relevant parties may wish to sign an agreement stipulating the agreed-upon solutions. However, the so-called "behavioral contracts" that serve only as precursors to involuntary discharge detract from good faith negotiation. It is reasonable, however, to include consequences to *both* sides for failed adherence to the agreed upon solutions. If there is an immediate safety risk to others, such as physical threat or harm, it is essential that staff immediately notify the appropriate authorities to mitigate the threat.

The medical director, working with the governing body, must not leave conflict resolution to chance, "common sense" or social-worker expertise. Conflict resolution is a team effort and a quality of care issue. Medical directors must assure that written policy and procedures exist, and continual conflict-resolution training occurs. Medical directors must assure that disruptive events are accurately described in writing, and that solutions and their outcomes are well documented.

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