Ramiro Valdez, PhD

The Intolerance of Zero Tolerance

About ten years ago I co-authored an article[1] with Alex Rosenblum—also of the ESRD Network of Texas—describing the process for dismissing a problematic end-stage renal disease (ESRD) patient from a dialysis clinic. Such an act was virtually unheard of at the time.

The article prompted a considerable amount of controversy and correspondence, but eventually the process described therein became an accepted procedure. Today, the idea of dismissing a problematic ESRD patient from a dialysis clinic is so commonplace that the pendulum may have swung completely in the opposite direction.

Dismissing a problematic patient does not solve a problem, but only transfers it to someone else. In some cases, patients are dismissed without having another clinic already prepared to accept them. The problematic patient *still needs dialysis*. This creates a compounded problem, i.e., the original problematic behavior coupled with an ESRD patient without a clinic.

Over the past few years, most of the ESRD Networks in the country have become aware of a growing number of patients being dismissed from clinics for problematic behavior. To date, there is no systematized tracking of these patients by the Networks. Most of these patients eventually find other clinics, but some do not. For a few, dismissal from a dialysis clinic is tantamount to a death sentence.

While death for a dismissed patient is rare, this same patient presenting at an emergency room and requesting evaluation for dialysis is not rare. These patients receive dialysis based on the opinion of the emergency room physician. This could mean one treatment a week or even less. This situation taxes the Medicare system heavily and hurts patients even more.

Complicating matters is the "zero tolerance" policy of many renal corporations and clinics. Essentially, zero tolerance means that if a patient even threatens to do violence, then he/she can be dismissed. In some cases, even routine noncompliance—such as repeatedly signing off early, or chronically skipping treatments—can result in dismissal. In one case, a patient was dismissed because he attempted suicide in the clinic.

There can be no tolerance of acts of violence in renal clinics. Any person who strikes another deserves immediate dismissal. Nor should clinic managers tolerate the creation of a hostile work environment or the putting of patients at risk. Patient security and staff safety must continue to be a top priority at all clinics at all times.

However, in many cases zero tolerance is too severe. Dismissing a patient for making a threat without considering the alternatives may create more of a problem than it solves. Of course, such threats cannot be ignored or dismissed casually. When a patient makes a threatening statement such as "I'm going to blow up the clinic" or "I'm coming back with my gun," a behavioral contract may be more appropriate. To make that determination, the following factors—patient history, circumstances, and the opinion of the patient's "ally"—must first be taken into account.

Patient History

First, the history of the patient should be considered. A positive psychosocial history, a good history with the nursing staff, the patient's medical history, and so on—coupled with the patient's usual behavior in the clinic—should all be taken into account. The best predictor of future behavior is past behavior. If a patient has a history of aggressiveness, violations of the law, and arrests, it is more likely that he/she will carry out a threat of violence. Further, patients who have never been problematic but then suddenly burst out with a threat are most likely suffering a life-changing event or personal

The author is Director of Patient Services for the ESRD Network of Texas, Inc., Dallas, Texas. The opinions expressed are those of the author alone and do not represent the Network in any way.

crisis and may have no real intention of harming anyone.

Circumstances

Secondly, staff should consider the circumstances surrounding the patient's threat. When patients make repeated requests for information, treatment, or changes that go unanswered, the verbal threat may be more an expression of frustration, or even a cry of agony. Some circumstances in some clinics would cause *anyone* to scream!

The Opinion of an "Ally"

Third, the patient's "ally" should be consulted. Nearly every patient is close to *someone* in the clinic or has a confidant among the staff members. Someone on the staff "understands" some particular patient, so that almost every patient has an advocate or ally on the staff. (Ideally, it is the physician, but sometimes it is the nurse or the social worker.) This ally should be asked whether he/she feels that the patient truly meant the threat and might harm someone. If the ally feels that the threat is genuine, this opinion should weigh heavily with the treatment team, who can recommend to the patient's physician that the patient be dismissed.

If the patient has no ally on the staff, therein lies a major problem. The patient may see the clinic as an "us" versus "them" situation. He/she will always feel like an outsider as long as this situation remains. If this is the case, the patient's physician will then have to be the one who provides the "ally's opinion" to the treatment team.

The Behavioral Contract

If the patient does have a history of violence, the circumstances alone did not prompt frustration, and the staff ally feels that the threat was, in fact, serious, then dismissal is indicated. However, those patients who have no history of problematic behavior and then find themselves in circumstances that foster verbal aggressiveness may be candidates for other, more preferable options, especially if the staff ally feels that the patient was simply "blowing off steam."

Verbal aggressiveness and threats *should* be targeted for change, as they do not belong in the renal setting. However, the best way to do this may be the initiation of a strong behavioral contract, rather than simply passing on an unresolved problem to someone else.

Reference

1. Valdez R, Rosenblum A. Suggested steps for dismissal of the problematic patient. *Dial Transplant* 1993; 22(10):610-613. DOI