

## Short Communication

# Dealing with Violent Dangerous Patients: The Medicolegal Pitfalls

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“Takedown” in the Emergency Department (ED) an all too regular occurrence that is set to escalate dramatically in years to come. This was prophesized by a newspaper headline from 1991, “The growing ranks of aggressive, addictive and deranged people for whom the emergency department is the last resort.”<sup>1</sup>

Making the call to “Take someone down” in the ED is never to be taken lightly. The only time such a drastic decision should be made is to prevent imminent harm to the patient or others. It should always be the most senior doctor in the department at the time who makes the clinical decision that the physical and/or chemical restraint of a person is necessary and sanctioned by law at that time. This area is a minefield for doctors. The duty of care of the physician is in direct conflict with the patient or violent person’s right to bodily integrity, freedom of movement, freedom from bodily infringement, refusal to consent to medication, and several other inherent civil liberties that every person has as an automatic right to.

Giving the order to have several people as of necessity they need to be big strong well-trained people, physically overwhelm and subdue someone and then place physical restraints to continue to subdue, and without consent inject chemically sedating agents into the body of that person, is a treacherous path for any doctor, no matter how experienced or qualified an ED practitioner may be (author personal experience, October 2019). A successful takedown often leads to the person requiring intubation, ventilation and ongoing sedation until there is the capacity to deal with a safe extubation. There are many recorded deaths as a result of involuntary physical and chemical sedation,<sup>2</sup> and almost inevitably it will involve some sort of bodily injury. If the initial facility does not have the capacity to safely deal with such a patient after forced and necessary sedation, they may require transporting

to more appropriate facility capable of dealing with a safe extubation in a known violent aggressive patient.

The law is vague as to duties of care, etc, especially when the violence does not come from a patient. Violent non-patients are best dealt with by the police and hospital security without requiring a medical takedown. There are times when violent behaviour from a non-patient escalates to the point where that person becomes a danger to others and himself. If that person is behaving in a manner that falls beyond what is considered normal, does it preempt a psychiatric diagnosis and place a duty on the doctor in charge to consider a medical takedown?

EDs are especially prone to violence. They provide an environment filled with emotional stress; patients may suffer prolonged waiting times, confusion, and gaps in communication. In addition, the 24-hour open-door policy and the widespread availability of drugs and weapons in the community compound the problem.<sup>3</sup>

The 1993 shooting of three physicians on duty in Los Angeles County ED underscores the tragic consequences of ED violence. The problem is not isolated to a few urban areas. In a 1988 survey of 170 U.S. teaching hospitals, 32% reported at least one verbal threat daily, 18% at least one threat with a weapon daily, and 25% reported restraining at least one patient per day. Within the previous five years, 7% of the institutions experienced a violent death in the ED. Eighty percent had a staff member injured due to violence.<sup>4</sup>

Assaults may come from patients, visitors, or members of a patient’s family. Parents of ill children may turn to violence from frustration. A 1994 survey of 44 pediatric EDs revealed that

more than half reported one or more verbal threats a week, 77% reported at least one physical attack on staff per year, and 25% sustained actual injury to staff.<sup>5</sup>

ED nurses are particularly likely to be assaulted. Nearly 70% of all emergency nurses are assaulted on duty during their career.<sup>6</sup> Yet, as alarming as these statistics are, up to 80% of all ED assaults are not reported.<sup>7</sup>

The articles referenced provide a comprehensive and exhaustive discussion of the duties that need to be complied with in the circumstance of a “Medical Takedown”, and every emergency doctor and nurse should regularly read the brilliant article by Louis Kao and Gregory Moore.<sup>8</sup>

A polarizing discussion of some controversy is presently surrounding the conventional agents that should be chosen for takedown situations. This article is not intended to explore the medical decision making related to the emergency choice of a tranquilising agent. That is a complex and voluminous topic that is deserving of an arena all on its own. This article is intended to merely enlighten front line medical practitioners about the potential legal dilemmas that they may expose themselves to through the use of physical and chemical restraints. There is an understanding that some hospitals arm their security personnel with tazers and firearms. In our ED, the choice is mostly limited to our security that are mainly big burly men and a few drugs, including droperidol, haloperidol, olanzapine, midazolam and ketamine. The huge concerns about the safety of droperidol and the need for an electrocardiogram (ECG) prior to administration being a prerequisite have come into question.<sup>9</sup>

The use of ketamine as a first-line takedown drug seems to be growing in the emergency medicine literature and pre-hospital emergency medical situation.<sup>10</sup> The literature supports its use and advocates it in some instances where treatment-resistant depression and suicidality have featured.

At 4 mg/kg intramuscularly, ketamine renders most recipients incapacitated within a few minutes with a patent, self-maintained airway. It is the duty of the ED physician to ensure protection and patency of the airway and is a crucial aspect of coordinating a takedown. Ketamine was traditionally contraindicated in head injury patients due to a perceived risk of raised intracranial pressure. This has since been debunked.<sup>11</sup>

The physical and chemical subduing of a person complies with the definition of assault, including assault with the intent to do gross bodily harm. physicians can be referred to numerous statutory bodies for investigation and are also open to internal investigations and police and criminal reporting. Having a second equally qualified and experienced, or better qualified and more experienced colleague, ratify the decision to takedown is advisable and must be documented.

Footage of violent rampages by patients, or non-patients, should be recorded and used to justify contentious takedowns, and

for training purposes.

De-escalation of violent situations is always the goal, and ED staff and security must be regularly trained in de-escalation techniques. The use of bodycams by security staff are advocated when dealing with violent and dangerous patients, and for proof of the danger, a patient presented at the relevant time. The effect of violence on doctors and nurses is profound and devastating. An assault at work is demeaning, insulting and often devastating to a doctor or nurse’s psyche and well-being. Violence to medics often causes them to leave the profession and may lead to serious ongoing psychological and mental health issues. Retro-thinking mandatory reporting laws relating to healthcare workers and mental health issues, perpetuates the problems faced by victims of violence at work for fear of mandatory reportings. Post-traumatic stress disorder (PTSD) often follows significant acts of violence, and victims suffer lifelong consequences.

The advent of more and more potent mind-altering narcotics, an ever-increasing violent society, the normalization of violence in sport and as part of masculinity, political and religious polarization, alcohol, religious secularism in a global village context, and racism itself are all factors that seem destined for continued violence to be part of human existence. EDs need to factor in this reality and ensure that their staffs are not only well protected from any violence itself, but also the legal outfall from necessary takedown decisions. I will go so far as to say that health departments and governments have an obligation in this regard.

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