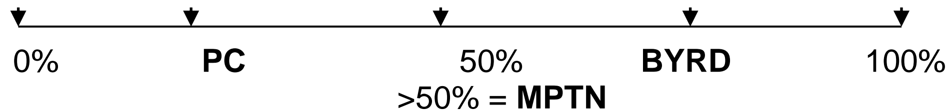
GRIEVANCE PROCESS - BURDEN OF PROOF

[NOTE: "Burden of proof" is a legal term used in court and in the grievance process to determine who has the **responsibility** for **proving** facts through testimony and other evidence and the **amount of evidence** that must be proven in order for that party to prevail.]

Continuum of evidence presented:



(**PC** = Probable Cause. **MPTN** = More Probable Than Not (any amount of evidence over 50%. **BYRD** = Beyond a Reasonable Doubt.)

The burden of proof in situations **for a service provider**:

Type of situation:	**Burden falls on:**	**Burden to be met is:**
Security measure	Staff	"Significant risk" [probable cause]
Sanction Imposed on patient	Staff	"More probable than not"
Patient claims abuse	Patient	"More probable than not"

There needs only to be a showing of a "**significant risk**" (probable cause) for staff to take a "**risk-reduction**" measure. However, the risk should be more than remote or speculative to take a security measure such as denying a patient certain property. [See the **Risk Reduction Measures** section of this digest.

Where a **patient** is **sanctioned** for a rule violation, the staff must show that it is **More Probable Than Not** (any amount of proof over 50%) that the patient violated the rule. [See **Rules and Consequences** section of this digest.]

Where a **patient claims wrongdoing** on the **staff's** part, the burden is on the **patient** to show that it is More Probable Than Not that the staff acted as alleged.

The standard of "**Beyond a Reasonable Doubt**" is the one the state must meet to show that a **crime** has been committed by a particular person. It only applies to criminal court charges.

- CRO training materials

DECISIONS

1. There must be **sufficient evidence** to show it was **more probable than not** that a **doctor departed from professional judgment** in his prescribing medication to a patient after a phone call with her. Such evidence would have to come in the form of a second opinion from a professional of equal or greater standing than the doctor. Where there was **no such evidence** presented, the finding of a **rights violation** will be **overturned**. (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)

2. The sister/guardian of a woman filed a grievance about **the care the woman** had received while she was **living in her own apartment**. She had been receiving supportive home care services from an independent service provider under a general contract with the county. The **guardian alleged abuse and neglect** because of failure to report theft of monies and possessions and fraud and/or misrepresentation of funds. These issues were properly referred to other authorities. **To criminally convict a person of abuse**, **neglect, or criminal misconduct, there must be proof beyond a reasonable doubt**. A **patient rights violation only requires** a finding that the allegations are proved "**more probable than not**" true. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

3. Where a client asserted that his AODA counselor used foul language, was confrontational, and was generally disrespectful to him, the **burden of proof was on the client** to provide sufficient evidence that a rights violation had occurred. This was a verbal exchange and no witnesses were present. While it would not be appropriate or acceptable for a counselor to use foul language or be disrespectful to a client, the allegations were self-reported and technically only constituted **hearsay evidence**. The client **had not met his burden** of showing a rights violation. (Level III decision in Case No. 09-SGE-04 on 7/06/09)

4. A patient complained about a nurse practitioner violating his confidentiality and his right to dignity and respect by in the manner in which she talked to him in a hallway. The **evidence, records, and witness reports did not provide sufficient evidence** to show that **it was more probable than not** that his right to confidentiality or his right to be treated with dignity and respect were violated. The **client's burden of proof had not been met.** (Level III decision in Case Nos. 09-SGE-07 & 09-SGE-10 on 3/18/10)

5. A patient claimed a staff member did not treat her with dignity and respect. The **complainant had the burden of proof of the alleged staff wrongdoing**. This called for the weighing of the two parties' credibility. Based on the written materials she provided, it was found that complainant's description of events was credible, but, if true, it did not rise to the level of a

rights violation because it **did not describe what the staff did to upset her**, **nor did it describe proof of that occurrence**. Thus, s**he had not met her burden of proof** and no violation of her right to respect and dignity was found. (Level III decision in Case No. Case No. 11-SGE-07 on 06/22/12)

6. A patient complained **about termination of his services** by his provider. However, he was no longer receiving services from the program and had no desire to continue with them. Thus, even if his rights had been violated by the termination from that program, there was no remedy that could have been granted to him that would have rectified the situation. The State Grievance Examiner (SGE) opted to use her discretion to address this issue anyway in the Level III decision. The subsequent analysis of the situation led to the conclusion that **he had failed to meet his burden of showing that his rights had been violated** by the termination of his services. He provided **no new evidence in his appeal** to Level IV **that would add sufficient "weight" to meet his burden of showing that his rights were, in fact, violated**. (Level IV decision in Case No. 10-SGE-15 on 03/27/13)

7. A patient received services at a provider's partial hospitalization program in the psychiatric and bariatric programs and withdrew within 24 hours. Among the patient's grievances was the allegation that she did not receive notice of her client rights upon admission. The patient signed a document containing a "notice of privacy practices, payment policy and client rights." **Such documentation is dispositive evidence that the client did, at a minimum, receive some client rights information from the provider.** The provider's policy was to give all patients three pamphlets, go through each of them orally and then give them the acknowledgement form to sign and date. The provider's claims that they have in-patient and out-patient client rights posters up in their units and that they inform patients of their rights in writing upon admission were credible. The patient's right to proper notification was held not to have been violated because the patient failed to meet her burden of proof to show that she did not receive client rights information from the provider.(Level III decision in 13-SGE-0005 decided on 11/18/2013)

8. A patient claimed that the provider violated her rights to adequate treatment and to be treated with dignity and respect. The patient found that the topics discussed in group therapy, including many disturbing past and present psychological problems, were extremely upsetting. The patient alleged that this experience traumatized her and caused her anxiety, stress and depression. The **patient has the burden of proof to show that his or her allegations are more likely than not (more than 50% likely) to be true in order to prove wrongdoing.** Thus, the patient had to prove that it was more likely than not that the client's right to adequate treatment was violated when the group therapist discussed personal matters in therapy. The client claimed that a nurse stated that the provider's services were inadequate, but this was not corroborated by any documents provided or by the provider's staff. **Even**

if the nurse's statement corroborated the girevant's claims, it would not prove that it is more probable than not that the group session was inadequate treatment or that other aspects of the services received by the client were so poor as to rise to the level of inadequate treatment. Similarly, the patient provided no supporting evidence that the group therapist directly caused her problems or that the alleged mental or physical problems existed. Self-reported evidence standing alone is not generally sufficient to meet the patient's burden of proof to show wrong doing by staff. (Level III decision in 13-SGE-0006 decided on 12/18/2013)

9. A husband and wife were receiving therapy from different therapists employed by the same provider. The wife claimed that her husband's therapist kissed her hand as a response to the couple's decision not to continue with a complaint. The therapist claimed to have no recollection of kissing the patient's hand. If proved, **kissing a patient's hand would constitute a violation of a client's right to be treated with dignity and respect.** When a patient claims that a staff member violated his or her rights the burden of proof is on the grievant to show that it is more probable than not that staff violated a specific client right. If the testimony offered by the parties is contradicting and there is no other evidence, it is not possible for a patient to meet the burden of proof unless the patient is more credible than the other party. Here, the grievant was a witness to the incident, her testimony had been reliable and she had no reason to be untruthful in one complaint when she was truthful regarding all other complaints she brought forward. **The grievant's version of events was slightly more credible because the therapist has been found to have violated the client and her husband's dignity and respect on other occasions. A violation of the patient's right to be treated with dignity and respect was found.** (Level III decision in 13-SGE-0011 decided on 4/11/2014)

10. A patient filed a grievance stemming from a disagreement between the patient and the therapist about whether the client should be tested for PTSD. When a grievant makes an allegation against a staff member the burden of proof is on the grievant to prove that it is more likely than not that his allegations are true. In this case the parties were alone together in a therapy session. **The client alleged that the therapist told the client that he was not giving him a PTSD test because he thought that the client was trying to get on SSDI, which was causing the patient to be ambivalent about getting better. The therapist's notes reflect similar content. The allegations were likely to be true. However, no rights violation was found because this decision was within the therapist's professional discretion. Further, different psychologists can arrive at different determinations of whether the same person meets the DSM diagnostic criteria for a given disorder**. (Level III decision in 14-SGE-0002 decided on 11/19/2014)

11. A patient indicated that he would be willing to provide evidence to back up his claims upon request from the State Grievance Examiner. A **deadline for providing evidence was imposed on the patient so that the patient would have the opportunity to submit everything that he felt would support his grievance without further extending the decision making process**. (Level III decision in 14-SGE-0003 decided on 6/26/2015)

12. A patient alleged that his rights to adequate treatment and to be free from arbitrary decisions were violated when his therapist failed to provide medication that he requested. Due deference must be given to treatment professionals in making decisions regarding a patient's treatment plan. Such decisions will not be found to violate a patient's rights unless it is more probable than not that the determination was inappropriate. In **order to meet this burden of proof a patient must show that it was more likely than not that the treatment team failed to meet established professional standards of psychiatry when determining the patient's treatment recommendations.** The patient did not meet this burden. There was insufficient evidence to show it was more likely than not that the grievant's treatment team failed to meet established professional standards. In fact, evidence in the grievant's treatment record shows that the medical staff made a considered professional judgement to deny pain medications to the grievant. No violation of the patient's right to adequate treatment was found. (Level III decision in 14-SGE-0003 decided on 6/26/2015)

13. A patient was receiving services at a Community Based Residential Facility under a commitment order and an involuntary medication order. The patient alleged that the provider took the patient's head scarf and did not return it. Her treatment record reflected that she wore a head scarf but never mentioned that the head scarf was a problem or that it was taken by staff. **The grievant did not meet her burden of proof that her scarf was taken away because she produced no evidence other than her own testimony**. (Level IV decision in Case No. 15-SGE-0001 on 10/17/2016)

14. Evidence submitted by a grievant's doctor showed that the grievant was disabled and had severe restrictions on his ability to walk or travel long distances in a vehicle, which the grievant alleged made him unable to transport himself to the clinic. His requests for telephonic or in house AODA services were denied. **In order to show that the provider provided inadequate treatment the grievant would have to show that it was more probable than not that the county departed from professional judgement in the delivery of the treatment by requiring the grievant to transport himself to the clinic for AODA treatment. Further, such evidence regarding the location of services would have to come in the form of a professional of equal or greater standing than the patient's doctor.** (Level IV decision in Case No. 16-SGE-01 on 12/15/2016)

15. A patient discontinued her mental health treatment from a provider for alleged misconduct by her therapist and other staff. **When a patient alleges misconduct by staff, the burden is on the patient to show that it is more likely than not that staff violated her rights**. (Level III decision in Case No. 16-SGE-04 on 4/20/2017)

16. A patient's mother acted on the patient's behalf and claimed that services received through the Treatment Alternative and Diversion program run by the County violated her daughter's patient rights. The grievant claimed that she was wrongfully discharged and incorrectly accused of violating program requirements based on inaccurate lab results showing the patient used heroin, cocaine and morphine. **The burden of proof is on the grievant to show that it is more probable than not that staff violated her rights when a grievant alleges misconduct by provider staff.** (Level IV decision in Case No. 16-SGE-0006 on 10/23/2017)

17. A patient **alleged that his county case managers were threatening him and lying about his behavior, however, the only evidence to support the allegation was the patient's statements.** The patient did not meet his burden of proof that staff were in fact threatening or harming the patient. (Level III Grievance Decision in Case No. 20-SGE-06)

18. A patient **claimed the provider forged her signature on a general consent form. The patient had the burden of proof to show it was more probable than not the consent form was forged, but she did not meet this burden**. The patient provided numerous signatures to show this one was falsified. However, the State Grievance Examiner does not have the expertise or knowledge to determine if one signature truly differs from another. On the consent form itself, the patient care representative that checked the patient in for her appointment signed the witness signature part of the form, with a time stamp of 2:15 pm. The grievant was checked in to her appointment by 2:26 pm. If the patient had not been present for her appointment on the day in question that may be evidence to suggest the consent form was tampered. However, the patient does not deny being at this appointment. Therefore, the main evidence the patient has is her own statements, which does not meet the burden of proof. (Level III grievance decision in Case No. 20-SGE-07)

19. The grievant alleged that her right to dignity and respect was violated during a one-on-one meeting with the Provider's Executive Director. The grievant **stated that she was berated and that the Director slammed his hand on the table.** There were **no witnesses** to the interaction, however, and interviews showed that **the Director uniformly treated others with dignity and respect, never raised his voice, and slamming his hand on a table would be very out of character.** While the grievant was very upset after the interaction, that alone did not prove that her rights had been violated. Without

additional evidence, the grievant had not met her burden to prove that it was more likely than not that the behavior occurred. (Level III Grievance in Case Number 23-SGE-00146).

20. The **grievant withdrew her permission to allow the Client Rights Office to examine her records during the investigation of a grievance**. In a subsequent grievance, the investigator attempted to clarify which records the grievant did, and did not want to be examined, however a valid Release of Information was not able to be obtained. Most of the claims alleged by the grievant concerned information in her records. As those records were not able to be examined, the grievances were not able to be substantiated. (Level III Grievance Decision in Case Number 24-SGE-00273).

[See: "Introduction to Digest-Date Last Updated" page]