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Stepping Carefully On The Stones: Turning Practice into Policy

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ABSTRACT

This is a case study of how the problems experienced with one particular student who has an unusual and difficult medical condition highlighted the need to develop a policy which would satisfy the needs of the student, the abilities of staff and fellow students to cope with the occurrences of the condition, and the stated requirements of the OH&S policies at the University. The story of this process illuminates some of the more general issues that arise when we are faced with the necessity to devise policy to fit practice.

The case involves an Occupational Therapy student who suffers from frequent and sometimes prolonged fainting episodes. Periods of unconsciousness range from a few minutes up to an hour, and can occur frequently. So this condition has an impact on a wide circle of staff and students.

As we DLOs worked on the policies we became aware that not all the stakeholders shared the same ideas about how the occurrences should be handled, what the limits of staff responsibilities are, what the implications of the different legislative requirements are. We found this case to be a challenging one, for accommodations both on campus and in practicum placements.

I will present some details of the case and of the problems it has posed for us, and how we developed policies which we hope will meet all requirements not only for this particular case but for other ones of a similar degree of severity and frequency.

1. INTRODUCTION

This paper describes the development of a policy to handle what we have termed 'chronic medical conditions'. The policy was prompted by the need to accommodate a student who suffered from very frequent and sometimes prolonged fainting episodes and who did not wish an ambulance to be called routinely. The policy is designed to cover all occurrences which could be termed "emergencies" but with particular reference to chronic cases.

The "stones" of the title are those things on which we need to rely such as legislation and established policies, and also what we might call "the facts of the case". The swirling waters around our feet are the differing perceptions and competing interests of other stakeholders. The paper was written with the consent of the student, who chose to be called Ophelia.

2. THE PROBLEM

I first met Ophelia when she was lying unconscious on the floor in Student Services. I had heard about her, but she had not identified as having a disability, and the academic staff had not advised her to see me as the DLO, though they had asked for guidance from the student

counsellor. Staff seemed not to be aware of the requirements of the DDA nor of what "discrimination" might mean. The course coordinator had advised the student to stay away from campus until she got medical help and recovered, and this was just before Ophelia's first exams. I am telling you this so that you understand that there was quite a sense of urgency about "what should we be doing", it was not the ideal case where the student discloses and arranges their support before they commence studies. So there were two main stages in the development of policy: there was the initial ad hoc and hasty development of protocols to manage the immediate problem; then there was the more bureaucratic or political stage where a working party was set up, the problem was identified, we collected all the relevant other policies which would provide guidance to us, and we negotiated with other involved parties.

2.1 The Student's Medical Condition

Ophelia is a 22 year old student who moved to Albury 2 years ago to study Occupational Therapy. She has had a strange medical condition since about the age of 13, though she has had periods of remission. The problem with Ophelia as it presents is this: she can be walking, sitting, talking, even lying down, and then will very suddenly lose consciousness and sink to the ground. Generally she is not injured in the fall, but since the faints can and do happen anywhere, anytime, then she is liable to collateral damage such as bruises or more seriously, to head injury. The general diagnosis of her condition is NMH or neurally mediated hypotension – but as many doctors have discovered, it is not a typical case. Ophelia is sometimes unconscious for only a few minutes, but we have timed her at nearly an hour, and it is also quite common for her to have a series of faints. On one "bad" day, she had 7 faints and took the whole day to advance across a smallish lawn so that she could be helped into a car and taken home. Often the faint is a simple one, but sometimes she has tonic and clonic seizures as well. Ophelia has been seen and tested by many, many doctors and none has come up with any effective treatment; many people find this absence of a medical solution difficult to accept.

How does Ophelia react to her condition? Initially she tended to deny that it was a problem, though she has become more realistic both about the impact on her life of this condition and about the possibility that maybe she will not complete her chosen course. To say that the professional placements are challenging is an understatement.

So Ophelia's official position has been, *what's all the fuss about*. But as you can imagine, the reaction of those who have to deal with her sometimes alarming episodes is rather variable. Some staff want everyone on the campus to be informed as to the nature of Ophelia's condition, and how to respond to it. Some react in another way entirely: one staff member said to me "It's disgusting, seeing her lying on the ground like that. It shouldn't be allowed."

3. DEVELOPING SOME POLICY OPTIONS

As with many policy making processes, this one had two phases. First we had to make some immediate arrangements to deal with the presenting problem of Ophelia. We used this phase to clarify our ideas about the scope of the issue and developed some options as to what we might do. The policy proper came out of discussions about how we could – should – generalise this one case to other similar cases which may have already been present (such as students with epilepsy) or which may arise in future. It involved consultation with other areas of the university whom we identified as being relevant stakeholders. The final policy as it is implemented will demonstrate, we hope, the three assumed characteristics of policy: coherence, hierarchy and instrumentality (Colebatch 1998).

3.1 The Campus Context

The campus at which I work and Ophelia studies is small, central, easily accessible to the surrounding streets and - most importantly - most of the staff know one another and there is a culture of co-operation, informality, and a good level of trust. What eventually happened with this particular student was much facilitated by this trust. For example, other staff had to trust me when I said that an anonymous doctor had made certain recommendations; and we benefited from a high level of trust between Ophelia and the staff most closely involved – such as myself and the Senior First Aider – though this doesn't mean that the protocols that we developed cannot be used with other students. It might just mean that the risk equations are a little different, and it also raises a general question: is it realistic to consider "policy" apart from the circumstances in which it is implemented?

3.2 Immediate Band-Aids

The immediate reaction to the problem, the action that in a sense constituted the first policy, was one developed on the horizontal dimension (Colebatch 1998). The interim solution of "stay away" from campus was not accepted. Another alternative was to follow what *many people said* was the correct procedure, and call an ambulance on each occasion when Ophelia fainted. If we had followed this approach, we would have in effect denied the existence of a new problem requiring a policy solution, by including Ophelia under supposed existing practices. The difficulty with this was that she strenuously objected to calling an ambulance each time she fainted, saying it was unnecessary. Her preferred solution was to be left where she fell, to be attended to by 'whoever was about' or – if we insisted, AND we did – by the campus First Aiders. This preference stated by her was the starting point and provided the frame within which we sought to establish a policy: was it possible to accommodate Ophelia's preference and still meet our legal obligations? The search for stones on which to cross the water began.

3.3 Finding the First Stone – medical advice

Firstly I contacted several of her previous doctors, and asked them – with Ophelia's written authorisation - to provide me with some guidance as to what her condition is and how we should handle it on campus. I asked them directly, did they think it was medically acceptable that she should be handled by First Aiders rather than by ambulances. I struck gold: one specialist physician responded to me, willing to talk on the phone and willing to put his advice in a fax; but not willing to be quoted by name. He advised that we could say:

"A medical practitioner who has treated Ophelia suggests the following during a fainting episode:

- *There is no need to call an ambulance.*
- *The best position for her when not responding is on her side (coma position).*
- *Keep her comfortably warm.*
- *Encourage her to lie down for 10-15 minutes after the episode."*
- *The things to look for are a change in colour particularly if there is any prolonged tendency for blueness around the lips or hands. A check of her breathing perhaps every 5-10 minutes would also be worthwhile looking for a reduction in her breathing.*

3.4 The Second Stone – complying with First Aid protocols

Flushed with success at landing on the first stone, I contacted the campus First Aiders (FAs). They agreed to the doctor's suggestions, provided these were not in conflict with the requirements of the Red Cross First Aid Manual or the University's policies on emergencies.

One OH&S committee member sent me an email asserting that "a first aider has a duty of care to call for an ambulance for an unconscious person, and would be admonished in court if they failed to do so." This seemed to be the initial consensus. However, when the Senior First Aider (SFA) checked the actual wording of the Red Cross Manual, she agreed that it was not always necessary to call an ambulance and that the FAs could fulfil their duties by attending to Ophelia until she regained consciousness. The SFA confirmed this verbally with the local Red Cross training people. At a later stage we also had a meeting with a representative from the ambulance service, and he too agreed that it was not necessary to call the ambulance unless there were indications such as blueness, loss of breathing etc; collateral damage such as hitting her head; or if she was in a dangerous location such as a driveway.

3.5 Third Stone – emergency procedures?

The involvement of the First Aiders meant that there was also an involvement by the campus OH&S committee. They expressed concern that the proposed protocols for handling Ophelia's episodes were not complying with the University's emergency medical procedures. However, it was surprisingly difficult to establish what in fact these were. I said earlier that "many people said" and we found in the course of drafting a policy that it was not easy to establish what in fact ARE the established procedures. The emergency procedures that we did find are those relating to sites where there is an emergency happening such as a fire or chemical spill, or critical incidents which also do not fit the occasion. I sought advice from the University's OH&S coordinator, and he in turn used his list to contact his colleagues, asking if they had any policies relating to this sort of problem. He sent me their replies, and it became evident that procedures to cover these sorts of conditions are at best in their early stages. There are procedures for "emergencies" such as suspected heart attack or other sudden collapses; but not for something chronic and arguably also an emergency. It seemed from the responses that most universities have very similar procedures, involving a network of FAs.

3.5.1. An unsteady pebble

At about this time we were given a copy of a draft proposal from one of the schools on another campus, suggesting procedures for dealing with "students suffering from serious medical conditions and experiencing medical episodes on campus". This document reinforced the importance of who frames the problem. It did not mention DLOs, nor First Aiders. Basically the model proposed was that the student should provide written instructions to all their academic staff, who would act as supervisors until the arrival of an ambulance, which would be called in all emergencies. We have not drawn on this model, and the fate of this proposed policy is not known to me.

3.6 Fourth Stone – OH&S legislation

Some OH&S committee members were still expressing concerns about the proposed procedures (which by now were in operation almost by default), along the lines of "the NSW OH&S legislation would take precedence over the DDA". One person expressed the view that where the risks cannot be minimised to an acceptable level, regardless of the control measures taken, the final course of action for the university would be to seek exclusion of the student. A check of the wording of the NSW OH&S Act 2000 shows that the employer's duty is to ensure the health, safety and welfare at work of all the employees – relating to premises, plant or substances, systems of work and the environment being safe, etc. The FAQs on the OH&S website also focus on the environment when talking about "duty of care": there is a general duty of care for employers to ensure the health, safety and welfare at work of all employees and others who visit the workplace. It is the employer's responsibility to ensure

that all reasonably practicable measures have been taken to control risks against all possible injuries arising from the workplace. Etc.

I sought HREOC advice and they reassured me, saying that they could see no defensible basis under the DDA for excluding a student in the circumstances described. They advised that it is "impossible to think that the Federal Court if it came to that would accept, that the university has any occupational health and safety duty which would justify a general exclusion in this case – any more than a shopping centre has, for example." They did mention that a tendency to suddenly lose consciousness could validly exclude involvement with particularly dangerous equipment or substances – and we incorporated this into our agreement with Ophelia, so that she did not for example handle dangerous chemicals or sharps during laboratory work.

3.7 Fifth Stone

Before finalising the Band Aid protocol of "how to handle Ophelia" and notifying the relevant people on campus, I discussed it at length with her, and also asked her to discuss it with her parents. She and they agreed it was suitable.

3.8 Sixth Stone

The final stone which provided a pathway across to dry land was acceptance by other staff on the campus that what was proposed was workable, responsible and safe. This was possible because of the active support of the Senior First Aider, the one who was most frequently called to attend Ophelia. The final draft of the protocol incorporated the medical instructions, the First Aid and ambulance advice, along with some general information. A copy of the protocol and the circulation list is on the overhead.

4. DEVELOPING A GENERAL POLICY

As soon as the procedures were in place, my DLO colleagues and I agreed that we needed some more general policy to cover such eventualities as those presented by Ophelia. We felt that even though her particular condition is unusual, the problem of chronic medical conditions necessitating first aid is not. For example, all of us would probably have contact with students who suffer from epilepsy.

The first step in developing a policy is to describe the problem that has caused an interest in the first place. In the literature this is often called "framing" and it is of great significance who does the framing, and what context and language they use. In this case it was we DLOs initially and then our Director who described the situation as one of "sudden-onset chronic medical emergencies". Our paradigm was of course that of trying to ensure appropriate support for the student. We wanted to ensure inclusion not exclusion; our primary focus was to meet the stated needs of students, not to minimise the risks to the university – although we were certainly mindful of these. I will display the final version of the policy and explain the significance of each of its sections.

5. CONCLUSION - THE LESSONS WE LEARNED

5.1 The end of the policy cycle

The academic policy analysts generally identify these stages in the policy cycle: first you identify the problem, then canvass options, develop drafts, consult, decide, implement,

evaluate, revise. As we probably all know, especially if we have been involved with large and complicated policies such as disability action plans, there can be problems, major ones, at the implementation stage. The question is, will other people, in other areas of the organisation, accept – REALLY accept – what has been decided. If many people have been consultated, they may really feel they own whatever it is you produce – BUT it may be so watered-down in order to achieve consensus that the goals become minimalist. There may be a trade-off between the strength of the policy and the degree of acceptance. Even with a small scale policy such as I have described here, we could see that in some ways it is better not to ask some areas to become involved, because they might not go along with what we wanted. On the other hand, if they don't go along with the policy, will they comply with it? Do we have enough power to enforce compliance, or will people just ignore the policy?

5.2 A guide for DLOs

Be first in identifying a problem and developing the options that may solve or manage it – that way you can frame the problem and that is being half way there.

If people say that there are other policies or laws and that they say such-and-such, always ask "where is this written?" Never assume, always CHECK.

In order to get other people more-or-less on side so that there is some hope of your policy being implemented, it is necessary to take people with you as you go. Sometimes they need encouragement to see the stepping stones in the water, so it is important to listen to their concerns and justify each step along the way. Don't go swimming off alone in the water.

6. REFERENCES

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