Dealing with Hostile Patients

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Objectives

- Learn to recognize and anticipate hostile patients
- Implement passive measures for countering situations
- Implement appropriate responses for active situations
- Understand the importance of de-escalation as a communication skill
The Essential Risk

- Physicians have the potential to interact with the full range of human emotion at any time, sometimes even with many extremes of human emotion in a single visit.
- Violence against healthcare workers is escalating.
  - OSHA estimates that there are 2,600 non-fatal assaults against hospital staff every year. This does not include attacks on outpatient staff, violence perpetrated outside the workplace, nor does it include fatalities.
  - FierceHealthcare tallied 150 hospital shootings from 2000 to 2011, with 30 percent in emergency rooms.
  - DOJ "the Departments of Justice and Treasury, with assistance from other federal agencies, have committed extensive resources to the reduction of threats and violence against health care providers on a national level."
The Essential Risk

• Violence against healthcare workers is escalating
  • Hennepin County Medical Center in Minneapolis, Minnesota saw 4 security lockdowns in the last 6 months: the latest weapon related incident was 9/21/14
  • July 24, 2014 Philadelphia, Mercy Fitzgerald Hospital
    • Patient shot case worker, fired at MD, had 39 unspent rounds, history of 4 gun arrests, assaults, drug charges
    • Psychiatrist shot patient: Psychiatrist Lee Silverman crouched behind a chair and pulled out his own gun, firing several shots
  • Although physical violence remains relatively rare it is a “low-probability, high-impact” event
Where are Your Vulnerabilities

- **At home**
  - Dr. Herbert Lourie (d) [http://www.amednews.com/article/20050307/profession/303079967/2/](http://www.amednews.com/article/20050307/profession/303079967/2/)

- **During commute**

- **At work**

- **When out of town (CME events, etc.)**

- Dr. Kenneth Pence (Vanderbilt U.) [http://www.rateyourrisk.org/](http://www.rateyourrisk.org/)
Personal Risks

Before an assault most assailants do their homework, conduct surveillance and look for weaknesses

- Do you always drive the same route to work?
- Do you always park in the same spot/“Doctor’s parking”?
- Do you have a uniquely visible vehicle?
- Do you always jog the same path?
- Are you prone to react to challenges aggressively?
- Is your line of site obscured when entering/exiting your vehicle at home or at work?
- Is someone carrying a vendetta or grudge against you?
Additional Risks

• Rural practice

• Emergency Room
  • *Annals of Emergency Medicine (2005)*
  • Verbal threats were the most common form of work-related violence, with 74.9% (95% [CI] 68.4% to 81.4%) indicating at least 1 verbal threat in the previous 12 months.
  • 28.1% (95% CI 21.3% to 34.8%) indicated that they were victims of a physical assault
  • 11.7% (95% CI 6.9% to 16.5%) indicated that they were confronted outside of the ED
  • 3.5% (95% CI 0.8% to 6.3%) experienced a stalking event.

• Pain management
  • Evolving regulatory prescription issues
  • Diversion/poly-pharmacy/alcohol

• Psychiatry/mental health providers

• Overburdened/overextended healthcare workers (primary care)
Who fits the profile?

• A patient who has/is:
  • A failure to conform to social norms
  • Extremely deceitful and/or manipulative
  • Impulsive
  • Constant irritability or aggressiveness
  • Blatant and reckless disregard for the safety of self or others
  • Consistent irresponsibility
  • Cognitively impaired (by medical condition, medication/drug, pain)
  • Complete lack of remorse after having hurt, mistreated, stolen from another person, or from the practice (material or economic)

• Does not require tattoos, piercings, monstrous physique
How Open is Your Door?

• **Barrier measures**
  - Are your (non-primary) external doors locked?
  - Are your internal doors locked?

• **Practice policies**
  - Pre-encounter - AAFP encourages all physicians to have a security manual/protocol in place and to go over security issues when training new staff.
  - Contracts for high risk patients with consequences
  - Intra-encounter (“Code White” versus “code silver”) raising the alert/appropriate response
  - “Post”-encounter – is it really over?, remember your attorneys

• **Practice physical arrangements**
  - Lessons from pharmacies: Layers, locks, specialty glass
  - The simple lesson of “Wild Bill” Hickok

• **Room arrangements**
  - The lesson of Richard Mansfield, MD (Case Study)
**Case study: The lesson of Dr. Richard Mansfield**

Sitting alone in an exam room with a patient with a history of violence is one of the most difficult parts of my VA Medical Center practice. This was driven home for me not long ago when one of my patients, a man bigger than I am, lunged forward and curled his hands around my neck.

In my mind, I instantly ran over our academic protocol for handling this kind of situation, but dismissed it in a split second. The phone to dial the emergency code was out of reach. Worse, I was seated, and he was standing, looming over me. Cut off from the door, I had nothing that I could use for self-defense.

Five minutes earlier, I'd opened the patient's electronic health record and seen the same pop-up message that greeted me during his last several visits: "Behavior warning." I'd gotten used to the message by now and clicked past it. On this day, the patient had been five minutes late, and I was running 10 minutes behind.

As he gripped my neck, he said, "I've hurt people in the past—but they made me do it!" And then, giving my head a twist that stopped just short of causing pain, he continued, "What would you do if someone did this to you?"

My mind raced. Should I try to break his grip on my neck? Hit him in the gut? Aim lower, hitting him in the crotch out of desperate self-preservation? As a primary care physician, I had an arsenal of weapons to fight disease, but in the face of physical aggression, I was helpless.

Then, as suddenly as he'd grabbed me, his grip relaxed, and he straightened up.

"So now you understand the position I was in, and why I did what I did." The way he pointed his finger at me still seemed threatening, but the redness in his face was fading and the beginnings of a smile crossed his lips. "And why I need you to give me more Percocets, given the shape I'm in after what I've been through." He sat down, finally, although he was still between me and the door. As he sat, I thought, "Did he just threaten me for drugs?"

Clinical reasoning gave way to survival instinct: At this point, whether or not he was due for his colon cancer screening seemed irrelevant. What I knew—and knew clearly—was that the fastest way to get him out of the room was to give him the prescription he'd wanted all along. Hastily, I wrote a script for a few Percocets, then folded the sheet in half. With luck, he wouldn't notice how few I'd prescribed until he left my exam room.

"Take this to our pharmacy," I said, my words trailing off. He took the script, stood up again, and backed out of the room, never breaking eye contact with me.
Case Study: what went wrong?

• Lack of situational awareness: ignored alerts, clinic procedures, failed to pre-plan the visit himself/with staff
• Lack of situational awareness: Did not make eye contact
• Lack of situational awareness: Did not assess patient demeanor
• Lack of situational awareness: Did not see patient coming
• Did not address his own tardiness to defuse patient
• Did not engage with interest/curiosity regarding his story
• Location of exam table & desk relative to the door
• Focus on the EHR, not the patient during encounter
• Did not report patient to security/police once out of room “meet him at the pharmacy. He is male, XYZ, wearing…”
• Follow-up with law enforcement, make sure arrest made, press charges
De-escalation

n. reduction in size or intensity of conflict
Approach to De-escalation

Essential Elements

- Anger must be acknowledged and reduced
  - Assess your own self. Are you:
    - preoccupied and paying attention to something other than your immediate circumstances and surroundings?
    - alert and reasonably aware of your surroundings and able to assess your options?
  - Are you personally and emotionally prepared to constructively intervene with this person’s anger?
  - Are you able, whether you agree with it or not, to perceive the mindset of the other person? Specifically, are you able to take a leap of faith that this patient is genuinely trying their best to resolve the problem?
  - Are you sufficiently rested and prepared to engage the patient without reciprocating the same level of anger and/or aggression that the patient is exhibiting?
  - Can you personally accept that this person may still leave your encounter feeling angry with you, though the cause be through no fault of your own?
**Approach to De-escalation**

*What it is*

1. Pure, patient, but active listening is an imperative
   - Often truly listening and allowing venting will suffice
     - Make excellent (non glowering) eye contact
     - Offer head nods, and brief intonations to continue
     - Attend to non-verbal communication, body language
   - Avoid interrupting, interjecting, **correcting until** he/she is finished
     - Let’s them be heard, and is fatiguing, both of which help openness

2. Ask “what can I do to help this situation?”
   - Allow step 1 to repeat itself, if necessary

3. Offer additional information, clarifications, corrections
   - If you agree with even a portion of what is said, voicing agreement can defuse anger without surrendering the larger issue(s)
Approach to De-escalation

What it is

4. Encourage them not to hold back what is on their mind
   - It seems like there may be still other things on your mind, making you upset. Go ahead and tell me everything on your mind. I want to hear all that you have to say.

5. When possible, offer an appropriate resolution
   - When the anger has a legitimate cause it is acceptable to give a straightforward acknowledgement, “I understand why that experience could make you angry”.
     - Convey in a believable, sincere manner
     - This doesn’t endorse behaviors, but legitimizes that emotions were felt
   - Apologize for clear errors or injustices, without inferring that you accept blame for something for which you are not responsible

6. After issue resolution consider addressing the behaviors and techniques chosen by the patient in a nonthreatening manner. (This can be at a future date)
Approach to De-escalation

What it is not

- Techniques are not simply to use reason with the person
  - Trying to get one who uses anger:
    - to control an encounter
    - to intimidate
    - to avoid personal responsibility
    - to make themselves feel more important
  to see reason is, at best, a futile effort.
- Anger is not an abnormal human emotion
  - Find a grain of truth in what your patient is saying and reflect this element to them (even if you believe that essentially they are wrong).
- De-escalation is not just telling the patient what they want to hear
  - It is not condescending
- De-escalation is not an acceptance of additional medico-legal liability
  - It may defuse some risks
# De-escalation Specific Example

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Useful Phrases</th>
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<tbody>
<tr>
<td>Pause and be attentive</td>
<td>“Tell me about what’s upsetting you.”</td>
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<tr>
<td>• Avoid being defensive</td>
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<tr>
<td>• Stay curious about the patient’s story</td>
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<td>Acknowledge the difficulty of the interaction</td>
<td>“Having to wait for 45 minutes to see me is really a long time.”</td>
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<tr>
<td>Find out the specifics of the story—encourage the patient to give the details</td>
<td>“Tell me more about what the receptionist said to you.”</td>
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<tr>
<td>Express empathy for the patient—acknowledge the emotion by name</td>
<td>“It’s very frustrating to have to wait so long.”</td>
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<tr>
<td>Make a statement guessing at the meaning behind the patient’s anger and validate</td>
<td>“Was it frustrating because it was a waste of your time?”</td>
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<tr>
<td>Take an action on the patient’s behalf if possible. Be an advocate</td>
<td>“I’ll see what caused the delays today. Maybe it’s something that can be avoided in the future.”</td>
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<tr>
<td>When possible, link the patient with resources that can help</td>
<td>“Would you like to register a complaint with the supervisor?”</td>
</tr>
<tr>
<td>Transition to purpose for the visit</td>
<td>“Well, now that you finally got to see me, what can I do for you today?”</td>
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• Remain calm and professional
• Be aware of body language and non-verbal cues
  • May provide a warning of an impending physical escalation
• Exit
  • Maintain the availability of routes of egress for you and the patient
  • Avoid either of you feeling trapped or confined
• Tactical Pen/Kubaton – potentially acceptable – with training
  • Strike, stab, apply to pressure points, across neck / small joints to control situation
• Exit
• When the Patient is the one with the Scalpel (knife)
  • The key to a good knife defense is to control the knife hand and strike with everything you’ve got, immediately
• Exit
• Use a firearm in the examination room—“action beats reaction”
  • This is a situational issue of the wisdom, not the Right to bear arms
  • Training and practice
    • It takes a lot longer for ordinary civilian to pull a gun than most think, almost five seconds on average, from sitting to draw and accurate shot
    • Any doubters? The Tueller drill
  • Weapon retention
    • Apr '13 police officer murdered in Jackson, MS by suspect who grabbed the officer’s sidearm and used against the officer in an interrogation room
• Multiple assailants
• Projectile over-penetration
• Hearing loss
• Legal liabilities
  • Facility
  • Witness(es) or not
  • Premeditation
For Further Reading

- http://www.rateyourrisk.org/
- http://xnet.kp.org/permanentejournal/spring03/angry.html
For Further Reading

- http://www.staysafemedia.com/
- https://www.tactical-officer.com/articles/whats-so-tactical-about-a-pen/#.Ui1FPJLVCSO
- http://cppssite.com/
- http://boards.medscape.com/forums/?128@@.2a02e7c4!comment=1
- http://xnet.kp.org/permanentejournal/spring03/angry.html
For Further Reading

Questions?

Thank you for your kind attention