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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

How to Recognize & Manage an Angry Patient

Dr. Buch:
We all face angry and disruptive patients. So what's the best way to de-escalate and handle the situation?

This is *GI Insights* on ReachMD, and I'm your host Dr. Peter Buch. Here to provide answers to that exact question is Dr. Douglas Drossman. Dr. Drossman is co-author of an article that was published in the *American Journal of Gastroenterology* in March 2023 titled "De-escalate Don't Escalate: Essential Steps to Effectively Recognize and Manage the Patient Who Is Angry and Disruptive." He's also well-known in the field of gastroenterology and practices gastroenterology in Durham, North Carolina.

Dr. Drossman, welcome back to the program.

Dr. Drossman:
Thank you. Glad you had me back.

Dr. Buch:
It's always a pleasure. To start us off, Dr. Drossman, how common are verbal and physical assaults in clinical practice? And even more importantly, why do you think we're seeing an ever-increasing number of these problems?

Dr. Drossman:
Well, I think it's more common than people may think. Usually, it depends on the setting and a level of communication. They're most frequent in urgent care and ICUs and emergency rooms, maybe less common in the outpatient clinics but still pretty common. I think that's because there's not enough time to actively communicate with the patient and try to de-escalate as we say. There was a national survey that found 100 percent of emergency department nurses reported verbal assaults, and 83 percent had experienced physical, and then another survey in intensive care was about 88 percent verbal and 74 percent physical.

I think in general when providers take less time and make less effort to connect—some of it is unavoidable—you will see more disruptive behaviors.

Dr. Buch:
So the follow-up question to that is how do we prevent that in the future with fewer and fewer providers being out there and less and less time available to all of our patients?

Dr. Drossman:
We have to be aware of the signals. First of all, there could be inciting events. It often relates to patients wanting or expecting something the provider may not feel is medically indicated. Like opioids for pain, that could be a common one, and in the article, we give a case example of someone who wanted that. And maybe you can prevent escalation by engaging with them early on to help them understand why it might be problematic and then also don't just tell them "You can't do it" but give them alternatives like neuromodulators, but this takes some communication skills, training, or awareness. I think you also have to try to be aware of underlying factors that might be signals. Again, a history of substance abuse, drug seeking, a history of violent behaviors, or psychiatric hospitalization for that, people with borderline behaviors, or cognitive difficulties. If they're currently appearing to be distressed or anxious, sometimes that can lead to a triggering response. And then there are medical conditions that may happen more often—people with severe pain or sleep deprivation or multiple physical complaints or withdrawing from opioids or particularly amphetamines.

You can identify anger by nonverbal signals. We teach a lot about the clenched fists, the tightly closed mouth, a loud voice, if someone starts looking stiff and leaning forward towards you somewhat intrusively. Those are the kind of things you would look for. These kinds

of behaviors do go in stages. In the beginning, they might feel a little bit more anxious or agitated, but then they may become verbally aggressive, and then they might be physically aggressive. With the first and possibly the second components, you might be able to de-escalate by working on a dialogue to help them understand to de-escalate, but if physical aggression is starting to occur, I suggest you step back, open the door, and possibly get some help.

Dr. Buch:
And continuing with this thought, Dr. Drossman, what are the dos and don'ts when dealing with angry and disruptive patients?

Dr. Drossman:
Let me start with the dos. Nonverbal is important. Give the patient your attention, good eye contact, actively listen, and stay composed. You have to be respectful. Even if they are getting agitated or upset, you can use your body language to send a positive signal. The active listening means don't interrupt. Let them talk and then maybe even reiterate what they have said: "So you feel that people aren't treating you fairly," those kind of comments. I think you want to try to be empathic, be willing to compromise, and negotiate.

Keep in mind this is their issue. You don't know this person. You've never met them before if it's the first time, or you know it's not anything you've done. What you need to do is take a step back and say, "This is their issue," and that helps keep you from reacting.

So the things you don't want to do is to react, crowd the patient, try to touch them to reassure (they may be too agitated for that), turn your back on the patient—you want to keep actively engaged with them. And it doesn't help to give feedback like "Stop yelling at me," or "Don't get angry." That's only an affront to them. It will be seen as controlling, and so you don't want to take the patient's remarks personally. And I think those are the main ones. The overarching issue is to diffuse the situation early to prevent escalation to more serious verbal or physical violence.

Dr. Buch:
Our front lines in any office or hospital setting, is the staff. So, what should we know about debriefing the staff when dealing with these situations?

Dr. Drossman:
Well, I think it's helpful in advance to maybe have an intake session where you kind of talk about this. Send them the article and discuss it with them. Give them scenarios of how they would deal with it, and give them the information of how they can identify the angry patient verbally. You might talk about the three stages that if they are agitated or anxious, your role is to calm them down, send positive signals to them, but stay open and relaxed. If the patient is speaking, don't interrupt. And then at some point if it becomes more aggressive, then you may want to look for help.

If they get aggressive, physically violent, you excuse yourself, say, "I need to leave for a while, and I'll be back." Then you can ask for assistance and bring someone in with you, even if it's really aggressive, security to try to continue the discussion. It's good to validate the patient's feelings. "I came here, and they wouldn't let me in, and I'm really feeling terrible," and then you could say, "Well, I can understand why this might be happening given everything you've gone through." So you kind of validate their concerns without necessarily countering them. I think it's important not to come up with a quick fix. If they have been angry, you may want to say, "Well, let's take some time to figure out how we can work on this," rather than make a quick solution.

Dr. Buch:
And I'm sure there's additional communication that needs to be happening right then and there. So if you have an angry patient, your front office staff needs to communicate with mid-levels, etc., to let them know and then to let you know that this is going on. And I'm sure situations like waiting in the room an excessive amount of time is just going to exacerbate it. Can you just comment on that good communication?

Dr. Drossman:
Yeah. You have to engage, and leaving someone in the waiting room only adds fuel to the fire if they don't feel that someone is going to come back and listen to them, so you begin the process. You do the discussion and then say, "We're going to be right back to talk to you about that more." And when you have your debriefing, administration has to be in it too. They really are the front line, right? Someone could just walk up to the front desk and just blow at them, and you have to train your secretaries and administrators as well.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Douglas Drossman about how we can manage an angry and disruptive patient.

So, Dr. Drossman, when it is appropriate to discharge a patient from your practice?

Dr. Drossman:

If the patient chooses to stay, you can make efforts to address the issue with the patient using the kind of communication strategies that I mentioned, and I want to come up with the process of how to do it. If it doesn't work and they are staying angry, I think you should try to mediate the issues and bring in another colleague or counselor who can speak with the patient. And if all of these efforts fail and you feel it's not safe for the practice, you need to go through a process of discharging them.

Dr. Buch:
And that's a wonderful segue for my next question. What would be the process for discharging a physically abusive patient from your practice?

Dr. Drossman:
Well, first you do want to ensure that there's no underlying medical issues that are contributing. You know, a patient may have to be hospitalized for suicidal behavior or other severe medical reasons. Assuming that's not the case and you're going through a process, you want to be sure that anything that's happened you document. You want to keep records of the patients because this could become a medical legal issue, right? So you want to keep records of the patient's behaviors. You may want a colleague to also include confirmatory information, the dates, the times, the descriptions of each incident, and you may want to document any discussions you've had with the patient about their behavior as well. And then the next step would be to have a very frank but compassionate discussion about their behavior saying that it's affecting their treatment and the care of others in the work environment and allow them to improve their behavior. The more you can engage them in the dialogue, the less likely you have to discharge them.

If they want to still stay, you need to start setting boundaries. You inform them of what's expected during appointments and in the healthcare facility. No shouting, no abusive language, and reinforce the importance of mutual respect and cooperation. If necessary, as I mentioned, you could involve a mediator or patient advocate to facilitate. And if at that point the disruptive behavior persists, you would need to issue a formal written warning and outline the specific concerns and the consequences if their behavior were to continue.

If you're at a medical center, there might be policies about how to do it or in a large group practice. And then at some point you're going to need to consult with your legal counsel. Once that happens, you can issue the letter for discharge. It's always important when you do the discharge to provide some alternative for them as well.

Dr. Buch:
And before we conclude, are there any additional thoughts you'd like to share with our audience?

Dr. Drossman:
I think you know, Peter, my thing is communication skills, and it's all about how you communicate and the way you make that happen, to be respectful. I've mentioned this a couple of times before. And again, don't take it personally. It's not you that's doing this. It's them. They have the problem that we need to address. And sometimes don't just do something but stand there and let them talk.

Dr. Buch:
This was an excellent review on how to manage an angry and disruptive patient, and I want to thank my guest, Dr. Douglas Drossman, for sharing his experience. Dr. Drossman, thanks so very much for joining us today.

Dr. Drossman:
It's always a pleasure to be here, Peter.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.