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Handling the "Difficult" Patient

David C. Hutzel, M.D.
3/14/15

Format

- Definition
- Who is the one with the problem?
- What can we do?
- Violence in the medical environment
- Excursions

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What is a difficult patient?

- "Heartsink" patients
- Non compliant
- Unexplained somatic complaints
- Substance abuse
- Drug seeking
- Personality disorders
- Demanding

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What is a difficult patient?

- Threatening
- Verbose
- Untreatable illnesses or dying
- Psychosocial dysfunction
- Over-ultilizers
- Severe psychosis
- Unrealistic

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Not obvious

- Too similar: over identify and undertreat
- Too different

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Pete

- Sometimes a difficult patient is because of an acute change in condition
- Often there are legitimate concerns, fears and needs behind rude behavior
- “Even a squirrel gets sick”

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Rudeness

- Ken Follett “A Dangerous Fortune”
- The Amazing Mazey
- The advice given to her on how to handle rude customers
- Rudeness is people trying to communicate because they are afraid that they are not going to be heard

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Characteristics of physicians who have a higher % of “difficult patients”

- Greater perceived workload
- Lower job satisfaction
- Lack of training in counseling or communication skills
- Lack of post graduate qualifications
- Physician who require more diagnostic certainty
- Less experience

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Characteristics of physicians who have a higher % of “difficult patients”

- Poor psychosocial beliefs and attitudes
- Being uncomfortable with non-compliance, multiple complaints, lack of response to standard treatments
- Impaired physicians
- Not well read
- Not well traveled
- Lack of religious faith

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Who is the one with the problem?... A case study

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Look at it from a patient's point of view: the hospital visit

- Cost of parking
- Finding parking
- Paperwork
- Beds in the hallway
- Bumps
- Loud nurses
- Lack of coordination of tests

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Look at it from a patients point of view: in the hospital

- PCPs not in the hospital
- Different hospitalists/surgeons daily
- Med schedules different from home
- Who is the boss?
- Who are all these people in my room?
- Cost?
- Lack of convalescence

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Look at it from the patient's point of view: the PCP/outpatient clinic

- Parking
- Paperwork, insurance hassles
- Being turned away for being late
- Doctor running late
- Parking
- Doctor looks at the computer and not me
- "I am here for my shoulder…. Not XYZ"

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Difficult patients and lawsuits

- Levinson, JAMA, 1997; 277:553-559
- Malpractice claims on 124 physicians
- Videotapes of claims vs. no claim physicians
- Able to predict physicians who were sued >2/3

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No claim physicians

- More likely to educate patients
- No surprises
- Laughed and used humor
- Solicited patients opinions
- Encouraged talking and questions
- Had longer visits

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How long do you think a patient will talk?

- 2-3 minutes

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How long does the average doctor wait to interrupt a patient?

- 17-20 seconds

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What else can we do?

- Slow down,
- sit down,
- be quiet and
- don't act arrogant

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Mantra

God, help me to be:

- Kind
- Compassionate
- Careful

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“I am sorry”

- Apology laws began in Massachusetts in 1986
- Now in 36 states
- VA studies from early 2000’s
- University of Michigan reduced payouts by 47% (Boothman 2009)
- An apology does not = culpability

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Ok, enough “touchy feely mumbo jumbo!!”

Because there are:

- Entitled Jerks
- Cuckoo for Cocoa Puffs
- Nasty, mean, belligerent
- Litigious
- Foul mouthed, smelly, ungrateful, demanding, free-loading, smoke soaked, really un-pleasant people out there

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Transference

- Patient transfers emotions, experiences, desires
- From a relationship in the past
- To the practitioner

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Transference examples

- Military officers/CEOs: barking orders
- Loneliness: seeking acceptance
- Experiences with racism: distrustful
- Pediatrician always did ___: you do the same
- Mother was condescending: no tolerance

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Countertransference

- Practitioner transfers emotions, experiences, desires
- From past
- Onto the patient

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Countertransference

Classic example:

- Demanding father, hard to please
- Doctor caves to demands of patients
- Excessive testers
- Excessive prescribers of narcotics
- Avoid conflict
- I want you to like me

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A Borderline Example

- Female into the office for complaints of pelvic pain
- Has chaperoned exam, all is normal
- Plan of action in place: imaging, meds, tests
- Follow up arranged
- Seen in the ER with slash wrists because nobody believes me

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DSM Borderline

- Dysfunctional relationships:
  - -frantic efforts to avoid abandonment,
  - -idealization/devaluing
  - -splitters
- Marked impulsivity:
  - -sex, spending, substances
  - -often leads to self harm
- Unstable sense of self

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DSM Borderline

- Suicidal gestures/threats
- Affective instability: rapid changes in mood
- Emptiness
- Intense, difficult to control anger
- Paranoia

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How to handle a patient with Borderline PND

- Consistent support
- Firm limits
- Fix what you can
- Address fears and concerns one at a time
- Realize that the inability to satisfy the patient is part of the pathology, NOT your inadequacy
- Recognize splitting, limit # staff interactions

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Avoid borderline traps

- You are the best doctor
- You are a terrible doctor
- Sexual advances
- Contracting for safety

- Narcissist loves this
- Shuns & abandonment
- Enmeshment
- Appeaser is sucked in

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Narcissist

- Kevin: “I am going to the head of the line”
- Refusing to allow intern or resident
- Threatens lawsuits
- Demands to see the head of department
- Wants a bigger room
- Can be dismissive
- Can be condescending

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Narcissist

- “The rules do not apply to me”
- Feel special
- Cannot understand others points of view
- Expects rules to be bent, waived
- Wants special attention, treatment
- Hard wired patterns of behavior

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What can you do with a narcissist?

- Realize that you cannot change them
- Get specifics on what you can do make them happier
- Fix what you can
- Rationally explain why you cannot accommodate all of their needs
- **If you are doing good medicine, realize that you will be fine**

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Screamer

- Be patient
- Be calm
- Be relaxed
- Simplify tasks, 1 at a time
- Gentle redirection
- Engage family
- Haldol, small doses, frequently, titrate

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Sundowner

- Establish circadian rhythm
- Lights on/windows open
- Lights off/quiet halls
- Turn of the TV !!!
- Treat pain
- Long list of meds that cause delirium
- Reassure family, this will get better

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Angry patient

- Calm and Respectful
- Sit down, be quiet and listen
- Validate complaints
- Apologize if appropriate
- Do not force patient to do anything they do not want to do
- Weapons?
- Use show of force and Haldol as last resorts

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Compulsive patient

- GE engineers
- Accountants
- IT
- Librarians

- Like control, exact answers.
- Questioning versus questions??
- Can be very literal

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Compulsive patients

- Provide detailed, accurate, specific information
- Give yes or no answers when able
- Allow patient to participate in choices
- Do not prematurely reassure
- No false or empty promises
- Do not joke around, they are literal
- Identify the vagaries of medicine and how this can upsetting

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General poor strategies

Ignore problems such as:

- Code status
- Pain
- Answering patient's questions
- Not answering family's concerns
- "Punting" = it is not my problem
- "LGFD" rounds
- Ignoring problems = Abandonment

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General poor strategies

- Lying
- Giving false hope
- Not being forthright about prognosis
- Inaccurate results
- Caving into demands: drugs, tests, referrals
- “Our job is to give the patient what they need, not what they want.”

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Excursion

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Violence in the medical environment

- 2000-2011 154 hospital based shootings with 235 injured or killed
- 20 weapons confiscated/day at UPMC Hamot

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2/18/15

Emergency Department

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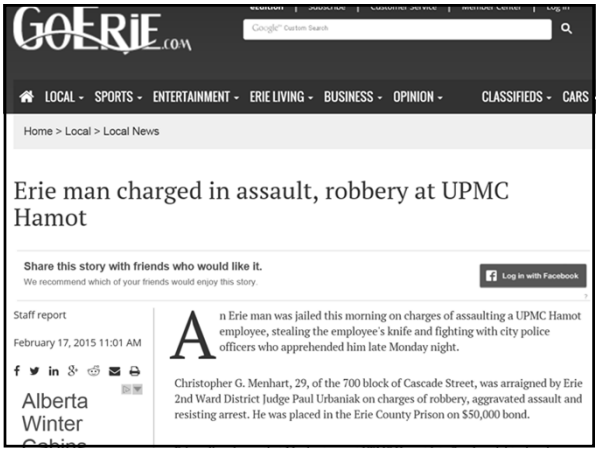
66



Brigham and Women's Hospital

1/20/15

- 42 yo CT surgeon Michael J Davidson, MD
- Married
- Wife a doctor with 2 kids & 7 months pregnant
- Victim hunted down by the son of patient who died in 11/14

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U.S.

Brigham and Women's Surgeon Dies After Hospital Shooting

By JESS BIDGOOD JAN. 21, 2015

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BOSTON — A cardiac surgeon who was shot when a man opened fire inside a Boston medical center Tuesday has died of his wounds, hospital and police officials said.

The doctor, Michael Davidson, 44, director of endovascular cardiac surgery at Brigham and Women's Hospital, was shot twice Tuesday morning at the hospital's cardiovascular center. The gunman, identified as Stephen Pasceri, 55, of Millbury, Mass., then shot himself, the authorities said. Dr. Davidson died late Tuesday.

Law enforcement officials say Mr. Pasceri walked into cardiovascular center, asked for a

Officials gathered outside Brigham and Women's Hospital in Boston on Tuesday. Dr. Michael Davidson, 44, director of endovascular cardiac surgery was fatally shot at the hospital.
Brian Snyder/Reuters

Mercy Fitzgerald Hospital, Darby, PA

7/24/14

- 1 case manager killed
- 2 wounded
- Doctor fired in self defense and killed patient

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Patient charged with murder in shooting at Darby, Pa., hospital

71

Caseworker Theresa Hunt, 53, of Philadelphia, was shot and killed July 24, 2014, after patient Richard Plotts, 49, allegedly opened fire inside Mercy Fitzgerald Hospital in Darby, Pennsylvania. Psychiatrist Dr. Lee Silverman, who was grazed by a round, shot and wounded Plotts, authorities say.

UPMC Western Psychiatric hospital

3/9/12

- 2 dead
- 7 injured

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post-gazette.com
Pittsburgh Post-Gazette

Two dead, seven injured in Western Psych shooting

March 9, 2012 10:15 AM

By Sadie Gurman, Liz Navratil, Moriah Balingit, Jon Schmitz, Sean Hamill, Amy McConnell Schaarsmith and Dan Majors Pittsburgh Post-Gazette

UPMC officials have released some information about the people who were wounded in a gunfight today at Western Psychiatric Institute and Clinic.

Seven people are expected to survive injuries they suffered after a gunman entered the lobby of the clinic and opened fire. One person died, and the suspected gunman was killed by bullets fired by University of Pittsburgh police.

Dr. Donald Yealy, chairman of emergency medicine at UPMC, said five patients were being treated at UPMC Presbyterian, and two were treated and released. One had an injury not related to a gunshot wound.

Shootings leave witnesses, city stunned

Two people are dead, including a person who began firing from two semiautomatic handguns inside Western Psychiatric Institute and Clinic of UPMC on Thursday. (Video by Andrew Rush, 3/9/2012)

Police have not released the names of the injured, who included UPMC employees and a hospital visitor.

"I expect all of these patients to survive and do well," Dr. Yealy said.

Those being treated at Presby for gunshot wounds include a 46-year-old man, who was in fair condition; a 64-year-old woman, serious condition; a 54-year-old woman, fair condition; a 35-year-old male, fair condition; and a 49-year-old male, serious condition.

Earlier this evening, officials held a press conference to discuss the shootings but released little information.

What can we do against violent patients?

- Take threats seriously and report them
- Work with local law enforcement
- Panic buttons
- Escape routes
- Empower staff to call for help
- Lock doors, limit access

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Imminent danger

- Charge the gun
- Run from the knife

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UPMC HR policy

- No guns
- No tasers
- No weapons of any kind

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My concern, my fear and what I dread

- How safe are we?
- When will this happen here?
- How can we protect ourselves?
- 2nd amendment rights?

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Munio self defense tool

- Munio – from Latin “to protect”
- Looks like a keychain
- Fits in the palm of your hand
- Distracts an attacker enough to give you a chance to get away from a hands on attack.
- Doesn’t look like a weapon, passes metal detectors

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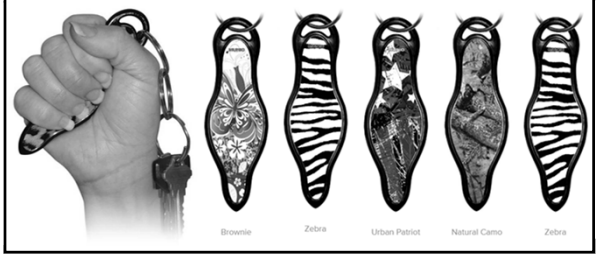
Munio self defense tool

- Gives victim an edge to make the attacker let go, or can be used like a whip with keys



UPMC LIFE CHANGING MEDICINE

Medical Center Response to *Active Weapon Situations*

Jason C. Chenault, PhD, CEM, CHEP, CMCO, FACEM
Senior Director of Emergency & Regional Services

Graphic Content Disclosure

This presentation may contain images or content that may be considered graphic by some.
Viewer discretion is advised.

Boston Hospital Surgeon Dead…

Responding to an *Active Weapon Situation*

- The UPMC ***Bronze Alert*** policy outlines the courses of actions on how you as staff should respond to an *active weapon situation*.
- No single response fits all *active weapon situations*; however knowing options to respond proves beneficial.

Responding to an *Active Weapon Situation*

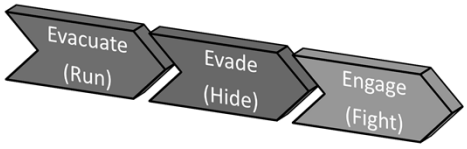
- Remember, during an *active weapon situation*, the natural human reaction, even if trained, is to be startled, feel fear and anxiety and even experience disbelief and denial.
- Expect to hear noise from alarms, gunfire, shouting, screaming or even explosions.

Responding to an *Active Weapon Situation*

- Active weapon situations can be over within 10-15 minutes.
- Characteristics of an active weapon situation:
  - *Victims are usually random*
  - *The event is unpredictable and evolves quickly*
  - *Law enforcement interaction is usually required to end an active weapon situation*

The Three E's…

- In an *active weapon situation*, you should follow the *Three E's* Training:



Responding to an *Active Weapon Situation*

- These procedures should be implemented in such order as necessary given the circumstances of the critical security incident:
  - From a safe location one person should contact the facility emergency number and report a "Bronze Alert" and the location.
  - Call the UPMC building Security/Safety emergency number only when it is safe to do so. Call 9-1-1 if no UPMC on-site security is available for the building.
  - Do not attempt to assist or rescue injured victims until you are sure the attack has been terminated and the situation is under control.

EVACUATE (RUN)

- If there is an accessible escape path, attempt to evacuate to a safe area away from immediate danger. Follow the Evacuation procedures in the Emergency Operations Plan for your facility. Try to have an escape route plan in mind. If it can be done safely, remove patients, visitors and staff from the area affected by the critical security incident.
- Evacuate regardless of whether others agree to follow.
- Avoid elevators.
- Leave your belongings behind.

EVACUATE (RUN)

- Help others escape if possible but do not allow them to slow you down.
- Prevent individuals from entering an area where the assailant may be.
- Follow the instructions of law enforcement and understand that they may not readily realize your involvement in the incident.
- Keep your hands visible and over your head when evacuating.
- Do not attempt to move wounded people.

EVADE (HIDE)

If in an enclosed area:

- Be out of the assailant's view; follow ***Shelter-in-Place*** procedures identified within the Emergency Operations Plan for your facility. Sheltering includes:
  - Identifying a safe location where staff, patients and visitors may safely hide during an event.
  - Locking all doors to the area, if possible; if not, doors can be barricaded with heavy furniture.
  - Finding a source of protection if shots are fired in your direction, i.e., behind a sturdy object.

EVADE (HIDE)

If in an enclosed area continued:

  - Hiding behind large items (i.e., desks or cabinets).
  - Silencing all cell phones and turning off other sources of noise (radios, televisions).
  - Turning off all lights and computer monitors in your vicinity.
  - Closing blinds, curtains or blocking windows to prevent an assailant from seeing you.
- If able to do so, allow others to seek refuge with you. Note: If in a group, do not cluster together. Stay as separate from each other as possible.

EVADE (HIDE)

If in an open area:

- Find a source of protection if shots are fired in your direction, i.e., behind a sturdy object.
- Drop to the ground.
- Look for a place that can provide protection from the assailant or their weapons (bullets, etc). Move to the identified location as quickly as possible; however, do not expose yourself unnecessarily; run, walk, or crawl as the situation allows.
- Make an effort to identify the location of the shooter, evaluate the situation and if possible, escape from the area and alert the authorities. However, if escaping is not possible, then stay put—behind a locked door, if possible--and try to hide behind cover and wait for help to arrive.

EVADE (HIDE)

If in an open area continued:

- Hide along the wall closest to the exit but out of view from the hallway (allowing for an ambush of the shooter and for possible escape if the shooter enters the area).
- Remain in place until an "all clear" is given by identifiable law enforcement or internal security.
- If evacuation and evasion are not possible:
  - Remain calm.
  - Activate panic alarm or call Security, if possible. Dial 9-1-1 only after internal Security has been notified of the situation.

ENGAGE (FIGHT)

- Confront the assailant only as a last resort and only when your life is in imminent danger.
- Act as aggressively as possible towards him/her. Improvise weapons or throw items as necessary.
- Yell.
- Commit to your actions.

Non-Hospital/Clinic Areas
Non-Immediate Danger

- Staff in areas in **non-immediate danger** or **not adjacent to** the Bronze Alert location:
  - Prevent staff/visitors/patients from using elevators.
  - Assure patient and visitors they are safe at the current time and tell them to follow your instructions.
  - Limit sources of noise:
    - Silence Mobile Devices
    - Turn off all unnecessary equipment such as televisions, radios, etc.
- Assign one employee to monitor phones and email for updated information.
- Stand by for further instructions provided by hospital leadership and/or law enforcement.

Non-Hospital/Clinic Areas
Immediate Danger

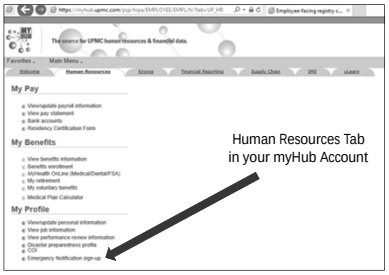
Follow previous steps for *Non-Immediate Danger* plus

- Close all corridor fire doors.
- Be out of the assailant's view. Use doorways and walls to your advantage for cover.
- Close and lock office door. If applicable, attempt to block it with furniture.
- Hide behind large items such as desks or cabinets.
- Close the blinds or otherwise block windows in which the assailant could potentially see you.
- Stand by for further communications.

Run… Hide… Fight…

Emergency Resources

- UPMC ENS System- sign up for Emergency Notifications in myHUB.



Emergency Resources

- iHamot- access the **Bronze Alert** and **Emergency Operations Plan** under Policies.

Emergency Resources

- myEOP- an electronic application for Android and iOS smart-phone devices for access to Emergency Response Guidebook.

??? ANY QUESTIONS ???

For More Information, Contact:
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Credits and Acknowledgements

- **Ready Houston/DHS**
  - https://www.youtube.com/watch?v=5VcSwejU2D0
- **WPRI Television**
  - https://www.youtube.com/watch?v=ETSmMLeIqeU
- **FEMA IS-907 Active Shooter Course**
  - http://training.fema.gov/is/courseoverview.aspx?code=IS-907
- **California Hospital Association**
  - http://www.calhospitalprepare.org/active-shooter