Evaluation and Treatment of the Angry Patient

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you ever been confronted by a patient who appeared angry? Have you ever feared for your safety while with a patient? Have you wondered how you could have approached or managed an apparently angry individual? If you have, then the following case vignettes and discussion of angry patients in the hospital setting should prove useful.

CASE VIGNETTES

Case 1

Mr A, a 92-year-old black man with a history of poorly controlled type 2 diabetes mellitus (complicated by end-stage renal disease on hemodialysis and a right below-the-knee amputation), was admitted to the emergency department from the dialysis clinic with pseudomonas bacteremia. Mr A became enraged when he was told that he needed hospital admission. He felt that this was an attempt to take his money and that it was not a strategy to improve his health; he maintained that he felt fine and that if intravenous (IV) antibiotics were required, he could receive them at the dialysis clinic. When the emergency department physician attempted to do a physical examination of his leg stump, Mr A began to yell, and he swung his crutch at the physician. He bellowed, "The infection is in my blood. There is no need to examine any other part of me!"

How could the emergency department staff have handled Mr A's worsening aggression?

Case 2

Ms B, a 43-year-old woman with chronic abdominal pain, arrived at her first visit with a new primary care physician. She felt that her prior doctors had not adequately addressed her pain or completed a thorough workup. She was convinced that she had Crohn's disease and was angry because her physicians had not agreed with her diagnosis. After the new physician took a history and determined that Crohn's disease was unlikely, Ms B became agitated and declared, "No one listens to me. I know my body better than all of you."

How could or should the physician have proceeded?

WHAT IS ANGER?

Anger is a negative emotional state that is generally accompanied by physiologic arousal and antagonistic thoughts directed toward a person or object viewed as the cause of an adverse event.[1] Manifestations of anger range from mild irritation to out-of-control rage.[2] Anger can also be suppressed, such as when directed inward toward the self, or it can be directed at others in the form of confrontations or aggressive behavior.[3]

WHY IS IT IMPORTANT TO RECOGNIZE ANGER IN OTHERS?

Recognizing patient anger is important for keeping health care providers safe. Among psychiatric patients, anger is one of the strongest

Clinical Points

- Recognizing patient anger increases safety for both physicians and patients.
- Anger, in itself, has a differential diagnosis that physicians should keep in mind.
- General approaches to angry patients in the acute setting include ensuring environment security, using verbal de-escalation techniques, and applying medical and physical restraints.
- General approaches to angry patients in a nonacute setting include validating the patient's beliefs, using verbal and behavioral de-escalation tactics, and aligning goals and cocreation of mutual understanding.

predictors of aggression.[4] Although uncommon, extreme instances of violence directed at health care providers do occur. In 2010, Warren Davis shot his mother's orthopedic surgeon before killing his mother and himself after he learned that back surgery had left his mother paralyzed.[5] In 2014, a strikingly similar situation occurred at Sacred Heart Hospital in Cebu City, Philippines, when a wheelchair-bound patient, who was upset about not being able to walk after spinal surgery, shot and killed his orthopedic surgeon before killing himself.[6] In 2015, Stephen Pasceri shot and killed Dr Michael Davidson, a Brigham and Women's Hospital cardiologist, who Mr Pasceri believed inappropriately prescribed his mother an antiarrhythmic agent, which he was convinced had contributed to her death.[7] According to police reports, prior to walking out to meet Mr Pasceri, Dr Davidson stated to a colleague, "Watch this, he'll probably shoot me." While it is impossible to know whether Dr Davidson really believed Mr Pasceri to be capable of violence, his statement might betray an unconscious awareness that a particular person has the capacity for violence. While extreme acts of violence are uncommon, violent crimes in health care institutions have increased significantly in recent years.[8]

Recognizing patient anger is also necessary for ensuring patient safety. Partially in response to the increase in violent incidents, in 2014, 52% of medical centers in a national survey reported that they allowed security guards to carry guns.[9] The increased presence of guns in hospitals has resulted in the injury and death of several agitated patients. In August 2015, a 26-year-old student, Alan Pean, who had been admitted for bipolar disorder, nearly died when 2 off-duty police officers shot him in the chest.[10] Psychiatric patients appear to be particularly at risk. In January 2016, a Central Lynchburg General Hospital security officer in Lynchburg, Virgina, shot Jonathan Warner, a patient with bipolar disorder, 4 times after he became angry and took the officer's taser. Jonathan Warner was left paralyzed from the waist down.[11]

Beyond physical harm, there are other consequences of failure to identify and appropriately respond to angry patients. Anger disrupts the doctor-patient relationship and can cause patients to miss appointments, to be less adherent with their medications, and to develop overall worse health outcomes.[12,13]

Additionally, anger contributes to many malpractice lawsuits. When physicians and hospitals address patient anger by admitting mistakes and apologizing, the rate of malpractice lawsuits declines.[14] Since lawsuits decline when physicians apologize, it is reasonable to surmise that such suits are often driven more by anger than the actual outcome.

HOW CAN ONE RECOGNIZE THAT A PATIENT IS ANGRY?

Individuals vary in how they manifest anger, and a single individual may express anger differently depending on the situation. Physical signs of anger include glowering eyes, knitted brows, pursed lips, slightly opened mouth, facial flushing, a tense jaw, or adopting an aggressive stance.[15] Behavioral manifestations of aggression include yelling, swearing, becoming quiet, or changing from one's baseline behavior. Some patients may not provide overt signs of anger but passively demonstrate their anger through their actions, such as noncompliance with medical treatment.

In the health care setting, anger can be described as falling on a 6-pronged continuum[16]:

1. Calm and nonthreatening: A patient may be frustrated but fail to show overt signs of agitation.
2. Verbally agitated: A patient may say, "This is ridiculous. I can't believe I have been sitting in here for 45 minutes," as he or she paces while waiting for a physician who is running late.
3. Verbally hostile: A patient may shift from offering phrases of discontent to unkind phrases, eg, "This doctor is incompetent and this entire practice is a sham."
4. Verbally threatening: A patient may demand an apology or threaten to sue.
5. Physically threatening: A patient may take a fighter's stance and make a fist.
6. Physically violent: A patient may attempt to injure providers.

Patients in phase 1 of the continuum are capable of thinking logically and responding appropriately. Providers can employ the techniques discussed in the following section to keep patients in or redirect them to this phase.

HOW CAN ONE PREDICT WHO IS AT INCREASED RISK OF BECOMING AGGRESSIVE?

There is no paper-and-pencil tool that can accurately identify which patients will become violent during a given hospitalization. However, some tools can help predict which patients are at higher risk for aggression. McNiel and Binder's[17] checklist is one such instrument; it contains 5 domains (eg, history of aggression within 2 weeks of admission). The checklist has a 25% improvement over chance at identifying which patients will become physically assaultive. While such checklists are helpful, they are far

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from perfect. For example, McNiel and Binder's[17] checklist has a 67.9% false positive rate at detecting those at risk of becoming physically violent.

Research to identify patient aggression risk factors is ongoing. In a preliminary study[4] of 200 psychiatric inpatients, researchers found that the most reliable predictors of patient aggression were younger age, shorter length of illness, hostility, depression, and difficulty in delaying gratification.

HOW CAN AN ANGRY PATIENT BE HANDLED?

In the case of the severely agitated patient, first and foremost, safety of the environment (eg, checking for weapons using hand or metal detectors and conducting a room search with security) must be assured.[18] In all cases, physicians should employ verbal de-escalation techniques, as outlined in Table 1. When de-escalation techniques fail, physical and verbal restraints may be required in the acute setting. Additional policies may be used at a systemic level to increase safety, and physicians should be aware of the policies at their institutions. Institutional policies should include a mechanism for alerting staff about escalating patients and guidelines for calling security. For a more complete list of protective measures, see Table 2.

WHAT IS THE DIFFERENTIAL DIAGNOSIS FOR ANGER IN AN ADULT?

While anger is a normal emotional response to certain situations, in other circumstances, it can be maladaptive or an indication of an underlying medical, substance-related, or psychosocial condition (Table 3). When anger is a symptom of one of these diagnoses, it is important to treat the underlying condition.

WHAT CAUSES ANGER IN HEALTH CARE SETTINGS?

While correlates of anger need to be considered, it is also important to recognize and address the origin of anger. Unfortunately, not all patients are able to correctly identify the root cause of their anger.[43] People can often quickly and accurately identify the immediate triggers of anger, but they are less proficient at recognizing the larger contextual landscape from which the anger arises. For example, a patient may be able to identify the immediate frustration that set them off, such as a delayed surgery, but be less proficient at understanding other predisposing factors to anger, such as the stress of the surgery itself and concern over one's general health. This shortsighted understanding of the causes of anger has been termed the *proximity bias*.[44] Due to this bias, it is important for health care providers to explore with patients the root cause of their anger.

Common provider, patient, and systemic factors that regularly cause anger in health care settings and their corresponding solutions are presented in Tables 4–6. Physicians and hospitals can attempt to prevent patient anger by addressing each of these causative factors. For example, physicians can attempt to prevent the development of patient anger by improving communication and bedside manner and minimizing significant delays, while hospitals can similarly work to minimize the cost of care and to improve efficiency in patient care.

Table 1. De-Escalation Techniques[a]

Communication	Tactics
Behavioral communication - Respect a patient's personal space; keep a safe distance and avoid touching an agitated patient - Maintain a neutral posture - Do not stare; eye contact should convey sincerity - Stay at the same height as the patient; do not look down on them - Avoid sudden movements	De-escalating - Acknowledge a patient's grievance - Acknowledge a patient's frustration - Shift the focus to discussion of how to solve the problem Aligning goals - Emphasize common ground - Focus on the big picture - Find ways to make small concessions Monitoring - Be acutely aware of progress - Know when to disengage - Do not insist on having the last word - Have a staff member sit with the patient
Verbal communication - Speak in a calm and clear manner - Personalize yourself - Avoid confrontation; offer to solve the problem	

[a]Based on Onyike and Lyketsos.[18]

Table 2. Protective Measures For Handling Aggressive Patients

Systemic Safety Policies	Protective Measures
Physicians should be instructed to remain between the patient and the door so exiting is possible if the patient becomes threatening or violent	Physical restraints
Have security available for physicians who feel unsafe	Chemical restraints (eg, haloperidol, benzodiazepines)
Legal protection: document a patient's complaints and the physician and hospital responses to complaints and the outcome of each incident to protect physicians from frivolous lawsuits	Seclusion rooms with minimal stimulation
Label patients who have a history that suggests a propensity for anger or violence (using scales such as the checklist by McNiel and Binder[17])	

Table 3. Medical, Substance-Related, and Psychosocial Causes of Anger

Medical Causes	Substance-Related Causes	Psychosocial Causes
Alzheimer's disease[19]	Steroids[30]	Mania or depression[3,34,35]
Hyperthyroidism[20]	Methamphetamine[31]	Pain[36,37]
Hypoglycemia[21]	Phencyclidine[32]	Personality disorder[3,38,39]
Insomnia[22]	Alcohol intoxication[33]	Posttraumatic stress disorder[40]
Lead poisoning[23]		Grief[41,42]
Premenstrual dysphoric disorder[24]		
Temporal lobe epilepsy[25,26]		
Traumatic brain injury[27,28]		
Delirium[29]		

CASE DISCUSSION

The case of Mr A (vignette 1) illustrates how misunderstandings and distrust can set the stage for patient

Table 4. Provider Factors That Put Patients at Risk of Becoming Angry and Potential Solutions

Factors	Solutions
Misdiagnosis or medical error	Apologize, be honest, explain fully what happened, and tell the patient what will be done to prevent similar instances from occurring in the future[45]; according to the American Medical Association, physicians have an ethical obligation to disclose harmful medical errors to patients[46]
Poor bedside manner	Training physicians on how to show empathy in patient encounters ultimately increases patient satisfaction[47]
Giving bad news	Train medical students and house staff on how to give bad news; training should include the rationale for the training and a behavioral component during which students are given the opportunity to role play giving bad news with patient-actors and to discuss their emotions about giving bad news[48]
Running late in clinic	Patients' satisfaction scores increase when physicians apologize for their having kept a patient waiting and give a reason for the lateness; for example, "I am sorry that I kept you waiting. It has been a hectic morning! Some of my patients have needed extra time today"[49]
Poor communication with the patient	Provide your rationale for procedures and medications or why a certain medication is not being prescribed; keep the patient updated on test results, the medical plan, and next steps; when communicating with a patient, make direct eye contact and minimize use of technology during the encounter (eg, writing your notes in the computer)
Lack of responsiveness (eg, hard to reach by phone or e-mail)	Electronic medical record systems that allow direct communication between patients and physicians via e-mail have increased patient and physician satisfaction, as well as increased convenience and efficiency[50,51]
Not acknowledging or exploring a patient's beliefs	Training in cultural awareness, which incorporates self-reflection and self-critique and aims to address the power imbalance in the patient-doctor relationship and ultimately helps create mutually beneficial, nonpaternalistic partnerships[52,53]

Table 5. Patient Factors That Put Patients at Risk of Becoming Angry and Potential Solutions

Factors	Solutions
Chronic pain[36,37]	When treating a patient with chronic pain, consider not only the physical aspects of pain, but also the social and psychological ones; the biopsychosocial model of pain treatment recognizes the complex interplay between the different aspects of pain[54]; interdisciplinary pain management programs have improved treatment efficacy and cost-effectiveness; adequate pain control reduces pain-induced irritability and frustration
Substance abuse	Cognitive-behavioral therapy improves drug abstinence and treatment retention[55]; dedicated inpatient addiction consultation teams help with screening, detecting, and managing patients with substance abuse disorders in acute care settings; such consultation teams also have a higher rate of successful enrollment of patients into drug rehabilitation programs following discharge[56]
Underlying illness	See Table 3 for medical risk factors for anger; these diagnoses should be considered in the appropriate clinical context; if an underlying condition is found, addressing it may improve a patient's emotional state
The patient feels that he or she is not being listened to	Practicing motivational interviewing techniques (eg, paraphrasing and reflective listening) lets a patient know that he or she is being listened to; reflective statements allow the physician to convey a hypothesis about the patient's underlying feelings or desires; reflective listening serves to deepen the conversation between the physician and patient; simple reflections involve the physician repeating or rephrasing the patient's words; complex reflections occur when a physician articulates the unspoken meaning behind a patient's words; examples include "You feel . . . ," "What I hear you saying is . . . ," "On the one hand you feel . . . , on the other you feel . . ."[57]
Cultural and religious misunderstandings	Cultural training, which incorporates self-reflection and self-critique, aims to address the power imbalance in the patient-doctor relationship and ultimately helps create mutually beneficial, nonpaternalistic partnerships[52,53]
Psychosocial issues in a patient's life	Nonpsychiatric training programs need to do a better job of mental health training; physicians can directly or indirectly inquire about stressors in the patient's life and about how a patient's symptoms are impacting his or her life; the physician can empathize with the patient's experiences[58]
Anger over difficult diagnoses	Recognize that anger is a normal part of grief and the diagnosis is not the physician's fault; help your patient process grief; many patients find participation in support groups helpful[59]
Transference (eg, a patient may be angry at the current doctor for the transgressions of prior medical professionals or angry about prior personal experiences)	Explore the source of a patient's anger and try to identify aspects of the interaction that trigger the patient's anger; help the patient express his or her feelings as a conflict mediation technique[60]
The patient has a low anger threshold	Cognitive-behavioral anger management interventions can reduce anger and its expression[61,62]

Table 6. Systemic Factors That Put Patients at Risk of Becoming Angry and Potential Solutions

Factors	Solutions
High cost of care	While some elements of high health care costs cannot be altered, several steps can reduce the burden; physicians should inquire about their patients' financial concerns and, if applicable, help them reach out to appropriate resources, such as social workers; care costs can also be reduced by improved medical record sharing so that fewer tests are repeated
Lacking physician education on how to manage patient anger	Implementing targeted courses that teach emotional intelligence in medical education curricula will equip medical student with emotional skills, such as empathy, that will ultimately improve patient-doctor interactions[63,64]; such courses can be extended to include specific clinical challenges, such as dealing with an angry patient
Physician burnout	Strategies that improve a doctor's emotional wellness (eg, mindfulness meditation techniques, work hour restrictions, and programs to promote personal health including exercise, nutrition, and sleep) help reduce burnout rates[65–67]; the system needs to reduce pressures on physicians, such as seeing as many patients as quickly as possible
Systemic inefficiency	Coordinated care, such as can occur with accountable care organizations, can streamline patient care; however, inefficiencies in health care are inevitable; for example, patients may have to repeat their medical history multiple times as each new provider confirms the accuracy of the medical story
Complications from therapy	Carefully set expectations prior to initiating therapy; ensure that patients are aware of possible treatment side effects

anger. Mr A's deep distrust of the health care system was evident in his assumption that the system was trying to make money off of him and his care. He believed that he was admitted to the hospital so he could receive IV antibiotics, something that he could get at his hemodialysis center. He did not understand that the main purpose of admitting him was to discover the cause of his bacteremia. He similarly did not understand why the emergency department physician was attempting to do a physical examination. He felt that his problem had already been diagnosed. The purpose of the physical examination was to identify the source of the pseudomonas bacteremia, as well as whether he had any pressure ulcers on his right leg stump or left foot. Unfortunately, Mr A rapidly progressed along the anger continuum from calm and nonthreatening to physically violent before the physician could explain the rationale behind the hospitalization and the examination. When patients become physically violent, physicians' must first ensure their own safety and the safety of other patients and staff. Hospital security can accompany the physician to see the patient so they are on the scene if required. In the case of Mr A, the physician should first use de-escalation techniques to try to calm him down. The physician should speak calmly and maintain a neutral posture at a safe distance from Mr A, always remaining between the patient and the door. From this position, the physician can acknowledge Mr A's frustration and align their goals by telling Mr A that the physician also wants to get him home as soon as possible but wants to make sure that when he goes home he is safe and won't become so ill that he ends up needing to be in the hospital for a longer period of time. If verbal de-escalation fails to calm Mr A down and he remains assaultive, physical or chemical restraints may be necessary.

In Mr A's case, once the reasoning behind the admission was explained, he agreed to stay in the hospital overnight. He was also willing to compromise with his physicians, and while he continued to refuse to have his stump examined, he did consent to X-rays and computed tomographic imaging, which helped diagnose a soft tissue infection on his stump. He was treated and discharged.

The case of Ms B (vignette 2), which occurs in a primary care setting, describes a situation in which the patient disagrees with her doctors about her diagnosis and treatment plan. The patient feels that her health care providers are not listening to her. Given the benefit of being in a nonacute environment, the new physician could start by affirming that the patient does know her body best, thus acknowledging the patient's own beliefs and making her feel listened to. The physician could then explain that they need to work together as a team to discover what is causing her abdominal pain. By carefully explaining why the symptoms that Ms B reported do not fit with the diagnosis of Crohn's disease, the physician demonstrates that he or she paid attention to Ms B's symptoms and why Crohn's disease is unlikely. The physician could explore why Ms B is fixated on Crohn's disease as a diagnosis and address the underlying concern or need. Perhaps the patient feels that her friends and family think she is making up her symptoms and she desperately wants a "real" diagnosis to prove them wrong. Or, the patient might have remote experience with a friend or family member who has that same diagnosis. The physician can then address this concern head-on as well as explore any underlying proximity biases that may be propagating Ms B's anger.

Patients are unique, and strategies that work with one patient in a particular situation may not work with a different patient or slightly different situation. Thus, the primary purpose of our discussion is to provide tools to equip physicians with strategies to recognize subtle warning signs of brewing anger, minimize impulsive response to patient anger, and consider secondary causes of anger.

CONCLUSION

As our vignettes intended to illustrate, anger compromises patient care. Anger is manifest in multiple ways and for a variety of reasons and can occasionally become dangerous. Therefore, it is important for physicians to recognize when a patient is angry, determine the cause of the anger, and implement de-escalation techniques to improve care.

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