

Virtual Mentor

American Medical Association Journal of Ethics
September 2001, Volume 3, Number 9: 299-302.

PERSONAL NARRATIVE

Through the Physician's Eyes: Difficult Patient-Physician Encounters in the Emergency Department

Faith Lagay, PhD and Art Derse, MD, JD

There's a good reason—many, in fact—that the television drama "ER" has been a runaway hit for 8 years. The emergency room is a crucible for the medical encounter. Life-threatening illness and trauma are more likely to appear here than in the office or clinic, hence, decisions often must be made quickly. Patients' physical distress and fear push them to extremes of behavior. Crisis, fear, strange behavior, and the opportunity for heroic success or failure—the elements on which drama and melodrama thrive—are commonplace in the emergency room or emergency "department," as the expanded service in most hospitals is now more properly known.

It makes sense that these high-pressure conditions turn up the heat on the patient-physician interaction also. The personalities of individual patient and physician and the range of personal, social, and professional expectations that each brings to the interaction always have the potential to turn the medical encounter into a difficult one; they are almost certain to do so in the emergency department where patients are frequently hostile, angry, combative, or abusive if special care is not taken to avoid potential problems. Examining the conditions at work in difficult emergency department encounters yields the rewards of studying any "worst case": the examination reveals signs that might be present but overlooked in less exaggerated or pressured encounters.

Characteristics of the Emergency Department Encounter

Several characteristic features of the emergency department encounter combine to create the potential for very difficult patient-physician interactions.

1. Perhaps the most consequential characteristic is that the patient who walks or is brought into the emergency department and the physician who is there to treat that patient are generally meeting each other for the first time. There is no prior relationship and no patient history to refer to. Neither party knows what to expect and either or both may be suspicious. Incidentally (some would say "unfortunately") some office and clinic visits these days are coming to resemble emergency room visits in this regard more closely than they resemble office visits of the fee-for-service days. That is, more patients are seen by practitioners who do not know them and who may or may not have a written or online history available. Thus, knowing what

makes for troublesome emergency room encounters and how to diffuse them may have broader application in today's managed care system than it had in the past.

2. The emergency department is frequently the "re-entry" point for patients who have severed themselves from a patient-physician relationship and from routine medical care. Not only is the patient unfamiliar to the physician, but members of this patient group may also be non-compliant, perhaps because of psychiatric illness or distress, perhaps because of substance dependence, denial, or inability to pay for routine medical care and prescription drugs. When acute illness or injury eclipses the reason for the patient's neglect of proper medical care, he or she presents in the emergency department, often with many slight to severe, untreated health problems.
3. Patients may have been brought to the hospital against their wishes, by friends, family members, an emergency response team, or police. If so, they may be hostile, combative, or abusive and attempt to refuse treatment or to leave the hospital.
4. Some of those whose only medical care comes through the emergency department are homeless or otherwise outside the community's safety nets of care. These patients, whose numbers are greater in urban areas, may have become dependent upon street survival behaviors that don't rely on the open exchanges of information and discourse expected in the patient-physician relationship. Their unkempt appearance and lack of manners may be off-putting to the clinician.
5. Ethnic, cultural, and language differences may present barriers to good communication.
6. Finally, even those patients who receive routine medical attention, have no psychiatric diagnosis, are compliant, and may be meeting their own primary care physicians in the emergency department are in some physical or psychological distress or they wouldn't be seeking medical care. They are often upset, perhaps fearful, and maybe unable to process information in their characteristic rational manner.

Managing Difficult Emergency Department Encounters

Emergency physicians cannot anticipate that all encounters will unfold according to the standard expectations for successful patient-physician relations, that is, that privacy and confidentiality will be maintained and patient autonomy exercised. Any of the typical emergency department characteristics described above can frustrate these ends. Privacy, autonomy, even assessing and addressing the medical complaint itself are often not the emergency physician's first priority in managing uncooperative patients.

To begin with, the physician should see the patient in or near the presence of others, not in private where there may be physical danger. In most emergency departments aides or security personnel are available to assist if the patient becomes unruly. Those not involved in the patient's care (hospital security personnel or police

officers) should be discretely placed so that the patient is aware that they are present or nearby, but they should not intrude on the patient-physician encounter unless they are actively engaged in guarding or controlling the patient.

The physician's first intervention is to assure the patient in a non-threatening way that, regardless of the circumstances, his or her health is the physician's primary concern. Often physicians must maintain control of their own emotions, responding to patient anger and even abuse calmly and undefensively.

It is difficult to list what goes on next in sequence. The physician must determine, almost simultaneously:

- Whether the patient is likely to pose a threat of harm to him- or herself or to others.
- Whether or not a medical emergency or need exists? Whether the patient is in physical distress? Intoxicated? Psychotic? Attempting to get a prescription for narcotics?
- Whether the patient is competent to accept or refuse treatment? If not, whether someone is present who can speak as the patient's surrogate?

The possible combinations of answers to these questions determine how the encounter proceeds. If a medical need is present and the patient is not combative or hostile and is competent to discuss and consent to or refuse treatment, the encounter resembles a traditional acute medical intervention. If medical need is present and the patient is highly combative or frenzied, with frankly compromised mental status, he or she can be restrained or sedated so that the need can be assessed and treatment can proceed. The physician may ask security personnel or police to detain or control the patient.

The situation is far trickier when the patient is in such emotional or psychological turmoil that medical need cannot be easily ascertained and when competency is not easy to determine. Suppose the patient is intoxicated and resisting attempts at diagnosis. Most people with a .10 percent blood alcohol level are competent to weigh the risks and benefits of proposed medical interventions. Most people with .20 percent blood alcohol levels are not. The blood alcohol level at which competency is compromised differs from individual to individual, so the physician must make a judgment and proceed, knowing that the judgment could be contested by the patient or others at any point during that long period of calm and hindsight that follows the emergency.

The general guideline for determining decision-making competency is the computer model. Patients should be able to "take in," "analyze and measure," and "give back" information. In this case "take in" is shorthand for understanding the facts of one's medical condition, its consequence if left untreated, and the nature and risks of treatment options. "Analyzing and measuring" means that the patient can weigh the risks and benefits of proposed treatments and their probable outcomes and can

measure those risks and benefits against an internal set of values and future goals. The competent patient then arrives at a decision and can "give back" that information in a consistent way, that is, not changing the decision each time it is stated. The decision should make sense relative to his or her values. Refusing surgery because it is frightening, for example, may be perfectly reasonable but not consistent with a goal of continued life. Obviously, the need to feel secure about the patient's competency increases as the risk associated with an intervention or the refusal of an intervention increases. A psychiatric consult may be needed. In all events, seriously injured or ill patients who refuse treatment should be given comfort care rather than turned away because of their refusal¹. As the distress from the injury or illness increases, and with continued encouragement of medical staff, they may change their decisions.

Conclusion

The majority of emergency department encounters never become difficult enough to warrant intervention from security staff or police. Nothing is lost, however, in the brief period of time taken to approach the unknown patient with calm reassurances, in the presence of others who may need to assist the physician, and to determine whether emergent or urgent medical need is present. On the other hand, questions regarding patients' competency to consent to or refuse treatment commonly arise in the emergency department.

Given the likely physical and emotional distress of patients with emergency medical needs, their possible estrangement from routine health maintenance, and the diverse psychosocial and cultural backgrounds and expectations that converge in the emergency department, it's small wonder that the real life "ER" offers an intense immersion course in managing difficult clinical encounters.

References:

1. Derse AR, Rosen P, and Friedman JB. Consent: Explicit and presumed-patient refusal of emergency care. In Iserson KV, Sanders AB, and Mathieu D, eds. *Ethics in Emergency Medicine*. Tucson, AZ: Galen Press; 1995:95-105.

Faith Lagay, PhD is managing editor of *Virtual Mentor*.

Art Derse, MD, JD is on the editorial board of *Virtual Mentor*.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2001 American Medical Association. All rights reserved.