Addressing (Not Tolerating or Ignoring) Verbal Abuse

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With civility seemingly on the decline across all social sectors, healthcare staff need to be more prepared than ever to deal with hostility directed at them. How soon should it be dealt with? The first time is not too soon. However, especially in healthcare, it can be helpful to keep in mind the question conflict resolution consultant Robert Bacal asks: would you treat an angry patient differently if you knew they experienced a tragedy the day before? Most likely, the answer is yes.

TIP: It can be helpful to recognize that in humans, *frustration, fear, stress*, and *desperation* all may be expressed as anger.[i]

Verbal Abuse

Nothing excuses verbal abuse, but starting with the mindset that the person is in need won't make the situation worse and allows for the opportunity to attempt to diffuse the situation early. Examples of verbal abuse include[ii]:

- Persistent swearing
- Yelling
- Sexist comments (both explicit and implied)
- Racist comments (both explicit and implied)
- Irrelevant personal remarks (e.g. about your appearance)
- Threats (e.g. I'll have you fired)
- Intimidating silence
- Accusations of various sorts (e.g. calling you a racist)
- Comments about your competency, knowledge, dedication

Example: A patient accuses you of being incompetent. The patient is upset by the clinic's policy requiring insurance authorization prior to scheduling procedures, a policy put in place to avoid last-minute cancellations. The policy benefits the clinic, and may or may not be perceived by patients as beneficial to them. If not, trying to convince an upset patient that the clinic policy benefits them may only serve to fuel their frustration. Instead, explaining simply that the basis for the policy is to avoid last-minute cancellations (which is factual) may be better received.

TIP: Offer Honest, *Brief* Explanations

Whether speaking or documenting, whenever possible, avoid use of subjective words because **subjectivity leaves room for argument.** For example, "Mr. Jones, I can't help you

when you're irate." Mr. Jones: "I'm NOT irate!"

In response to an upset person's circular rant, psychologist James Cawood recommends interrupting their cognitive process; for example, in a soft, calm tone of voice, "Mr. Jones, I feel your frustration, but you're ***shouting so loud I can't hear you.*** So much energy is coming at me I'm afraid I'm missing some of your words and I want to hear you so we can find a way forward." Dr. Cawood advises calmly listening and using non-assertive, non-judgmental statements ("I heard you say . . ."), and not challenging the person's statement or perception.[iii]

An example of subjective documentation of an encounter may be: *Mr. Jones arrived for his appointment without wearing a mask. Clinic staff gave Mr. Jones a mask to wear, but he angrily refused to wear it and became combative.*

Compare objective documentation of the same encounter: *Mr. Jones arrived for his appointment without wearing a mask. Clinic staff gave Mr. Jones a mask to wear, but he refused to wear it, threw it on the floor and stomped on it.*

It can also be helpful to avoid subjective *labels* because not everyone may have the same understanding of the label's meaning, and people are unlikely to see themselves as a label that denounces the person as a whole. For example, the word "bully" may have different meanings to different people. By contrast, the word "mean" is probably more universally understood (opposite of *kind* or *nice*). Describing a certain behavior as "mean" rather than depicting the *person* as a "bully" may be more effective to address the specific behavior without prompting defensiveness. During instances of hostile interaction, it's best not to introduce subjective (and additionally judgmental) terms that are susceptible to argument.

TIP: Avoid subjective descriptions; instead, remain *factual*.

Where possible, Bacal advises that offering choices may be helpful because it helps the person avoid feeling trapped and helpless. People who feel there's nothing they can do can be some of the most difficult to interact with.[iv] Using the prior clinic scheduling example, while deviating from its policy is not a choice the clinic can reasonably offer, other choices that can be offered may include, "The insurance authorization paperwork is already in process. Would you like me to call and check its status, or would you like the phone number so you can check?" or, "The next step to obtaining insurance authorization is completing this form and faxing or mailing it in. Would you like to complete it here so I can fax it in for you, or would you like to take it with you?"

Offering choices helps to acknowledge the person as an individual and their specific situation, and is likely to yield more productive results than unnecessary declarations such as "If I made an exception for you, we'd have to for everyone." **Choices allow the person to re-gain a sense of control and feel less helpless.** Importantly,

those who perceive they have some control over a situation **are less likely to act out violently.**

Example: Mr. Peacock, a roofer, was hospitalized after a car accident left him paralyzed from the waist down. He was verbally abusive to staff and no one wanted to enter his room. For example, while throwing things, he yelled "Stop telling me what to do! Get out of here!" Recognizing his outbursts were likely rooted in *fear* (how would he now make a living? support his family?) rather than anger with the staff, the situation improved when staff made a concerted effort to offer him choices wherever possible: "Mr. Peacock, would you like to take a shower now, or would you like to wait until 3:00, when I can come back?"

TIP: Offer choices where possible.

If, after offering a clear, brief explanation to the patient (and choices where possible) the person remains argumentative or otherwise behaves unreasonably, do not continue to try to reason by offering repeated or further explanations. High emotions such as anger can affect the way the brain processes information, limiting the ability to process logical statements and accept explanations and solutions that are offered.[v] Dr. Cawood explains that high emotions can result in a loss of 10-15 I.Q. points.

Instead, let the person know how they can help. For example, "The system is not allowing me to schedule your procedure on that date. If you have another date, I can see if the system will let me schedule it then." Importantly, the speaker conveyed that it's the *system* (rather than the speaker) that is preventing scheduling.[vi] (See below if situation continues to escalate.)

Non-Verbal Abuse

Non-verbal abuse includes manipulative behavior through body language, facial expressions, gestures, and physical aggression such as pounding on a counter, and may be intended to send messages such as "I don't like you," and "I'm fed up," or meant to intimidate. [vii] Examples include:

- Standing in your personal space
- Staring at you (long eye contact)
- Table pounding
- Throwing things
- Leaning over you (using height advantage)
- Fearsome facial expressions
- Loud sighing
- Pointing, other offensive gestures
- Unwanted physical touching/contact (e.g., finger pointing that makes contact)

Like verbal abuse, these behaviors can be intended to demean and gain a sense of control.[viii] Dr. Cawood views control as "the foundational construct for all human behavior."[ix] The person who feels they have no control may use verbal or non-verbal abusive tactics as a way to gain control of a situation. **It's important to diffuse the situation early because violence is one way a person may choose to establish or re-establish a perception of control if they do not perceive there to be an alternative option.**

TIP: Asking yourself, "How does this person perceive they are losing control?" may quickly provide insight regarding a way in which to help the person re-gain a feeling of control.[x]

However, if the hostility continues or escalates, it is appropriate and recommended that you take steps to remove yourself from the situation ("I'll be right back" then immediately leave the area) and ask for help as the situation warrants, either by seeking help from a supervisor, or calling security (or police, if an off-campus clinic):

- At Froedtert hospital, call 5-2828 for a **"Code Orange"**
- At CHW, dial 88.

The **MCW-FH-CHW Threat Assessment Team** is here to help with long-term (non-immediate) management of threatening or hostile patients. This multi-disciplinary team meets monthly to develop strategies for delivery of safe patient care. Members are from MCW, FH, CHW and MCWAH risk management, FH Human Resources, Psychiatry, Trauma Psychology, FH Security, MCW Public Safety, and CHW Security. The team can be contacted by emailing: ThreatManagement@mcw.edu OR (if a huddle is desired to discuss a non-immediate but concerning safety situation): ThreatHuddle@mcw.edu

Finally, the **MCW, FH, and CHW Patient Relations** offices can also be an excellent resource for help with difficult patient/family interactions.

Please do not hesitate to reach out for assistance – we are here for you!

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[i] *See e.g.,* Bacal, Robert, "If it Wasn't for the Customers, I'd Really Like this Job" and "Perfect Phrases for Customer Service." *See also* Mr. Bacal's website: www.work911.com and video tutorial: http://angrycustomer.org/faq/index.php?sid=1378191&lang=en&action=artikel&cat=2&id=117&artlang=en

[ii] Bacal, Robert, "If it Wasn't for the Customers, I'd Really Like this Job" (Ontario, Canada: CreateSpace Independent Publishing Platform 2011).

[iii] Cawood, James (live presentation at Medical College of Wisconsin Risk Management's seminar *Threat Assessment & Management with a Healthcare Focus*, November 9, 2018.)

[iv] Bacal, *supra* note 2.

[v] John Schafer, "Controlling Angry People," Psychology Today 2011.

[vi] Cawood, James (live presentation at Medical College of Wisconsin Risk Management's seminar *Threat Assessment & Management with a Healthcare Focus*, November 3, 2017).

[vii] Bacal.

[viii] Bacal.

[ix] Cawood, James and Corcoran, Michael, "Violence Assessment and Intervention: The Practitioner's Handbook" (CRC Press: FL, 2009), p. 143.

[x] *Id.* at p. 147.