

Dealing with Violence in the Emergency Department

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There is no doubt that we live in a violent society. Violence in our streets, in our schools and in our homes is a national emergency and a national shame¹. Violence in our emergency departments is becoming increasingly common and lethal. Emergency physicians and nurses are alarmed and incidences of serious harm or death receive widespread media coverage^{2,3}. ED personnel are demanding more and more security measures to protect themselves and their patients. Some staff members are taking safety measures into their own hands and some even carry weapons with them to work.

The Scope of the Problem

Incidences of hostage situations, gunshot wounds and assaults on emergency personnel are common^{4,5,6}. In a study in the *Annals of Emergency Medicine* in 1988, Lavoie reported the results of a survey of 127 teaching hospitals with a volume of 40,000 or more patients visits per year⁷. 32% reported 1 or more verbal threats per day. 18% reported that weapons were displayed at or near staff at least once per month. 57% of ED staff said they had been threatened by a weapon in the last 5 years. 43% said there was a physical attack on a staff member at least once per month and 81% of the ED's had staff injured in the last 5 years. 7% of the ED's surveyed said they had violence that resulted in death in the last 5 years. From the patient perspective, 25% of the ED's surveyed restrained at least 1 patient per day, 13% of patients that had to be restrained had injuries resulting from the restraint and there were multiple lawsuits against hospitals by patients injured through restraint. Clearly, both staff and patients are at risk⁸.

Weapons in the ED

Data have also been collected on weapons in ED's. Ordog reported that 26% of major trauma patients presenting to the ED carried weapons⁹. Interestingly, female trauma patients were more likely to be carrying lethal weapons (36%) than their male counterparts. 46% of the ED's surveyed by Lavoie confiscated 1 or more weapons per month⁷. Metal detectors at one hospital identified and led to the confiscation of over 300 weapons in one month. These were not pocketknives but included shotguns, 357 magnum handguns, M-1, AK-47 and a 9mm UZI⁹. Goetz, at the University of Oregon emergency department where they see a volume of about 39,000 patients per year found that weapons carrying was about equal in medical and psychiatric patients¹⁰. In his study, they searched 1.3% of all patients. 16% of those with weapons were medical patients and 17% were psychiatric patients.

Disarming the Patient

Patients who are armed should not be evaluated until disarmed¹¹. Generally, patients should be disarmed by security before entering the emergency department. If you suspect a weapon, you may simply ask the patient if they are armed. If they tell you they are armed, or if you discover the weapon during your exam, ask the patient to check the weapon at the front desk with security. Assure them that you will be glad to evaluate them when disarmed and they may retrieve their weapon upon discharge from the ED. It is unwise to take the weapon yourself. If offered, have them lay the weapon on the stretcher and call for security to hold the weapon for the patient. Since weapons, legal or illegal, are personal property, they should be returned at the end of your exam unless you are committing the patient for potentially violent behavior.

Why do we have all this violence in our emergency departments?

Many of our ED's, especially our major trauma centers, are in intercity, urban settings where violence is endemic. I once worked in an ED that was 1-2 blocks from the illicit drug area of the city. It was not uncommon for fights to break out there, and because of the proximity, the violence would spill into the ED. The injured combatants would find themselves side by side with their enemies, police, and medical personnel minutes after leaving the streets. ED personnel are sometimes involved as innocent bystanders in drug related vendettas. Emergency departments are also high stress areas for patients, a place where unexpected sudden illness and death are common. Recently, we had one of our patient representatives injured when she was trying to assist a grieving family. The family's grief had gotten out of control and she became a victim when she was body slammed by a large, muscular male relative of the deceased. It is also true that hostility is increased by long waiting times and delays in care, much of which is not under emergency department control⁷. A normally pleasant and well-adjusted patient can become irritated after a 3 or 4-hour wait, and a not so well adjusted patient may become dangerous after the same wait.

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ED's also offer ready availability of drugs and hostages and have open access 24 hours per day. A patient experiencing the discomfort of drug withdrawal may go to the ED when the street supply is exhausted. Being told that no drugs will be given by the doctor or nurse may illicit a violent outbreak in an already agitated, paranoid and perhaps hallucinating patient. Our nation's ED's are also increasingly called upon to be the safety net for psychiatric patients since "deinstitutionalization" some years ago. Few citizens realize that this "deinstitutionalization" was dependent on the 24 hour open access to the care provided by our nation's ED's. A great deal of the care once provided by psychiatric facilities is now provided in our ED's and we are often called upon for "medical clearance" for psychiatrically ill patients. Most of the above, can not be changed or modified.

With all this evidence, still many of our ED's are unprepared to deal with the violent patient. Many ED's do not have protocols for dealing with violence even though it is a JCAHO requirement¹². In Lavoie's study, many of the ED's had no specific training for nursing staff on the management of the aggressive patient⁷. It is clear that we need to protect ourselves, we need to protect our patients and the community expects us to be able to protect them.

Profiles of potentially violent patients

Some patients demonstrate habitual violent behavior and others are violent depending on the circumstances. The habitually violent patient is often a male in his teens to 30's who has access to weapons and may be involved in alcohol or substance abuse. This is a person who has absent "roots" and problems with authority¹³. He may have multiple arrests, often for assault, and if he has been in the military, he may have a dishonorable discharge. This is a "fighter" who rarely backs down from a fight and has had many battles since childhood. It is well to remember that 5% of homicidal threats culminate in murder. This means that most patients are still ambivalent about homicidal threats and can still be treated. Patients delirious from medical problems can often strike out without warning. Depressed patients who are suicidal sometimes feel as though they have nothing to lose and might as well take you or their loved ones along with them- the ultimate in power and control. After all, if they are so miserable, why let you live a happy life or why let their spouse live to remarry when they are gone? Psychiatrically ill patients do not account for any more violence than the "normal" population. However, paranoid patients are especially worrisome, particularly when the paranoid person shifts from generalized paranoia ("they are after me") to a specific person or group ("John is after me", or the FBI etc.).

Recognizing the warning signs

Often our own gut reaction is sufficient to warn us of impending violence¹⁴. If you begin to feel uncomfortable around a patient- listen to your own feelings. If a nurse or colleague says that they feel uncomfortable, this should be enough to alert us to take further precautions. Most of the time, but not all of the time, there is a period of mounting tension before physical violence occurs. This may involve a tense, threatening posture or loud, profane speech with increased motor activity or restlessness¹⁵. Recognizing the clues and taking precautions may prevent a violence outburst. Unfortunately, at times, especially in medical conditions that cause delirium or confusion, violence may be sudden and unpredictable and even the most sensitive interviewer may not be able to predict the violence¹⁶.

Safety Tips

The emergency department can be a cauldron for violence with long waiting times, high acuity illness and both patients and staff can be easily provoked by disagreements and overheard informal remarks. ED staff should be careful not to aggravate patients with discourteous remarks and unnecessary roughness. If you find yourself with a potentially violent patient, minimize eye contact and give the patient plenty of "body space". Some advocate a "body space" or buffer zone about 4 times larger than normal. Patients are especially attuned to incursions into their "body space" from the rear. A patient who moves back from the examiner is trying to tell you something¹⁷. At times you can ask the patient where they want you to stand so that they are comfortable. If you are frightened, it's OK to say so. Tell them that they frighten you. When you become aware of a threat- deal with it immediately. Alert other staff or security at your first "gut" feelings and enforce limits. Don't bargain or compromise your safety, the patients' safety or the safety of other staff.

The emergency physician frequently finds that he or she must interview and examine a potentially dangerous patient to determine the degree of danger the patient represents or to medically clear the patient who will be committed for violent behavior. This is best done with the help of security personnel. Notwithstanding, there are multiple ways to make this encounter safer. When interviewing or examining a potentially violent patient, make sure the room is free from all objects that can be used as weapons or are

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light enough to be thrown. This might include trays, hot drinks, scalpels, all sharps and instruments and electrical cords etc. Remove all potential weapons from yourself as well. Consider stethoscopes, scissors, necklaces, pocketknife, belts and clothing such as neckties as possible weapons (I was once held down for several minutes by a large hand on the knot of my favorite tie). It is preferable to have two doors, one for your escape and one for the patient's escape if things escalate. If there is only one door, negotiate with the patient so you are both equidistant from the door. If you are blocking the exit, the patient will have no choice but to go through you to get outside, thus you are exposing yourself to an unnecessary risk. Maintain a safe distance- usually at least one arm's length and position yourself to one side since it is easier to dodge a blow from the side than one coming straight on. If you are choked, tuck in your chin to protect your carotids^{11,18}. If bitten, do not pull away as this causes tearing. Push towards the patient and hold their nose closed. Eventually they will open their mouth. If a weapon is displayed, try not to display fright but comply with demands. Avoid argument, despair, crying or whining. Never run or fight unless assured of success and try to establish an emotional human relationship. A hostage taker will seldom murder a hostage if a relationship has been established.

Safety Tips for Dealing with Unanticipated Violent Patients

Call security when you first become aware of a threat Trust your "gut" reaction if you feel uncomfortable Minimize eye contact and provide increased "body space" Make sure both you and the patient are near a door for "escape" Maintain a safe distance (at least 1 arms length) and stay to one side Never run or fight unless assured of success
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Tips for Interviewing or Examining a Potentially Violent Patient

Security personnel in or just outside the exam room with an open door Have security search and remove weapons from the patient ahead of time Use a room with two doors if possible, one for you, one for the patient Remove all potential weapons from the room ahead of time Remove all potential weapons from yourself ahead of time (tie, scissors etc) Maintain a "body space" or buffer zone 4 times larger than normal Never approach from the rear

Organic versus psychiatric causes of violent behavior

As physicians, we will need to make an estimation of whether **this** behavior is organic or psychiatric. We need to know if the patient can be safely discharged home, or whether they need to be admitted to care for their medical condition or will need psychiatric admission or commitment for their or others' safety. It is a common error to assume that all violent behavior is psychiatric¹⁹. Be especially aware of the patient with abnormal vital signs and remember that no patient should be discharged from the ED without an explanation or understanding of each abnormal vital sign. Clues that the violence may be organic include rapid onset of psychotic, agitated or violent behavior in a patient without a prior history of psychiatric disease. Also be careful of diagnosing patients with psychiatric illness after the age of 40 without a prior history of psychiatric illness. Violence from organic illness can be more severe than that from psychiatric illness and can be sudden without warning signs. Other clues to organicity include confusion or slow mentation, intellectual or cognitive deficits, slurred speech, visual hallucinations and disorientation.

Psychiatrically ill patients also present with violent behavior. Paranoid schizophrenia accounts for the largest amount of ED violence by psychiatrically ill patients. Personality disorders are the second largest group. Health care workers often underestimate the potential for violence in bipolar affective disorders. A manic patient may give the staff a false sense of security but may turn quickly on them when demands are made. Clues to the psychiatric diagnosis of agitation include a previous psychiatric history, auditory hallucinations and a logical thought content even if it is bizarre. Usually the patient is alert and oriented with normal vital signs. The patient is rarely over the age of 45 and avoids drugs of abuse.

Verbal de-escalation

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If violence appears eminent or actually erupts, there are three methods that may be helpful: verbal de-escalation, physical restraint and chemical, or pharmacologic restraint. Some authors advocate verbal management of the violent patient and believe this is as effective as pharmacologic restraint. They encourage empathizing with the patient's concerns, even if it involves another staff member. Try to let them know that you are their advocate and on their side. Offer food and drink, which may gain cooperation of agitated patients. Verbal techniques are not effective in florid psychosis, delirium, severe intoxication and agitation and manic episodes. You may even ask the patient if he/she would like to be restrained- sometimes they agree and this helps them feel like they are a part of the decision and helps them gain control of their lives¹⁶. If you need to apply physical restraints for safety, don't offer or bargain²⁰. If they disagree and you have to apply them anyway, this will increase the patient's distrust of the health care worker.

Physical restraints and patient rights

Most emergency departments apply physical restraints daily. In Lavoie's study, 32% of EDs surveyed applied physical restraint daily⁷. Once the decision is made, do not discuss further and do not negotiate. For legal and ethical purposes, you must clearly state why you are restraining the patient even if you don't think he/she will hear or understand- a kind of physician's Miranda rights²¹. You are, after all, removing the patient's civil liberty. All orders for physical restraint must also be in writing stating the time restraints were applied and the reasons²². You are now in complete control of the patient's welfare. Once restraints are applied, any injury or harm to the patient is *de facto* evidence that you were negligent. The American Psychiatric Association lists several criteria for physical restraints²³. These include 1) to prevent harm to the patient or others when less severe means are ineffective or inappropriate, 2) to prevent serious disruption of the treatment program or significant damage to the physical environment, 3) to decrease stimulation the patient receives and 4) at the request of the patient. Remember, never use restraint as a punitive measure or for convenience or for mild obnoxiousness. Patients can be injured or killed in the process of restraint. Ideally, five people, including security officers, are needed to apply restraints properly with the least amount of force; one for each extremity and one for the head. If the patient is a woman, at least one woman should be in attendance. Use 4 point, padded restraints either supine or on the side to prevent aspiration. A Philadelphia collar can be applied to control head banging, spitting and biting. If additional straps are necessary, place them over the pelvis or knees, not the chest as this may interfere with respiratory effort. If a patient is restrained, a health care worker must attend the patient at all times and there should be a q 15 minute check for peripheral perfusion, mobility, posture and mental status.

American Psychiatric Association Criteria for Application of Physical Restraints

To prevent harm to patient or others when less severe means ineffective
To prevent serious disruption of treatment program or significant damage to the physical environment
To decrease stimulation the patient receives
At the request of the patient

Application of Physical Restraints

Security to assist with ideally 4-5 people- one for each extremity, one for head
If the patient is a woman, at least one woman to help restrain
4 point padded restraints supine or on the side to prevent aspiration
Philadelphia collar, if needed, to prevent head banging or spitting
Additional straps, if needed, over pelvis or knees
Q 15 minutes checks of perfusion, mobility, posture and mental status

Pharmacologic restraint

Pharmacologic (chemical) restraint is considered by many to be more humane than physical restraint. Medications such as opiates, barbiturates, neuroleptics, benzodiazepams and in extreme conditions neuromuscular blockade have been used.²³⁻²⁶ Medications may be given orally, intramuscularly, or intravenously and given in combination depending on the situation and adjusted as needed. No one medication is right for every situation. An oral benzodiazepam may be appropriate for mild to moderate agitation or a patient suffering from cocaine or alcohol withdrawal. Intravenous benzodiazepam or a parental neuroleptic is appropriate in agitation where there is immediate threat to safety. However, more

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extreme measures might be necessary for a multiply injured trauma patient who is combative and whose injuries necessitate the OR. In such a situation, the best solution may be total paralysis using neuromuscular blockade and intubation in the ED in preparation for operative intervention.²⁴⁻²⁶ This addresses the safety issue for both staff and patient and prepares the patient for anesthesia.

The most common drugs used for chemical restraint or rapid tranquilization are the benzodiazepams and the neuroleptics. Diazepam (Valium) or lorazepam (Ativan) are benzodiazepams that are recommended for use in incremental dosing depending on the situation. Diazepam in dosages of 2 to 10 mg or lorazepam in a dosage of 2 to 4 mg may be used initially and titrated up as needed. The main side effects of the benzodiazepams are sedation and respiratory depression. Haloperidol (Haldol) and droperidol (Inapsine) are neuroleptics and may be given alone or in combination with the benzodiazepams. Both haloperidol and droperidol work well in patients with acute psychosis resulting from multiple causes and relieve agitation regardless of etiology.²⁷ Either drug may be considered as a first-line drug with the exception of patients with drug withdrawal or sympathomimetic-induced symptoms, such as cocaine intoxication, where the benzodiazepams are preferred. Haloperidol and droperidol can be given intramuscularly or intravenously. Haloperidol additionally is effective given orally. Response occurs within minutes and patients remain awake and alert. Both drugs are relatively safe with minimal adverse respiratory or hemodynamic effects (e.g., transient hypotension with droperidol) and no lowering of the seizure threshold. Extrapyramidal side effects occur in less than 10% of patients and are more common with haloperidol. Such effects are not dose related and usually occur outside the ED at least 12 hours following administration.

Conclusion

It is clear that emergency physicians and nurses are exposed to a variety of patients with violent potential. Physicians and nurses are injured every day in emergency departments across the nation and, unfortunately, that will probably continue to be the case. While it is every worker's right to have a safe workplace, it is also true that we can not deny patients the right to access the health care we provide²⁹. However, we can control that access to make our ED's safer. Modern ED's that are properly planned and control patient access through protected entrances, metal detectors, perimeter doors that allow staff to exit but remained locked and secure from the outside, protective plexiglass and 24 hour on site security will help decrease the risk of injury significantly³⁰. Still, the major burden lies with the individual staff members. Training programs aimed at rapid identification and appropriate treatment or restraint of the violent patient must be a priority for each of us who work daily in the emergency departments of our nation.

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