CRACKCast E187 – The Combative and Difficult Patient

Note: Italicized text is used to indicate passages quoted directly from Rosen's Emergency Medicine (9th Ed).

Key concepts:

Your ED should have a written emergency plan for violence or hostile events.

• ED staff should be trained to recognize potentially violent individuals and to intervene with verbal de-escalation techniques prior to physical or chemical restraint when possible.

For the undifferentiated severely agitated patient requiring rapid tranquilization, we recommend a benzodiazepine (such as, lorazepam) either alone or with a first-generation antipsychotic (such as, haloperidol).

• The possibility of an organic (medical) cause of aggressive behavior should be considered in all violent patients, even those with known psychiatric disease.

• The negative reactions from difficult patient encounters may result in undesirable implications for both patients and their ED caregivers, including compromised patient care, compassion fatigue, and professional burnout.

• Management of the difficult patient can be optimized by understanding the multiple issues contributing to the impaired physician-patient relationship, including factors of the ED setting (such as, time constraints and lack of privacy), individual physician influences (such as, personal bias and poor communication), and patient contributions to the interaction, including behavioral, social, and substance use issues.

• Pejorative stereotypes of difficult patients should be avoided—to aid in physician strategies for these challenging encounters one should instead aim to characterize the patient's primary difficult behaviors, such as dependent clinger, entitled demander, manipulative help rejecter, and self-destructive denier.

• Strategies, including understanding one's own biases and reactions and optimizing communication, are helpful in dealing with the impaired physician-patient relationship.

Core questions:

1. **List 6 patient problems associated with violence**
2. **List 8 strategies for the management of a potentially violent patient other than chemical/physical restraint**
3. **Describe essential elements of physical restraint**
4. **List 3 medications used for chemical restraints, their dose, and their side effects**
5. **List 6 Psychiatric, 8 Organic, and 8 Drug causes of violence**
6. **Distinguish organic from functional causes of violent behaviour**
7. **List 2 ED factors, 3 physician factors, and 2 patient factors that impair the physician patient relationship/interaction**
8. **List 5 communication strategies for dealing with the difficult patient encounter**

9. **List 5 basic steps in crisis intervention**
10. **In a single sentence, describe each of the Cluster A, B, and C personality disorders, and describe an alternative approach to labelling four difficulty patient behaviour types.**

Wisecracks:

1. **What are four patient behaviours suggesting impending violence?**
2. **What are some elements for verbal de-escalation?**
3. **Describe seven toxidromes**
4. **What are some tools for managing negative physician-patient reactions**

Rosen's in Perspective

This episode does have two natural themes - the combative AND the difficult patient. Obviously these overlap!

Throwing any agitated, confrontational, intoxicated or demanding patient into the chaotic, noisy, cramped ED is a recipe for both violence and negative physician-patient interactions.

The difficult patient is one who is perceived to interfere with the physician's ability to establish a normal patient-physician relationship. Difficult patients are experienced across medical specialties and may represent 15% to 30% of physician-patient encounters. Younger physicians, physicians who are more uncomfortable with diagnostic uncertainty, and physicians with poorer communication skills and psychosocial orientation are all more likely to have difficult patient encounters.

Difficult encounters not only harm us, but also harm patients.

Key priorities for us in the ED:

- **For the combative patient**
  - **control the patient and the situation,**
  - **diagnose and treat reversible causes of violence,**
  - **protect the patient and staff from harm.**
- **For the difficult patient**
  - **Maintain a professional physician-patient relationship (appropriate emotional distance)**
  - **If possible, focus on a shared therapeutic alliance**
  - **Respectfully offer alternatives when the interaction is no longer therapeutic**

Core questions:

[1] List 6 patient problems associated with violence

Categories:

- **Psychiatric**
- **Street drug abuse or withdrawal**
- **DIMES**
- **Situational / Antisocial behaviour**

Positive predictors of violence:

- **Male gender**
- **Prior hx of violence**
- **Drug or ETOH abuse**

The Complete List…

Box 189.1: Selected Problems Associated with Violence

Psychiatric

1. Schizophrenia
2. Paranoid ideation
3. Catatonic excitement
4. Mania
5. Personality disorders
    1. Borderline
    2. Antisocial
    3. Delusional depression
    4. Post-traumatic stress disorder
    5. Decompensating obsessive-compulsive disorders

Situational Frustration

1. Mutual hostility
2. Miscommunication
3. Fear of dependence or rejection
4. Fear of illness
5. Guilt about disease process

Antisocial Behavior

1. Violence with no associated medical or psychiatric explanation (these patients may be managed by the police or security)

Organic

Diseases

1. Delirium
2. Dementia
3. Trauma

4. Central nervous system infection
5. Seizure
6. Neoplasm
7. Cerebrovascular accident
8. Vascular malformation
9. Hypoglycemia
10. Hypoxia
11. Acquired immunodeficiency syndrome (AIDS)
12. Electrolyte abnormality
13. Hypothermia or hyperthermia
14. Anemia
15. Vitamin deficiency
16. Endocrine disorder

Drugs

1. Unanticipated reaction to prescribed medication (especially sedatives in brain-injured or elderly patients)
2. Alcohol (intoxication and withdrawal)
3. Amphetamines
4. Cocaine
5. Sedative-hypnotics (intoxication or withdrawal)
6. Phencyclidine (PCP)
7. Lysergic acid diethylamide (LSD)
8. Anticholinergics
9. Aromatic hydrocarbons (eg, glue, paint, gasoline)
10. Steroids

[2] List 8 strategies for the management of a potentially violent patient other than chemical/physical restraint

Break this down into: system, department, and primary-secondary-tertiary prevention.

1. Preparedness
- **Prohibition and screening for weapons**
- **Alarm systems / panic buttons**
- **Direct line to police / security**
- **Centralized ED flow with buzzers, barriers, and protective glass**
- **Secure, violent proof examination rooms with exits and panic buttons**
- **No neck ties, stethoscopes, lanyards**

2. Primary prevention
- **Minimize frustration and aggression**
- **Calm, efficient, short stay ED visits (preferentially see violent patients sooner)**
- **Police / security / surveillance presence**

3. Secondary prevention
- **Recognize pre-violent scenarios or patients**
- **Verbal de-escalation**
- **Staff training and caregiver training**

4. Tertiary
- **Physical restraints - police, security**
- **Chemical**
- **QI - Post-incident debrief and review**

See Box 189.2

[3] Describe essential elements of physical restraint

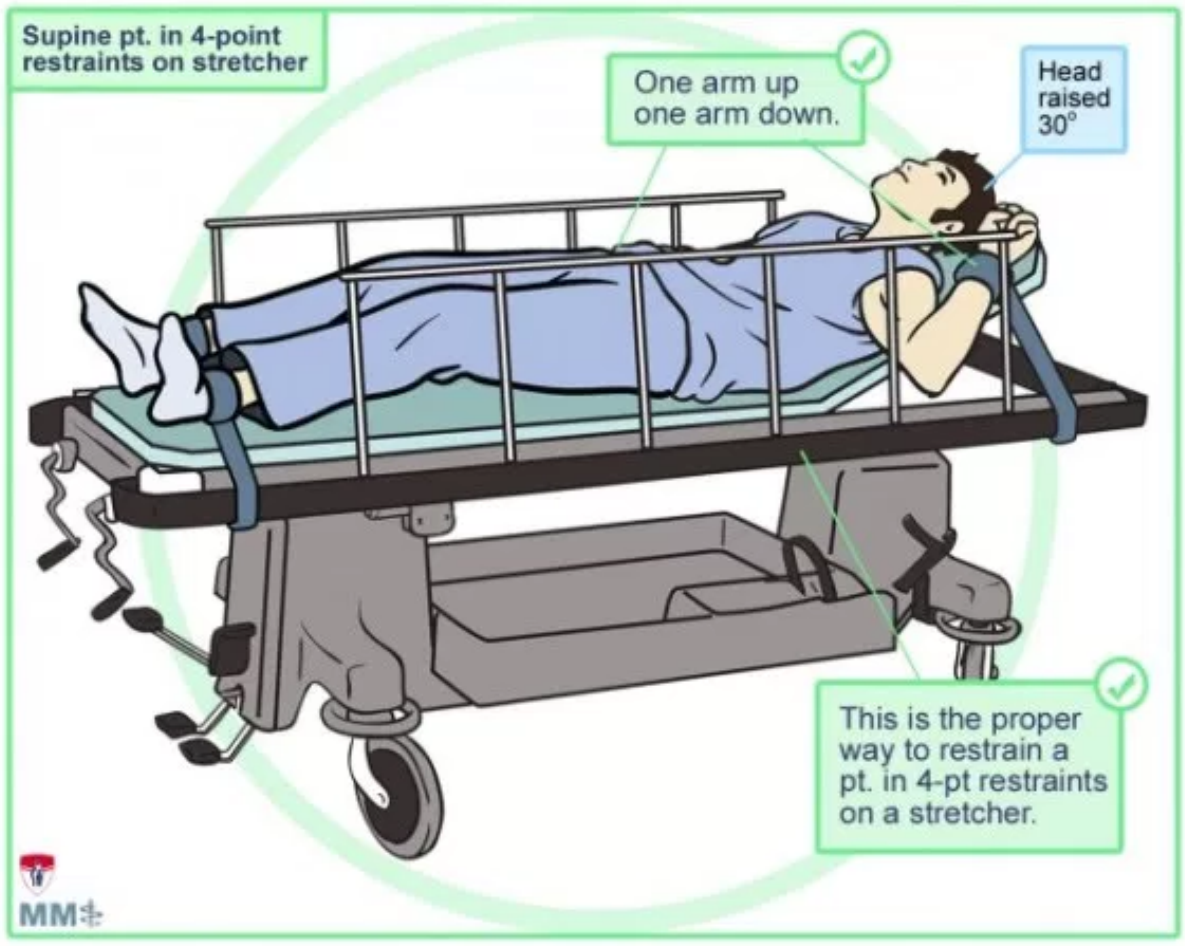
Physical restraints should be considered when verbal techniques prove unsuccessful. *The use of restraints can be humane and effective in facilitating diagnosis and treatment of the patient while preventing injury to the patient or medical staff.* **It is important to document why you initiated restraints.**

Examples:
(1) those with an organic disorder for whom restraints facilitate evaluation,
(2) those with functional psychosis for whom verbal techniques are less effective and restraints facilitate administration of neuroleptics, and
(3) those with personality disorders prohibiting the usefulness of verbal techniques.

Essential elements:

- **Appropriate indication and failure of other non-physical strategies**
- **Follow hospital protocol and use a restraint team (who has briefed the team on the plan)**
- **The restraint team: *explain to the patient in a calm and organized manner, explaining why restraints are needed and what the course of events will be***
- ***Restraints are applied securely to each extremity and tied to the solid frame of the bed (not side rails, as later repositioning of side rails also repositions the patient's extremity).***
    - **Soft vs. hard restraints**
    - **Prone vs. supine vs. side lying (supine with head elevated is the best - see EMRCIT: https://emcrit.org/racc/human-bondage-chemical-takedown/)**
    - **Know when to escalate to chemical means**
- **Close observation and extremity assessment for neurovascular injury**
- **Remove as soon as safe**
- **Documentation**
- **Debrief and process improvement**

Generally speaking, the liability one incurs for restraining a patient against his or her will is negligible compared with the potential liability for allowing a patient to lose control and cause physical harm to themselves or others. Restraints should not be applied for convenience or as a punitive response for disruptive behavior and should be removed as soon as possible, usually once adequate chemical sedation is achieved.



[4] List 3 medications used for chemical restraints, their dose, and their side effects

Three main agents:

- **Benzodiazepines**
  - **SAFEST choice for the completely undifferentiated agitated patient of an unknown cause**
  - ***particularly preferred for the management of agitation caused by ethanol or sedative-hypnotic drug withdrawal, as well as cocaine, amphetamines, and sympathomimetic drug ingestions.***
  - ***Side effects:***
    - ***sedation, ataxia, confusion, nausea, and respiratory depression, which may be amplified in the presence of concurrent alcohol and other depressant use.***
    -
- **Antipsychotics**
  - **Typical (Haldol) vs. Atypical (Olanzapine)**
  - **Side effects:**
    - **Vary based on the drug, but some are:**
      - **Sedation, hypotension, anticholinergic, EPS, QTc prolongation (highest risk when given IV)**
      - **EPS:**

        - ***akathisia (extreme restlessness) and uncoordinated involuntary movements known as dystonia, including of the muscles of the mouth (buccolingual), neck (torticollis), back (opisthotonos), eyes (oculogyric crisis), and trunk (abdominopelvic).***
        - ***Trxt benztropine 1-2 mg or diphenhydramine***

    - Avoid with alcohol, benzodiazepine, or other sedative withdrawal syndromes, patients with known seizure disorders, and when possible avoided in pregnant or lactating females and patients with phencyclidine overdoses.
- **Ketamine**
    - ***initial dose of 1 to 2 mg/kg IV or 4 to 5 mg/kg IM. The onset of drug action is typically 1 to 2 minutes after IV use and often 4 minutes or longer after IM administration, with duration of action of approximately 20 minutes.***
    - ***Notable side effects include hypertension and tachycardia (usually mild and transient), drooling, laryngospasm and other respiratory complications (uncommon), emesis, and emergence reactions, worsening psychosis.***

It is usually best practice to offer a PO version of sedation to the cooperative but agitated patient - assuming it is safe to wait and no immediate threat to the staff. Here the options are:

- **Lorazepam 2 to 4 mg PO or Risperidone 2 mg PO* or Olanzapine 5 to 10 mg PO***
- **For elderly patients, it's probably best to reduce the dose by half**

Ideally it's helpful to think through the specific type of patient you're trying to sedate:

- **Severely violent vs. stimulant intoxication vs. CNS intoxicated patient (ETOH) vs. the patient with a known psychiatric disorder**

In general here are some options:

- **Droperidol 2.5 to 5 mg IM/IV, titrate as needed**
- **or**
- **Midazolam 2.5 to 5 mg IM/IV, titrate as needed**
- **or**
- **Midazolam 2.5 to 5 mg IM/IV with droperidol 2.5 to 5 mg IM/IV, titrate either as needed**
- **or**
- **Haloperidol 2. 5 to 5 mg IM/IV with lorazepam 2 mg IM/IV, titrate either as needed**
- **Ziprasidone 20 mg IM* or Olanzapine 10 mg IM* (for the known psychiatric patient)**

Could remember: 2+2 - lorazepam 2mg + haldol 2 mg; but we know that midazolam is the fastest of the choices when given IM. So I'll keep it simple: Haldol 2.5 mg IM and Midaz 5 mg IM. Lorazepam takes 15-30 mins to work when given IM! Note that Droperidol and haldol are dosed similarly!

[5] List 6 Psychiatric, 8 Organic, and 8 Drug causes of violence

Unfortunately, these often overlap. This is a repeat from question 1:

Psych	Organic	Drug

• Schizophrenia
• Paranoid
• Mania
• Personality disorder
• Fear and guilt reactions
• Antisocial behaviour
	☐ Drugs
	☐ Infections
	☐ M
	  ○ Hypoxia
	  ○ Hypoglycemia
	  ○ Electrolytes
	  ○ Delirium
	  ○ Dementia
	☐ E
	  ○ hypo/hyperthermia
	  ○ CO or CN poisoning
	☐ S
	  ○ CVA
	  ○ Traumatic bleed
		☐ Withdrawal
		  ○ ETOH
		☐ Intoxication
		  ○ ETOH
		  ○ Amphetamines
		  ○ Cocaine
		  ○ MDMA
		  ○ PCP
		☐ Rx:
		  ○ Steroids
		  ○ Anticholinergics
		  ○ Sedatives

[6] Distinguish organic from functional causes of violent behaviour

FORTY

- **Family hx**
- **Onset < 40 more likely functional**
- **Recent trauma / drugs / stressors**
- **Toxidrome**
- **Y? Why are they presenting now?**

Table 189.1: Distinguishing Organic from Functional Causes of Violent Behavior

CLINICAL FEATURE	ORGANIC		FUNCTIONAL
	DELIRIUM	DEMENTIA	
Onset	Acute	Gradual	Gradual
Age at onset	Any	>50 years old	<40 years old
Alertness	Altered	Normal	Normal or hyperalert
Orientation	Impaired	Normal	Normal
Hallucinations	Common; can be visual, auditory, or tactile	None	Auditory in schizophrenia, otherwise uncommon
Symptom picture	Fluctuating	Stable	Stable
Abnormal vital signs	Common	Uncommon	Uncommon
Psychiatric history	No	No	Yes

Table 95-1. *MADFOCS* Mnemonic

	ORGANIC	FUNCTIONAL
Memory deficit	Recently impaired	Remotely impaired
Activity	Hyperactivity and hypoactivity Tremor Ataxia	Repetitive activity Posturing Rocking
Distortions	Visual hallucinations	Auditory hallucinations
Feelings	Emotional lability	Flat affect
Orientation	Disoriented	Oriented
Cognition	Some lucid thoughts Perceives occasionally Attends occasionally Focuses occasionally	No lucid thoughts Unfiltered perceptions Unable to attend Unable to focus
Some other findings	Age >40 Sudden onset Physical examination often abnormal Vital signs may be abnormal Social immodesty Aphasia Consciousness impaired Confabulation	Age <40 Gradual onset Physical examination normal Vital signs usually normal Social modesty Intelligible speech Alert, awake Ambivalence

Goal to determine whether the patient is "medically stable for psychiatric evaluation."

[7] List 2 ED factors, 3 physician factors, and 2 patient factors that impair the physician patient relationship/interaction

Box 189.7: Factors Impacting the Difficult Patient-Physician Interaction

Emergency Department Factors

1. Lack of patient choice of facility or physician
2. Time constraints, frequent interruptions, other priorities of care
3. Suboptimal patient privacy or comfort (eg, hallway examinations)
4. Long waiting times, department crowding
5. Negative non-physician bias toward the patient (eg, by prehospital team, nursing)

Physician Factors

1. Poor communication
2. Difficulty expressing empathy or becoming easily frustrated
3. Personal negative bias and prejudices toward conditions and interactions
4. Limited knowledge of the patient's condition or psychosocial situation
5. Overly rigid medical agenda or interaction
6. Outside stresses affecting work
7. Emotional burnout or insecurity
8. Personal health issues
9. Situational stressors and perceived time pressure
10. Sleep deprivation or shift fatigue

Patient Factors

1. Behavioral issues (eg, argumentative, manipulative, medical noncompliance)
2. Fear of abandonment
3. Psychiatric conditions
4. Low literacy
5. Financial constraints
6. Chronic pain syndromes
7. Multiple complaints
8. Beliefs or goals of care foreign to the physician
9. Unrealistic expectations
10. Substance use disorder
11. Past or current physical, emotional, or mental abuse
12. Life stress or social disarray

[8] List 5 communication strategies for dealing with the difficult patient encounter

SALTER V

Structure the interview
Actively listen
Limit setting / ground rules
Take a time out
Expectations
Redirect the interview to the main concern
Validate emotions

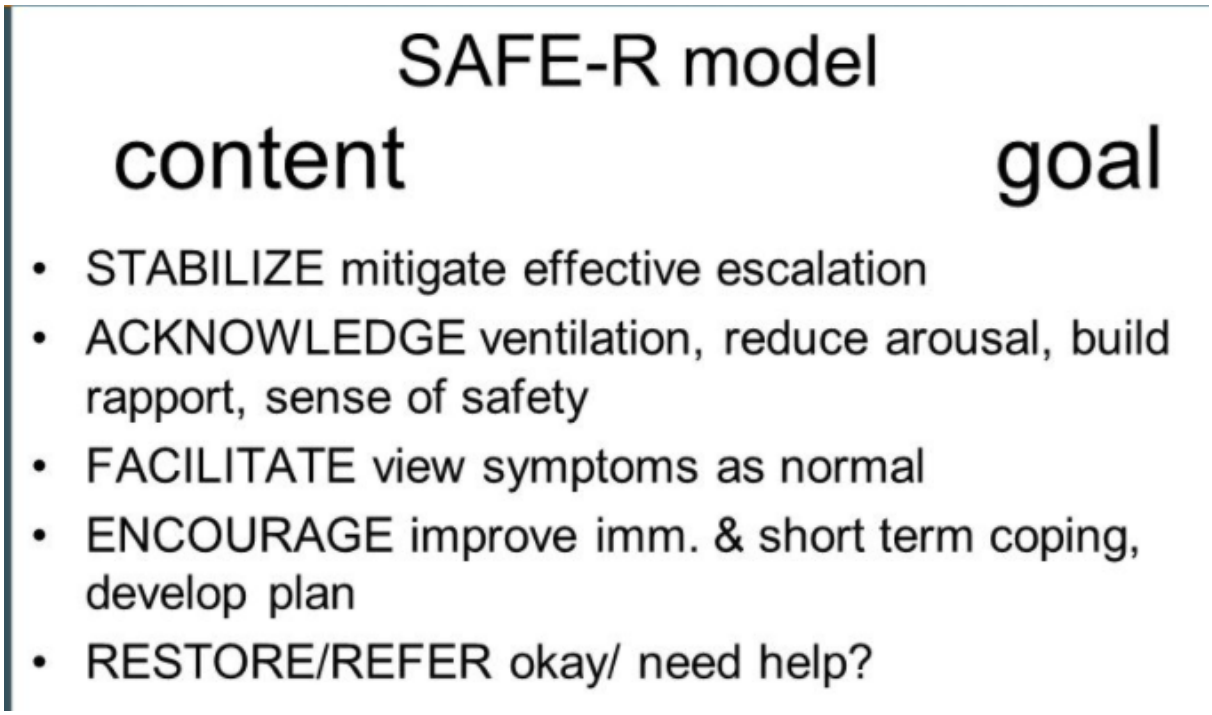
Table 189.3: Communication Strategies for the Difficult Patient Encounter

GOAL	PHYSICIAN ACTION	EXAMPLE
Structure the interview	Set time limits and expectation that interruptions may occur	"Thank you for your patience. I may have to excuse myself to care for another patient, but if we are interrupted, I will return to pick up where we left off and provide you with the care you need."
Set limits	Establish ground rules for behavior	"We want to help you, but your language and behavior is offending other patients—making it difficult to care for you and other patients. Please be mindful of your remarks or you may need to be escorted out."
Active listening to improve understanding	Allow the patient to talk without interruption, summarize concerns, and recognize that anger is usually a secondary emotion	"Help me to understand what is upsetting you so much right now."
Understand the patient's agenda	Nonjudgmentally inquire about the patient's primary needs, concerns, expectations, and so on	"What is the most important thing that we can do to help you right now?"
Validate emotion and empathize	Disarm intense emotion by attempting to name the patient's emotional state and express concern and empathy	1. "You seem upset." 2. "You are right. It is frustrating to wait a long time to be seen."

GOAL	PHYSICIAN ACTION	EXAMPLE
Redirect the interview	Avoid pursuing trivial, chronic, or tangential complaints by redirecting focus	"I think I can help you most right now if we focus on your main concern first."
Take a time out	Leaving a patient's room and returning after both parties have regained composure is prudent if unable to contain one's frustration	1. "Thank you for your openness. I need to step out, and I will be back to see what we can do to help you."

[9] List 5 basic steps in crisis intervention

SAFER-R model. See pdf on the subject:
https://www.ncemsf.org/about/conf2010/presentations/polk_crisis_response.pdf



- **Remove agitated patient from other provocative patients to a quiet area**
- **Triage violent patients to be seen quickly**
- **Utilize nonverbal (space, relaxed posture, exit plan) verbal de-escalation techniques**

[10] In a single sentence, describe each of the Cluster A, B, and C personality disorders, and describe an alternative approach to labelling four difficulty patient behaviour types.

- *CLUSTER A*
  - *Odd eccentric cluster: isolated or paranoid*
    - *schizotypal, schizoid, and paranoid personality disorders.*
    - *Schizotypal personalities often have one or no significant others outside family members; thus, it is often assumed that they have no desire to become involved in relationships.*
    - *Schizoid personality is consistently associated with a lack of desire for intimate human connection*
    - *Paranoid individuals are incessantly alert for threats and see threats where others do not, ie, they are vigilant for perceived slights, finding offense in even the most benign remarks or circumstances. Challenges to building a therapeutic relationship are pronounced, since a therapist will inevitably say or do something that provokes such an interpersonally sensitive patient.*
- *CLUSTER B*
  - *"Dramatic cluster" borderline, narcissistic, histrionic, and antisocial personality disorders*
    - *They want to TEST and PUSH the limits of the physician patient relationship;*
  - *The borderline person: splitting leads to a poorly developed and integrated self-concept and identity problems; exhibit pronounced emotional upheaval, self-destructive acting-out, and views of the therapist that alternate between idealization and denigration.*
  - *Narcissistic individuals: These patients may have hidden compensation strategies reflected in a private sense of entitlement to being seen as special. Constant reinforcement from others is sought to bolster fragile self-images.*
  - *A patient with a histrionic personality needs to be the center of attention and may behave in seductive ways in an attempt to keep the clinician entertained and engaged. Emotional expression is often shallow or greatly exaggerated. The histrionic patient, however, assumes a deep connection has been made with the therapist and dependence can develop very quickly. He or she has very little tolerance for frustration, resulting in demands for immediate gratification.*
  - *Antisocial personality is associated with ongoing violation of society's norms, manifested in such behaviors as theft, intimidation, violence, or making a living in an illegal fashion (eg, by fraud or selling drugs). People with antisocial personality disorder have little or no regard for the welfare of others. This personality disorder is found extensively among inmates within the prison system.*
  - *Sadomasochistic interpersonal patterns are characteristic ways of engaging others in a struggle in which one party is suffering at the hands of the other. Patients with a sadomasochistic approach to relationships often subtly sabotage treatment in an attempt to punish the therapist.*
- *CLUSTER C*
  - *Dependent — Fearing abandonment, dependent patients tend to be passive, submissive, and in need of constant reassurance.*

- *Avoidant — The avoidant individual is interpersonally sensitive, afraid of being criticized, and constantly concerned about saying or doing something foolish or humiliating.*
- *The obsessive-compulsive character is associated with more stable interpersonal relationships than some other personality styles, but individuals with this style are often unaware of their emotions, have very limited ways of functioning in the world, and deny interpersonal and psychological conflicts*
- *Passive-aggressive traits include argumentativeness, scorning authority, resistance to carrying out social and occupational responsibilities, angry pessimism, alternating between defiance and contrition, envy, and exaggerated complaints about personal misfortune.*

Compiled from *Uptodate*

Rosen's uses this approach:

Categorizing potentially difficult patients based on four common dominant behavior Types. (Table 189.4)

1. dependent clinger (formerly dependent, borderline, histrionic)

DEPENDENT CLINGER

• Excessive need for attention and reassurance • May use helplessness and seduction • Worried about abandonment • Escalating requests and demands	• Physician may initially feel special and welcome the patient's praise • As patient demands increase and physician time and energy commitment increases, a feeling of frustration, exhaustion, and resentment dominate	• Recognize the inflated positive self-esteem feeling that is being cultivated • Maintain a professional demeanor • Establish boundaries of care early and maintain them • Crisis intervention may be needed • Involve the patient in decision making including appropriate follow-up

2. entitled demander: CEO, narcissistic, paranoid

ENTITLED DEMANDER

• Uses intimidation, hostility, name dropping, blame, and threats • May refuse necessary steps of assessment or treatment • Behavior caused by fear of loss of power or physician abandonment	• Initial desire may be to engage in the patient's conflict • Physician may feel intimidated, inadequate, or fear litigation	• Resist urge to enter into conflict and avoid power struggles • Reinforce concept that the patient is entitled to good medical care while setting limits on unreasonable demands and behavior • Allow the patient to choose between reasonable treatment options • If a specific emotion is evident, recognize it and address it with the patient

3. manipulative help rejector: borderline, antisocial PD

MANIPULATIVE HELP REJECTER

• Excessive need for attention through multiple visits and unsolvable problems • Rejects the possibility that any treatment will help	• Physician may feel frustrated and overlook real significant illness, but also may share the patient's pessimism and fear that serious illness has been missed	• Be mindful of cognitive distortions that may obscure real illness • Set limits on expectations while being supportive

4. self-destructive denier: violent, chronic suicidal, substance abuser, borderline PD.

SELF-DESTRUCTIVE DENIER

• Disregard for own health with repeated self-destructive behaviors • Feels helpless or hopeless about changing the situation	• Physician may feel frustrated, helpless, or guilty for lack of empathy • Physician may avoid being available for the patient and unconsciously provide poor care	• Be mindful of one's own feelings and keep appropriate emotional distance • Set realistic expectations and provide appropriate care • Search for signs of mental health or social needs and consider referral or consultation as needed

Wisecracks:

[1] What are four patient behaviours suggesting impending violence?

- **Loud speech**
- **Tense posturing / angry demeanor**
- **Pacing**
- **Aggressive behaviour**

See Box 189.3

[2] What are some elements of verbal de-escalation?

SAFE PLACE

- **Safe space**
  - **Remove agitated patient from other provocative patients to a quiet area**
  - **Triage violent patients to be seen quickly**
  - **Distance yourself, remove hazards in the room (objects that can be thrown)**

- **Posture**
  - **Non-confrontational body posture (arms at sides, palms facing up, sitting at eye level**
- **Listen carefully**
  - **What can we help with today? What you hoping for? Tell me if I understand this correctly?**
- **Acknowledge**
  - **Agree with truths: "we want to treat you with respect", "there are others who feel like you",**
  - **Note their frustration**
- **Clarify limits and offer Choices**
  - ***Clearly state that violence, threats and abuse will not be tolerated***
  - ***"I can help you with your problem, but I cannot allow you to continue threatening me, the emergency department staff, or other patients."***
  - ***"You obviously have a lot of will power and are good at controlling yourself."***
  - **Offer choice between**
  - **Consider offering a cold drink or a sandwich to build a bridge**
  - **Ask and explain what you're doing before you do it:**
    - **"I'm going to feel your sore wrist; I'm going to listen to your lungs; I'm going to look at that wound"**
- **Exit strategy**
  - **Know to trust your gut feeling if you notice things escalating**
  - **Have security nearby**
  - **Know where the exits are - have at least two exits**
  - **Don't ask to leave, just walk out**

Counterproductive approaches to the combative patient include arguing, machismo ("mano a mano"), threats, deception, and condescension. These inappropriate strategies fail to build rapport and may challenge patients to "prove themselves." An open threat to call security personnel also invites aggression. Clinicians should be aware of their own reactions to such patients and avoid transference of anger. The deception of a patient (eg, "I am sure you will be out of here in no time.") may serve to invite violent consequences once the false promise is uncovered and an unsuspecting nurse or colleague who follows the interviewer may be victimized. Do not deny or downplay threatening behavior, and if verbal techniques are unsuccessful and escalation of violence occurs, the physician should leave the room and summon help.

See Box 189.4

[3] Describe seven toxidromes.

TABLE 189.2 Vital Signs and Toxic Syndromes

TOXIN	BLOOD PRESSURE	PULSE	RESPIRATORY RATE	TEMPERATURE	PUPIL SIZE	SKIN	EXAMPLE
Sympathomimetic	↑	↑	↑	↑	↑	Wet	Cocaine
Anticholinergic	↑/↓	↑	↑/↓	↑	↑	Dry	Diphenhydramine
Cholinergic	↑/↓	↑/↓	—	—	↓	Wet	Pesticides
Opioids	↓	↓	↓	↓	↓	—	Morphine
Sedatives	↓	↓	↓	↓	↑/↓	—	Lorazepam
Withdrawal (ethanol, sedative-hypnotics)	↑	↑	↑	↑	↑	Wet	Benzodiazepine withdrawal

- **The sympathomimetic and withdrawal toxidrome present similarly**
- **The main difference between the sympathomimetic and anticholinergic toxidrome is wet vs. dry skin**

The seventh being the hallucinogenic toxidrome.

[4] What are some tools for managing negative physician-patient reactions

SOUR situation

Box 189.8 Tools for Managing Negative Reactions

Maintain Appropriate Emotional Distance

1. Avoid reciprocating hostile behaviors while maintaining a sense of empathy for the patient

Understand Negative Behavior as a Symptom

1. View the patient as a victim of their circumstances

Look for Cognitive Distortion

1. Be cautious not to overly-stereotype and cloud clinical judgment and avoid perpetuating negative labels

View Negative Reactions in Context

1. Recognize when one feels overwhelmed by the expectations of the emergency department (ED) work environment to gain perspective on personal reactions

Cannarella Lorenzetti R, Jacques CH, Donovan C, et al: Managing difficult encounters: understanding physician, patient, and situational factors. Am Fam Physician 87:419-425, 2013.