

My Patient Wants to Kill Me

David Bittleman, MD

Veterans Affairs San Diego Health Care System, San Diego, California

ABSTRACT

A few years into my practice at the Veterans Affairs (VA) clinic, I was threatened by an angry patient when I had to discontinue his opioids. I placed a civil restraining order against him and when we met in court he admitted to the judge that stopping opioids improved his behavior. I discovered that the legal system could support the medical system's care of threatening patients but found the process stressful. My story outlines my journey and suggests that safety-net institutions such as the Veterans Affairs clinics might consider creating "patients of concern" panels where patients who have made threats meet with clinicians and administrators as part of ongoing treatment and, as a result, perhaps avoid courtroom visits. These panels could allow patients to air their grievances as well as see that a group of concerned clinicians are reviewing their care and making decisions as a team. Violence in the workplace, especially in health care, is on the rise. The stress this causes doctors, nurses, and staff is considerable. Leadership at safety-net institutions such as VA need to explore novel ways of addressing workplace violence.

Ann Fam Med 2020;18:269-271. <https://doi.org/10.1370/afm.2517>.

As my patient left the office, his guardian slipped me a note: "Call me tomorrow." I called her the next morning. She said: "He wants to kill you." I am a 56-year-old man, an internist and have been practicing primary care internal medicine at a Veterans Affairs (VA) clinic for over 5 years. Before that, I was in private practice for almost 20 years. My wife and I moved to be near family and I thought I would enjoy working in VA, working with veterans, medical students, residents. I have experienced what I thought was the gamut of human emotions in all my years of practice. I have cared for very sick patients, patients under tremendous stress, patients who were happy with what I was able to do for them, patients whom I could never seem to help at all. But I had never had someone say they wanted to kill me.

Over the previous 6 months, from June 2018 until January 2019, a team of psychiatrists, psychologists, pain specialists, social workers, and I had been helping my patient, a veteran in his early 60s, with musculoskeletal pain and mental illness. He had been transferred to my care from another physician who left VA. The patient had been on and off prescribed opioids for many years and at the time of transferring to my service in June 2018 he was taking about 4 5mg oxycodone daily. His pain specialist, psychiatrist, and I felt that his progressive mental illness, combined with alcohol, marijuana, and other substance use, made opioids risky and counterproductive. He was upset and thought that opioids had a role in his care plan. I met with him and a substance-use disorder psychiatrist for a half-hour conference call. We explained that we would need to taper and eventually stop the opioids. We offered inpatient care where he could be monitored and treated for withdrawal. He turned us down.

Primary care clinicians at my VA clinic are the main prescribers of long-term opioids. Since the late 1990s, pain assessment—with pain as the 5th vital sign—has been integrated into each clinical encounter at VA. Even though the evidence for the safety and efficacy of chronic opioid use

Conflicts of interest: author reports none.

CORRESPONDING AUTHOR

David Bittleman, MD
3970 Kenosha Avenue
San Diego, CA 92117
wbashant@yahoo.com

is poor, many veterans have been on them for years as part of the initiative to lower pain scores. In recent years, VA, the Centers for Disease Control, and others have worked to combat the epidemic of opioid misuse and overdose. Opioid safety committees at VA, staffed by physicians, pain pharmacists, and other experts advise primary care clinicians to reduce opioid dosages and avoid combining opioids with benzodiazepines to reduce the risk of overdose, injuries, and death. Thus, the primary care teams have become the "face of no" when stopping opioids. This leads to confrontations and, as in my case, death threats.

Two months before my call to his guardian, in November 2018, the patient sent me a disturbing secure message through the VA electronic health record messaging system, saying I had better learn jiu jitsu and hand-to-hand combat if I was ever to take his opioids away. He ended with a warning: I better learn how to defend myself. I reported this to VA police. Mental health professionals interviewed him, but believed he wasn't a danger. When his caregiver passed me the note and later told me of his plans to kill me, I reported it VA police. Again, I was told the patient would be assessed. At that point, the VA officer also said that I could file a restraining order at the city courthouse. The same officer told me he had previously worked at the courthouse and said, "Doc, it can be a hassle to file a restraining order, but you certainly have that option." I had no idea how to go about doing this. I took my lunch and drove to the courthouse where I learned that there are different kinds of restraining orders one can file: those related to problems in domestic relationships and others for civil cases, such as mine. I completed paperwork, wrote out my statement, included a copy of the threatening secure message, and submitted it all for the judge to review. Was this a breach of confidentiality? Probably not. It didn't reference his health, just mine. It took the rest of the afternoon to have the judge issue a temporary restraining order. At the end of the day, the plan was that my patient would be served papers informing him he could not come within 100 yards of me, my clinic, my car, or my home. I live in a big city. I doubted he knew my address. The process, however, was not over yet. The temporary restraining order was only for 2 weeks. I would have to appear again in court to get a permanent restraining order.

As I waited for the next court date, I became more anxious. I, like many young children, was bullied and beaten up in childhood. However, that was over 40 years ago. Since then I have not experienced threats of physical violence. I come from a protected, safe, and privileged world. I work with a male nurse, a Navy veteran who was shot and knifed in combat. He accom-

panies me during my visits with angry or concerning patients. I know the armed guards in my building. They have stood outside my exam room door and have even been with me while I met with patients. I have a "panic button" under my desk in the event of attack. No one can enter my building without going through the metal detector and checking in with security.

In the days after the threat, even though the patient had been removed from my panel, I found myself talking to others about the problem. Several recommended I buy a gun. I have never fired a gun and have no interest in learning how. Another suggested that pepper spray would be good to have on hand. I also met with an Employee Assistance Program (EAP) therapist once. She was helpful, normalizing my anxiety, recognizing my newly formed habit of vigilance, acknowledging my fear.

The next time I saw my patient was at the courthouse. In addition to us, about 20 other cases were being heard. All morning I listened to stories of human conflict between neighbors, former friends, strangers, and enemies. People had called each other names, used racial slurs, spit on each other, keyed one another's cars, all because they did not like the way someone looked at them or parked their vehicles.

When my case came up, the judge explained that as the plaintiff, the burden was on me to prove that my patient was a threat. I provided the judge the threatening messages, a photocopy of the note the guardian had slipped to me. The judge then turned to my patient and asked him to explain his side. My patient spoke about how the VA had denied him certain benefits, how it had not provided good care, about how he was forced to go to mental health services, drug rehab, and inpatient treatment that he didn't need, but he also admitted much improved behavior since stopping opioids. My patient spoke to the judge as if he were one of his counselors or treating physicians. The judge was kind and let the man speak for what seemed like a long time. Finally, he stopped my patient and asked if he said that he wanted to kill me. "Oh yes, your honor, I did say that, but I was only joking," he replied. The judge responded that the temporary restraining order was permanent for 1 year. If he violated it, he would be arrested. In addition, he could not have any firearms. I breathed a sigh of relief.

My patient was no longer taking opioids and by his own admission was better off. I was not injured or killed. But, why did it have to come to death threats and court appearances to work this out? Our workplaces have become increasingly violent. In 2015 workplace shootings in the United States accounted for 354 fatalities.¹ That's nearly one gun-related homicide for every day of the year. Consider the case of

Dr Timothy Fjorbak, a Texas VA psychologist who was shot and killed by a disgruntled veteran in 2015. The murderer, who also worked as a desk clerk at VA, approached Dr Fjorbak in 2013 in a grocery store and said something like, "I know what you did, and I will take care of that." Dr Fjorbak filed a complaint, just like I did, but was later killed anyway.²

There is an ongoing national discussion about gun violence and mental illness, however, violence in health care is both underreported and understudied.³ At VA, we have mental health professionals who have experience caring for patients who have firearms. We have the resources to face head on angry, potentially violent patients. But we have no consistent protocols to deal with violent patients in the workplace.

I recommend that safety-net institutions, such as the VA, consider creating "patients of concern panels" where threatening, angry veterans must meet with clinicians and administrators, as part of their ongoing treatment, and perhaps avoid courtroom visits. These sorts of panels already exist in many educational institutions.⁴ Two examples include the student care team and threat assessment program at DePaul University and the Students of Concern group at the University of Colorado Boulder.^{5,6} Such panels would allow patients to air their grievances as well as see that a group of concerned clinicians were reviewing their care and making decisions, as a team. In retrospect, when my patient said I had better learn jiu jitsu and hand-to-hand combat if I was ever to take his opioids away, he should have, at that point, had to come before a panel which would have included me, my registered nurse (RN), his mental health team, and my supervisor. Together we would have listened to his concerns, outlined his treatment plan, and made it clear that not only I was recommending stopping the opioids, his whole VA care team was making the same recommendation. I would not be the "single face of no" when it came to stopping opioids. Furthermore, we could make it clear that threats of violence would not be tolerated.

In the complex field of medicine today, we work in care teams, not simply as individual practitioners. In this case, the care team included the VA, my nurses,

my guards, the EAP counselor, the patient's guardian, and a kind, patient, but firm judge. We were all first responders acting with patience, justice, and care for the benefit of a sick veteran

Our safety-net institution administrators need to do more than simply provide online trainings for dealing with workplace violence. They also need to propose and pilot ideas to help deescalate this crisis. We need to consider creating "patients of concern" panels to further help patients, as well as clinicians, as we negotiate highly charged, emotional, and potentially lethal issues such as the treatment of chronic pain and the discontinuation of opioids.

Our patients deserve this. And health care workers do too.

To read or post commentaries in response to this article, see it online at <http://www.AnnFamMed.org/content/18/3/269>.

Key words: workplace violence; opioids; veterans; health care violence

Submitted June 27, 2019; submitted, revised, November 1, 2019; accepted November 29, 2019.

Acknowledgments: I would like to thank Wendy Bashant, PhD, Charles Goldberg, MD, and Tim Dresselhaus, MD for reviewing the manuscript.

References

1. Doucette ML, Bulzacchelli MT, Frattaroli S, Crifasi CK. Workplace homicides committed by firearm: recent trends and narrative text analysis. *Inj Epidemiol*. 2019;6(5). <https://doi.org/10.1186/s40621-019-0184-0>. Published Mar 18, 2019. Accessed Sep 20, 2019
2. Izadi E, Lamothe D, Wax-Thibodeaux E. FBI: El Paso clinic victim was VA doctor who had filed complaint against alleged killer. *Washington Post*. January 7, 2015. <https://www.washingtonpost.com/news/post-nation/wp/2015/01/06/doctor-shot-presumed-shooter-found-dead-at-el-paso-va-clinic/>. Accessed Sep 18, 2019.
3. Phillips JP. Workplace violence against health care workers in the United States. *N Engl J Med*. 2016;375(7). 10.1056/NEJMra1501998.
4. Cornell D, Sheras P. *Guidelines for Responding to Student Threats of Violence*. Longmont, CO: Sopris West; 2006.
5. Student care team and threat assessment. DePaul University Academic Catalog 2019-2020. <https://catalog.depaul.edu/student-handbooks/code-student-responsibility/student-care-team-threat-assessment/>. Accessed Oct 30, 2019.
6. University of Colorado Boulder, Division of Student Affairs. Students of concern. <https://www.colorado.edu/studentaffairs/students-concern>. Accessed Nov 2, 2019.