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Responding to patient anger: Development and evaluation of an oncology communication skills training module

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ABSTRACT

Objective: The purpose of this study was to develop a communication skills training (CST) module for oncology healthcare professionals on how to more effectively respond to patient anger. We also sought to evaluate the module in terms of participant self-efficacy and satisfaction.

Method: The development of this module was based on a systematic review of the literature and followed the Comskil model previously used for other doctor–patient CST. Using an anonymous 5-point Likert scale, participants rated their pre-post self-efficacy in responding to patient anger as well as their satisfaction with the course. Data were analyzed using a paired sample t test.

Results: During the academic years 2006–2009, 275 oncology healthcare professionals participated in a CST that focused on responding to patient anger. Participants' confidence in responding to patient anger increased significantly ($p < 0.001$) after attending the workshop. They also agreed or strongly agreed to five out of six items assessing course satisfaction 92–97% of the time.

Significance of results: We have developed a CST module on how to respond to patient anger, which is both effective and useful. Training healthcare professionals to respond more effectively to patient anger may have a positive impact on the patient–physician relationship.

KEYWORDS: CST, Difficult patients, Empathy, Patient-physician relationship

INTRODUCTION

Every physician has interactions with angry patients and/or family members at some point. In stressful situations such as inpatient hospital settings where patients are acutely ill or in ambulatory settings such as those found in oncology practices, patient–physician interactions can be highly emotionally charged. These interactions can lead to a rupture in the patient–physician relationship, resulting in a negative impact on patient care, decreased patient satisfaction, and poor outcomes. These interactions can also have a major impact on the physician, leading to increased job dissatisfaction and burnout more than can working with patients who have challenging medical problems (Steinmetz & Tabenkin, 2001). Ramirez et al. (1996) found that oncologists attributed job stress as arising from angry, distressed, and blaming relatives in 35% of cases in a 1996 study of burnout in the cancer setting. This proportion increased to 47% of cases in a 2005 replication study. In addition, the rating of exhaustion had risen from 32% to 41% over this time period (Ramirez et al., 2005).

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BACKGROUND

An angry patient is one kind of difficult patient. Difficult patients include those who are considered uncooperative; those who have multiple complaints, a psychiatric disorder, or "psychogenic illness"; and those with a history of substance abuse. A seminal article by Groves (1978) described four kinds of difficult or "hateful patients": the *dependent clinger*, the *entitled demander*, the *manipulative help rejecter*, and the *self-destructive denier*. This work was based on inpatient consultations done in the general hospital, and described approaches to these patients founded in a psychological understanding of the patient's coping and personality style. A further review of the literature suggests a series of communication strategies to work with the difficult patient in a more effective way to improve the doctor–patient interaction (Kissane, 1994; Pearce, 2002; Essary & Symington, 2005) One contemporary view is that anger can represent dysfunction in the doctor–patient relationship, and it is important for physicians to be observant of their participation in the interaction and adjust their behavior and communication accordingly (Lown, 2007).

In the oncology setting, observational studies indicate that between 9 and 18% of patients and a similar proportion of their family members have been found to have a level of anger deemed to be a clinical concern (Stefanek et al., 1987; Kissane et al., 1994; Hahn et al., 1996) In one study of families of patients with advanced cancer, 9% of patients, 13% of their partners, and 26% of their adult offspring had morbid levels of anger (Kissane et al., 1994).

Anger is not an emotional cue that needs to be uncovered, but rather it is an apparent, explicit emotion that can arise from a variety of underlying reasons. One may consider anger to be a normal phase of grief that patients may encounter related to the disease itself and multiple losses that may include loss of body parts, loss of normal day-to-day functioning, and loss of control over their own bodies. Anger may also arise over problems with the medical system such as being kept waiting for appointments or other delays or problematic interactions with other healthcare professionals. And finally, the anger may be directly connected to something their doctor said or did. Thus the anger may be displaced, comprehensible but not necessarily justified, or fully justified. No matter what has provoked the anger, it must be addressed if the patient–physician relationship is to continue in a useful way. However, physicians, particularly those still in training, do not always have the skills and knowledge to respond effectively to patient and family members' anger and may need formal training in this matter.

COMMUNICATION SKILLS TRAINING

Communication skills training (CST) is an essential component of graduate medical education and is subsumed under the core competency of Interpersonal and Communication Skills. A review of the oncology literature indicates that cancer patients often have unmet communication needs in several areas (Jenkins et al., 2001) and that communication skills can be taught to oncologists (Fallowfield et al., 1998; Gysels et al., 2004; Stiefel et al., 2006) In order to address this educational need at our institution, the Communication Skills Training and Research Laboratory, which is within the Department of Psychiatry and Behavioral Sciences at the Memorial Sloan-Kettering Cancer Center (MSKCC), developed a series of CST workshops called the Comskil Training Program. The curriculum covers such topics as Breaking Bad News, Discussing Prognosis, Shared Decision Making about Treatment Options and Clinical Trials, Transition to Palliative Care, and Discussing Death and Dying. (Brown & Bylund, 2008; Bylund et al., 2010). Because of the prevalence of anger among patients and family members, a CST workshop on Responding to Patient Anger was also developed.

The content of each workshop is based on a model we have developed, the Comskil conceptual model. (Brown & Bylund, 2008) One critique of the literature on CST is that it is not always clear which skills are being taught and if those skills are matched with those being assessed (Cegala & Broz, 2002). The Comskil conceptual model seeks to answer this critique by explicitly defining the important components of a consultation. We propose that consultation communication can be guided by an overarching goal, which is achieved through the use of a set of strategies. Strategies are achieved through the use of communication skills, defined as discrete, measurable utterances made by the physician to further the clinical dialogue. Process tasks, sets of dialogues or nonverbal behaviors that create an environment for effective communication, are also critical to achieving strategies. The development of each new workshop includes a series of seven consecutive steps: (1) a systematic literature review, (2) holding consensus review meetings, (3) developing modular blueprint, (4) producing training materials, (5) creating scenarios, (6) making revisions and adaptations, and (7) conducting assessments (Brown, 2010).

Using this process, we developed a module to teach oncologists how to communicate more effectively with the angry patient. How best to respond in such a situation may be one of the most difficult patient interaction challenges faced by a clinician The overall

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communication goal is to ameliorate the patient's experience of anger, to diffuse the emotion to a level where effective communication can occur allowing the consultation to continue. There are a series of five steps or strategies recommended along with appropriate communication skills and process tasks that allow the clinician to achieve this goal. Although the strategies can be applied flexibly, the sequence is reproducible across virtually every occasion in which one must respond to patient anger. The core components and their interrelationships have been organized into a modular blueprint (Table 1).

The first two strategies are: (1) Allow patients to recount their grievances and (2) Work toward a shared understanding of patient's emotion and/or experience. Good questioning skills are encompassed in both of these strategies. Patients want to be heard and understood. Asking open questions such as, "Tell me what's wrong," allows patients to tell their story in their own words. It is important that the clinician allow this to happen by not interrupting the patient, not acting defensive, and not simply dismissing the patient's complaints. Further questioning skills, such as clarifying and restating or paraphrasing, can help to deepen the shared understanding of the situation that is provoking the patient's anger.

Strategy 3 is at the core of responding to patient anger by empathically responding to the patient's emotion or experience. There are three basic components of empathy: the affective component in which the observer may actually experience or feel the patient's emotion, the cognitive component in which the observer can understand or imagine what the patient is feeling, and the behavioral component in which the observer may act in a manner that is socially appropriate to the patient's emotion (Bylund & Makoul, 2005). The affective component of empathy is most likely related to the clinicians' own self-awareness and openness to their emotions. Although it is important for physicians to be aware of the emotions triggered by the interaction with the angry patient so that they can respond appropriately rather than acting defensively or getting into a struggle with the patient, not all physicians will actually be able to experience what the patient is feeling. This component of empathy may not be something that can be taught in a CST workshop. The cognitive and behavioral components, however, lend themselves to specific communication skills and process tasks.

Acknowledging the patients' emotions ("I can see how upset you are") is simply stating what is being observed and furthers patients' feeling that they are being heard and understood. Validating the patient's experience ("I can understand why you would be so frustrated") deepens the empathy and also helps to negotiate the emotion to something less intense than anger or rage. Normalizing ("Many people would feel the same way in this situation") allows patients to feel that they are not alone and are in fact justified in having their emotions. Finally, praising patients' efforts ("It's good that you

Table 1. *Modular blueprint: Responding to patient anger*

Goal: To ameliorate the patient's experience of anger to a level where effective communication can occur progressing the consultation

Strategies	Skills	Process task
Allow the patient to recount grievances	Ask open questions	Do not act defensive Avoid interruptions (unless essential for control)
Work toward a shared understanding of the patient's emotion/experience	Ask open questions Clarify Restate	Avoid leading questions Avoid giving premature reassurance Negotiate the emotion's name proportional to intensity
Empathically respond to the emotion/experience	Acknowledge Validate Normalize Praise patient efforts	Apologize if appropriate
Explore attitudes and expectations leading to anger	Ask open questions Restate Clarify Acknowledge	Direct anger constructively
Facilitate coping and connect to social support	Make partnership statements Express a willingness to help	Make referrals If appropriate, explore problem solving options Explore patients' networks Avoid anger-causing isolation

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came to talk to me about this problem") enforces the non-adversarial role of the clinician. The clinician may need to respond empathically several times in order to diffuse the emotion to a level where the consultation can progress to the next strategies. After making an empathic statement or gesture, the clinician should allow patients to react and not block or interrupt them. Silence and allowing patients to have their emotions can itself be an empathic response.

As the emotion lessens and the consultation continues, the clinician can move on to the last two strategies, which can lead to problem solving: (4) Explore attitudes and expectations leading to anger and (5) Facilitate coping and connect to support. Once again, good questioning skills such as asking open questions, restating, and clarifying may lead to a better understanding of what may really be underlying the anger. For example, patients who are angry about a delay in discharge may be concerned about certain responsibilities awaiting them at home or at work or there may have been a previous miscommunication or misunderstanding about the discharge date. Patients who are angry about side effects may be upset about something specific that they are finding embarrassing or humiliating. Once clinicians have a clearer understanding of what is underlying the anger, they can try to work with the patient to resolve the problem. Specific communication skills involved include making partnership statements and expressing a willingness to help. The process tasks involved in problem solving may include making appropriate referrals or involving family members or others in the patient's networks to address the patient's concerns. Although not all situations involving angry patients can be wrapped up so neatly, by following the suggested strategies, one can hope that the patient and clinician can continue to work together in a constructive, mutually beneficial way.

METHOD

Participants

During the three academic years from 2006 to 2009, 275 healthcare professionals working in the oncology setting from MSKCC and the New York City area participated in a CST module focused on responding to patient anger. Sixty percent of the participants were residents or fellows, 36% were attending physicians, and 4% were nurse practitioners. Specialties of the healthcare professionals included medical, surgical, and radiation oncology; pediatric oncology; and radiology. The MSKCC Institutional Review Board approved the study and publication of these data.

Training in the Responding to Patient Anger Module

Prior to attending the workshop, participants were given relevant literature, including a workbook designed specifically for this training program, titled *Responding to Patient Anger*. The workbook included supporting literature and educational material about effective ways to respond to patient anger. These booklets were sent to participants before their scheduled training date and served as a resource for trainees after they participated in training.

The 2-hour workshop began with a didactic slide presentation that gave a brief summary of the literature and then focused on the strategies, communication skills, and process tasks that could be used to accomplish the communication goal. Videos of expert clinicians demonstrating these communication components are embedded into the slide presentation. After the presentation, the participants broke up into small group role plays in order to practice the recommended strategies and skills, using prepared scenarios and interacting with actors trained as simulated patients. Each role play session lasted at least 90 minutes and was facilitated by clinicians and/or behavioral scientists who had been previously trained as facilitators in a separate module and workshop described elsewhere (Bylund et al., 2008). During the practice sessions, participants had the opportunity for skills practice followed by instant feedback from peers, the facilitator who incorporated video feedback, and the actor. The workshops followed best practice principles in adult learning (learner centered and experiential, involving individualized targeted feedback) (Knowles, 1978).

Assessment

At the end of the module, participants were given an evaluation form that contained 8 statements about the workshop. This evaluation was anonymous and rated on level of agreement/disagreement using a 5-point Likert scale with anchors at 1 = "strongly disagree" and 5 = "strongly agree." A retrospective pre-post methodology (Hill, 2005) was used in the first two statements: (1) "Before this module, I felt confident responding to patient anger" and (2) "Now that I have attended this module, I feel confident responding to patient anger." The rest of the items focused on post-training attitudes regarding the skills learned and how they could be applied during routine clinical practice.

RESULTS

Using a paired sample t test, the pre-post questions methodology demonstrated that the participants'

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confidence in responding to patient anger increased significantly when compared before and after they attended the module ($p < 0.001$). Mean agreement to the pre-training self-efficacy item was 3.26 (SD = 0.88) and to the post-training item was 4.11 (SD = 0.60). Attending physicians and fellows did not differ significantly on their responses to these items.

In order to interpret the results of the module evaluation data, we determined a rating of "agree" or higher to be an indicator of satisfaction with the workshop and its effectiveness. Table 2 displays the percentages of workshop participants who agreed or strongly agreed with the six post-training items. Participants agreed or strongly agreed to five out of six items 92–97% of the time.

DISCUSSION

The primary aim of this research was to describe the development of a CST module targeting specific clinician behaviors during consultations with an angry patient or family. Although previous reports have suggested methods for working with angry patients and families, no one has published a detailed description of a communication skills intervention. The strategy of responding empathically to the patient's emotion in order to diffuse it and bring it to a level where communication and problem-solving can continue is at the core of this particular CST module. Questioning skills are emphasized in several of the strategies, in order to gain a clearer and ultimately shared understanding of what has precipitated the patient's anger and what implicit factors may be underlying the heightened emotional response. Our experience of role-play with attending physicians and fellows revealed that encounters with angry patients presented a particularly challenging experience. A key learning point was how to achieve a balance between delivering empathic statements allowing patient expression and understanding when it was possible to move forward in the consultation although a level of anger may persist. Responding to emotion is a strategy that is recommended in all of the Comskil modules and must be acknowledged and addressed in all situations, or the patient will not be able to fully hear information or advice that is being given to them. Whereas some clinicians may intrinsically have a greater capacity for empathy, particularly the affective component of empathy, the cognitive and behavioral aspects of empathy are components that can be taught. In addition, behaviors that should be avoided, such as rushing the consultation, dismissing the patient's concerns, blocking questions, or interrupting the patient, blaming the patient, and providing premature reassurance without fully developing a shared understanding of the patient's experience, are also emphasized.

Table 2. *Participant ratings of Responding to Patient Anger Workshop*

Item from Course Evaluation	Agree or Strongly Agree
I feel confident that I will use the skills I learned today. ($n = 274$)	95%
The skills I learned today will allow me to provide better patient care. ($n = 275$)	92%
The workshop prompted me to critically evaluate my own communication skills. ($n = 274$)	97%
The experience of video feedback was helpful to the development of my skills. ($n = 255$)	79%
The skills I learned were reinforced through the feedback I received in the small group. ($n = 273$)	93%
The small group facilitators were effective. ($n = 273$)	97%

Our secondary aim was to present preliminary data describing participants' confidence in responding to patient anger and their intention to use the skills in future consultations. This CST module allows participants to view videos of expert clinicians demonstrating the use of the recommended skills and process tasks that enable them to communicate with the angry patient more effectively. The experiential role-play sessions with simulated patients and facilitated by experienced clinicians then allow the participant to practice these skills in a safe, supportive environment. The actors do not automatically let go of their anger but are trained to react to the appropriate interventions from the clinician, including an empathic response. If the first attempts at getting the patient's story and diffusing the anger do not work, the clinician has a chance to try again after constructive feedback from the other participants and the facilitator. The experiential role-play session is meant to be learner centered in order to address participants' specific communication needs and to build self-confidence in their ability to handle encounters with angry patients. The finding that only 79% of participants agreed or strongly agreed that the video feedback was useful was surprising, and may be because of participants' discomfort with viewing themselves on video. Participants reported a statistically significant pre-post increase in confidence in their ability to respond to patient anger, which suggests that they found the workshop useful. This, coupled with the participants' intention to use the skills, suggests that this is a useful module.

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We also recognize that this preliminary modular evaluation has some limitations. The methodology used to evaluate the effectiveness of the module is limited to a one-time assessment done at the end of the training session. Whereas this type of assessment can evaluate the experience and its perceived effectiveness, it does not measure if the confidence gained is preserved longitudinally. Also, although retrospective pre-post tests may be biased toward socially desirable responses, this methodology is recommended to understand how participants feel about program effectiveness and personal growth (Hill, 2005). Another limitation of our assessment has been the lack of objective data to support the self-report evaluation method. Future work is warranted to develop standardized patient assessments (SPAs) as an evaluation tool for this communication skills training. Because SPAs are simulated doctor–patient consultations in which an actor is trained to play the role of a patient in a standardized way, they are useful in evaluating interpersonal communication skills in a specific domain. Using inter-item and split-half reliability methods, the SPA has proved to be a reliable assessment tool and has demonstrated discriminant validity (Sloan et al., 1995). Using SPAs will enable us to observe each participant demonstrate communication skills in a specific situation of a predetermined and standardized duration.

We also caution that the use of the techniques recommended in this module may not be appropriate in all clinical situations. There may be times when a patient is agitated and angry because of an underlying delirium. In these cases, the clinician should still respond in a supportive and caring way, but the medical abnormalities causing the delirium must take priority. Also, safety of the patient and medical staff must never be compromised. Although diffusing the emotion may be helpful in such situations, the first step is to assure safety for all.

Future development of this CST module may involve expanding these techniques to other types of difficult encounters with patients. Although the core strategies of helping the patient be understood and responding empathically will still apply, this will also require a deeper understanding of the different personality and coping styles seen among patients in the medical setting. Future research will follow participants over time, to measure the efficacy and self-confidence in the skills learned. In addition, patient outcome measures such as satisfaction with the encounter, feeling their concerns were addressed, and feeling that the clinician was empathic, will be studied pre- and post-training.

CONCLUSIONS

We describe in detail the development and implementation of a specific training and intervention to enable residents and fellows to more effectively communicate with an angry patient. Our assessment indicates that this module is both effective and useful.

Communicating with angry patients is stressful for the practitioner and can act as an obstacle to a constructive interaction. Learning more effective ways to respond to an angry patient by focusing on communication and interpersonal skills allows the interaction to continue and leads to a better patient–physician relationship.

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