Angry Patient Encounter

APE ©

A- Acknowledge, Agree, Apologize

P- Pause, move pt, or reboot cortex with a question

E- Empathy, Expectations, Explore options

“You’re right-it is frustrating/etc” or “I agree, parking here is difficult”, “I apologize that you’ve been waiting”
“My decision may have upset you and I regret that. Tell me if there is anything else I can do that would be of help”
(shifts brain back to cortex for thinking/problem solving). Pause
“I know that was bad news, I expect it was disappointing. I have the impression that you’re…” “I would be glad to talk to you now or later about your thoughts/feelings about this.
“From the facts I’ve just mentioned, I’m beginning to think….., is that what’s going on?” “Do you see things differently?” Pause
“I was wondering if part of the reason you’re……… is……………,” Pause
• Encounters are fragile when the stakes are high, emotions are strong, and opinions differ.
• Act quickly, anger begets anger. Look for nonverbal cues: eyebrows down, lips thin.* (see above)
• Dialogue is a free flow of information. Person must feel safe to share thoughts/feelings
• Start with facts, objective/least offensive/not personal. Reframing disengages the emotion.
• Tell what you think is happening, and then ask for them to share their thoughts with you.
• To fix misunderstandings, tell what you don’t want first, and then list what you do want.
  “I don’t want you to be …….. about…. I would like to ……” or “ My intention is …”
• Recognize the real purpose behind the request/problem; it may be something very different. “Is there a specific reason you want that?” Pts want what they think is best so explain the reason X is better.

Anger is a stress response, if HR>145=cognitive dysfunction
Social-appropriate behavior is sacrificed by feelings of a direct threat
If HR>175 forebrain/cognition shuts down and midbrain (primitive-dog brain) takes over=predatory reaction.
Normal-faces/emotions are recognized by fusiform gyrus, Objects are recognized by the inferior temporal gyrus
In autism, brain recognizes both from the inf. temporal gyrus. With Stress/anger the effect is the same as autism, =”temporary autism”, hence the term mind blind=can no longer reason or act appropriately
TX? Pause (called white space) allows brain to reset to forebrain function=return of cognition/reason
Serotonin primes cooperation (chocolate boosts serotonin-this has been verified by author).
COMMUNICATION SKILLS – THE ANGRY PATIENT

Anger in patients is usually obvious, but sometimes anger is expressed in more subtle ways such as discordant messages between the verbal expressions and the nonverbal communication. Physicians frequently avoid addressing anger, most commonly by ignoring it by changing the topic for example. The two most common reasons given for failure to address anger are for fear of unleashing more anger, or fear of time involvement. Best nip it before it escalates. Emotions are contagious-don’t get hijacked.

Techniques for understanding the situation and dealing with the anger

1. Pause-- The patient experiences being understood, is therapeutic
2. Stepping back/backing off--lets patient diffuse the emotion
3. Consider motivation-- Secondary gain? Hidden agenda?
4. Empower the patient –allow patient to save face/maintain dignity
5. Admit physician limitations
6. Empathy**

Actions

1. Active listening-- Paralanguage skills, position, posture, eye contact, facilitative responses, silence.
2. Framing--“Sounds like what your telling me”
   “Let’s see if I have this right”
3. Reflecting content--Factual as well as nature and intensity
4. Identifying and calibrating the anger-- Sometimes content is evident, but nature of anger is unclear
   “That situation really got to you, didn’t it?”
   “I can imagine how upset I’d feel if that happened to me”
   “It seems you’re not sure whether you should trust me further after I didn’t get that test result back to you last week” (transparency/acknowledgement)
5. Requesting and accepting correction- “Did I get that right”, “I want to make sure we’re on the same page

**Empathy to diffuse anger
Three implications- Cognitive-enter patient’s perspective but don’t lose your own
Affective-put yourself in patient’s place (doesn’t mean you agree or endorse)
Action component-verify emotion so patient can correct and/or feel listened to.

Sympathy-emotional identification with patient’s plight, i.e. Dr. feels sad when patient cries Empathy-is not dependent on having congruent feelings, more versatile. Can be empathetic without being sympathetic. Successive cycles lead to improved understanding. Physician’s honest attempt to understand facilitates respect and trust.
Empathy can be thought of as a feedback loop, like a neurological track with afferent and efferent arms.

Afferent arm
Verbal and non-verbal clues
Appraisal of patient’s message

Efferent arm
Physician response to elicit more information
Patient feels understood
Patient feels respected and validated
Communicating with and Understanding the Demanding Patient

Speaker: *There are about five thousand languages on earth, and we can’t find one we both understand!*
Listener: *What in the world are you talking about?*

**Communication: Latin com + unus = union**

A dynamic process of giving and sharing meaning, both verbally and nonverbally. Communication has been described as 7% verbal, 38% tone, and 55% nonverbal. The inherent duality can result in tension:

- being involved and maintaining independence
- being connected and sharing oneself and staying separate and protecting oneself
- as well as gender and social differences

These tensions make understanding one another a daunting task. No wonder we often get and give mixed messages when we do try to communicate. During stressful or upsetting times, effects of these factors are even more pronounced and can make an encounter aggravating for both physician and patient.

**The two models of communication:**

*Linear—mechanistic.* Assumes one meaning and thus one interpretation. Sender chooses correct words to convey the objective reality. Receiver is expected to interpret words as sender meant them.

*Helical—constructivist.* Dynamic, realities of both are interfaced and meaning is shared. Reality is constructed as it is experienced. Communication is a coordinated management of meaning.

**Tools of communication:**

<table>
<thead>
<tr>
<th>Verbal = linguistic</th>
<th>Nonverbal= paralinguistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>the message</td>
<td>the metamessage</td>
</tr>
<tr>
<td>the what-content</td>
<td>the how</td>
</tr>
<tr>
<td>words-vocabulary</td>
<td>voice-volume, pitch, rate, timbre</td>
</tr>
<tr>
<td>how strung together-syntax</td>
<td>posture, expression, eye contact</td>
</tr>
<tr>
<td>meaning-semantics</td>
<td></td>
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**Angry/demanding patients:** Anger -from ancient Norse = distress

Anger is a secondary emotion. Look for the root cause: hurt, frustration, or fear.

Examples of root causes:
- Perceived hurt
- Unmet needs/expectations
- Violation of rights/injustice
- Attacks on self-esteem

**Four A’s of anger management:**

- Awareness
- Acceptance
- Analysis
- Appropriate reaction

**Techniques:**
- careful choice of words
  - **address emotions**
  - correct language
  - reflection
  - nonverbal cues

“I know you believe that you understand what you think I said, but I am not sure you realize that what you heard is not what I meant”
Saying NO Effectively to Demanding Patients: (try not to use the word NO)
*Remember, a two-way conversation may not be part of their agenda*

- Set an example—don’t ask patient to calm down, model calmness.
- Get patients’ attention—lower your voice, move so they must turn in your direction, encourage them to sit down—but let them control where
- Listen—not just to the patient’s needs, but also for underlying issues/concerns and unexpressed expectations. Don’t assume. The use of “uh- huh” and “um” has been shown to help patients settle down on their own. Feels like a lot of time, but really isn’t.
- Avoid arguments—use disarming statements. Consider rolling with the resistance and agreeing with the patient if possible.
- Take a step back from the demand and ask probing questions to find underlying concerns. This may change a rant into a conversation. “I agree with you that a MRI is a good/fast test, what is it that you think you may have?” “What is your greatest concern?” , “most worried about?” “You seem adamant about the MRI, is there a specific reason you think it’s so important?”
- Summarize—paraphrase. The patient can correct any misperceptions, and can experience being heard and understood. Acknowledge the patient’s feelings. “I can understand that.”
- Explain your rationale/perspective—use “I” statements, be clear, direct and specific. Patients may not want to hear your side and may take this as a personal rejection, a one down situation. The patient may feel embarrassed. Pay attention to the way you say No (38% communication is tone of voice). Try to say what you can do/better option for pt.
- Find out the patients goals for the demands. “Is there a particular problem you think the MRI will diagnose?” “How had you hoped I could help you with this?”
- Set your goals; recognize your own values and triggers. Consider using a preplanned strategy for situations that you encounter often, i.e. narcotics/unnecessary tests
- Set boundaries—don’t back down, don’t become defensive, and don’t argue.
- Offer options—ask for a response, “I want to make sure we’re on the same page”
- Assess readiness of patient to work with you for a solution, “Are you interested in hearing about other options?” If the patient is not receptive, don’t push, offer to revisit topic at another time. “We can talk about options next time if you want to think it over”
- Reassurance is only meaningful when the patient’s reasoning for the problem is elicited

Disarming Statements: actively helps patient make their point
“See your point,”
- The “You’re Right” statement. “You’re right, you did have to wait a long time”, “You’re right, it is hard to find a parking space here”.
- The “I agree” statement. Shows collaboration. “I hear you, and agree with you. It can be dangerous to get the wrong prescription”, “I hear you and agree with you. It would be faster to just order the MRI of your knee…in your case X is a better option because…."

Clinical Scenario  Antibiotic RX demands for URI symptoms-Demanding patient/ Saying No
“I want an antibiotic, I feel sick, and I can’t miss work.”
- URI’s=20% of outpatient diagnosis. 90% are viral, but ABX prescribed in 50-70%
- Patient’s satisfaction is not necessarily based on getting ABX, but is based on listening, explanation, and a treatment plan individualized for and with the patient.
“I don’t blame you. Tell me what you’re experiencing and we’ll discuss the dx/options…My dx at this time is a virus, based on your sx of… An antibiotic would not be the best medical care for you in this case; I can give you other treatments that would be more tailored/effective for your symptoms. What do you think?”
Neuroscience of Anger Bibliography


• LeDoux,J (1996), The Emotional Brain, New York, Touchstone Press


• Patterson,K (2002), Crucial Conversations, McGraw Hill, 1. International Communication 2. Interpersonal Communication

• Goleman,D (1997), Emotional Intelligence, Bantam Books

WEB RESOURCES

• Center for Nonviolent Communication, an International Organization
  www.cnvc.org