In approximately one in five consultations patients raise a new problem in this final stage of the interview (White et al., 1994). Often this will be the problem the patient is most worried about. One way to avoid the problem being raised only at the end of the interview is to gather information as skilfully as possible earlier on. Research confirms that physicians who ask about patients' beliefs, who are responsive to patients, give plentiful information, and discuss treatments with patients are less likely to find such new problems being raised during the closing stage of interviews (White et al., 1994).

### Summary

- The doctor-patient model indicates the importance of considering the patient's agenda.
- The Calgary-Cambridge model is a useful guide to the communication skills that are important at different stages of the clinical interview.
- Good clinical skills include thorough introductions that encompass an explanation of who you are, what the interview is about, and consent.
- Gathering information is best achieved using a funnel of open-to-closed questions.
- Physical examinations should involve an explanation, respect, and a sensitivity to patient cues.
- Explanation and planning involves providing the right amount and type of information in a way that achieves a shared understanding and a treatment plan.
- Closing the interview should include a summary, a check of understanding and agreement, and safety netting.

## 18.3 DIFFICULT INTERVIEWS

In medicine we work with patients from cradle to grave. Medical care therefore often involves extreme emotions in response to birth, challenging events or illnesses, life-threatening events, and death. Some of the most difficult interviews for healthcare professionals are those that involve high levels of negative emotions such as anger, distress, grief, anxiety, or fear. Such emotion raises challenges for the doctor in an interview. It is hard to discuss, and make decisions, about treatment with a patient who is highly emotional. It is important to acknowledge and deal with patients' emotions because these will influence their thoughts, actions, and ultimately their wellbeing (see Chapter 2).

In this section we shall focus on the communication skills doctors need to help patients who are angry, anxious, or distressed. Then, in the final section of the chapter, we shall look at how to give sad or bad news.

### 18.3.1 COMMUNICATING WITH ANGRY PATIENTS

Though anger and aggression are linked, they are not the same. Anger is an emotion, whereas aggression is a behavioural response involving some form of attack on an object or person. The link between anger and aggression means that when we are confronted with an angry person it is normal to feel under attack, particularly if the anger is directed at us. However, the true cause of the anger may be something different – for example, illness, a disability, or frustration.

It has been suggested that, when confronted with an angry patient, doctors typically respond in one of three ways (Lipp, 1986): they may try to ignore the anger and keep going with the interview as 'normal'; they might get angry back; or they may try to pacify the patient. Each of these strategies may make the anger worse. Ignoring someone's anger rarely diffuses it and consequently the consultation is likely to go badly. Though getting angry back is an understandable human response, it merely escalates the situation. In addition, trying to pacify the patient (e.g. by telling them to calm down) may potentially inflame the situation.

As we saw in Chapter 2, anger has a range of effects on us. It is associated with strong physiological arousal and a narrowed focus on what provoked the anger. Until the anger has dissipated, it will be hard for the patient to think about or deal with anything else. Common underlying reasons for anger may include:

- Feeling hurt or let down: If people are emotionally hurt they will often protect themselves by getting angry about it. In this case the anger will usually be directed at a particular person or group. Expressing this type of anger may lead to crying.
- Broken rules: Cognitive theory suggests we all have our own 'rules' about how both we and other people should behave (see Chapter 19). If people break our rules we may get angry. For example, I might have a rule that 'I must always be there for people when they need me'. If a doctor is then not there for me when I need them (e.g. cancels an appointment or keeps me waiting for a long time) I might get angry.
- Goal frustration: If we are prevented from doing things or reaching goals that are important to us, then it is common to feel frustration and anger (see Chapter 9). Injury and illness often prevent people from attaining their goals so anger and frustration may be common.

#### ACTIVITY 18.2

- Think back to the last time you were really angry with someone.
- Why was this?
- Were you hurt or had they broken one of your rules?
- What could they have done that would have stopped you feeling angry?

Like all strong emotions, anger needs to be expressed and diffused before an interview can continue. The following points can be helpful when trying to achieve this:

- **Check your own emotional response:** If you feel angry, anxious, or upset it will be harder for you to calm the patient. Remind yourself that anger is an emotion and not necessarily an attack and that the source of their anger could be the illness or hurt and so is not necessarily about you.
- **Acknowledge the anger:** Recognise that the person is angry and that it is important to deal with this. For example, you may say, *'I can see you're angry and I think it's important we talk about this first'*.
- **Find out the source of the anger:** Let the patient talk! Giving them space to verbalise and vent what they are angry about is the first step towards diffusing that anger. People cannot remain angry forever – especially when they are with a sympathetic person.
- **Empathise:** The most effective way to tackle anger is to empathise or understand. You do not have to agree with the patient to be able to understand why they might be angry. Simple statements such as *'I can see why you're angry'* may prove very effective.
- **Disarm:** Many patients who are angry say all they want is for the other person to understand and apologise. Some healthcare professionals worry that an apology means they are admitting fault or liability, but it is possible to express regret without agreeing the person is right by saying something like *'I'm sorry if that upset you'*. In addition, in some circumstances it may be appropriate to give a clear apology.

### 18.3.2 COMMUNICATING WITH ANXIOUS PATIENTS

Anxiety and fear are a normal response to the perceived threat of illness or injury and thus are common in healthcare settings. People differ in their anxiety levels and responses. Those with the personality trait of neuroticism will have higher levels of anxiety (see Chapter 2).

Anxiety makes people hypervigilant for signs of threat. Consequently, they are likely to react strongly to unexpected events, symptoms, or negative news. Anxiety also makes people less flexible in their coping strategies, so specific strategies become more rigidly applied. Anxious people may need to know exactly what will happen next so that the additional threat of unexpected events is reduced. Mere reassurance does not often work with anxious people – in fact it can backfire because they may feel that you do not understand. In dealing with an anxious patient the following may help:

- **Use your body language and speech:** As we saw at the beginning of this chapter, characteristics of speech and non-verbal communication can help someone calm down. Adopt a relaxed and open body posture (non-threatening), lower the tone of your voice slightly, and slow your speech down.
- **Acknowledge the anxiety:** As with anger, recognise the person's anxiety (e.g. *'You seem quite worried'*).
- **Find out the main source of the anxiety:** Anxiety can become generalised, so asking someone why they are anxious may elicit only a general or defensive response. Use a more focused question such as *'Are you worried about anything in particular?'*, *'What is it you are particularly worried/anxious about?'* or *'What was it that brought this anxiety on?'*
- **Empathise:** As with anger, empathy and understanding can be very helpful responses to strong emotion. In cases of terminal illness, where the threat of death is inevitable, empathy is crucial. In these cases we cannot 'fix' anxiety or any other strong emotion – we can only empathise and provide support.

- **Minimise the threat:** Anxiety is based on a perceived threat. Therefore, one way to lower anxiety is to reduce or remove that threat. This is best done by providing information as opposed to mere reassurance. For example, a pregnant woman might be anxious about her baby dying. In this instance, finding out why she believes this will happen and giving her information about the actual risk of it happening (or not) will be more effective than telling her not to worry. If there is a high risk, then involve patients in planning screening or treatment so that the risk of adverse consequences is minimised.
- **Increase feelings of safety:** A related technique is to increase feelings of safety through information. For example, you might tell patients about monitoring or other procedures that can prevent complications developing.

Fear and panic are extreme forms of anxiety and require a different approach. They invoke very strong physical and behavioural responses such as fight, flight, freezing, or turning to the group (see Chapter 4). Soothing responses in these circumstances are similar to those we might use with a frightened animal. Our body language and voice can be used to calm the person. Offer support and empathy and, if something triggered their fear or panic, remove them from that situation or stop the procedure. Strong fear or panic rarely lasts long so this should subside after a few minutes at most. Be prepared to stay with the person and remain calm while their fear or panic reduces. Distraction can be useful, when it is sensitively timed, because this can help the patient refocus away from the threat.

### 18.3.3 DEALING WITH DISTRESS

Distress is a very general term. It is used here to describe situations where patients break down and cannot stop crying. Distress can result from anger, anxiety, or fear and so dealing with this draws on similar principles to dealing with those emotions. Two particular points should be borne in mind:

- Though it is natural to want to stop someone crying, it is not helpful to tell the patient to stop. Even if you say this empathically, the underlying message is that you think they should not be upset or crying.
- Though empathy and understanding are important, too much empathy can *increase* someone's distress. If they are really distressed they will be consumed by their feelings: in these circumstances empathy may serve to keep them focused on these feelings. In such cases it is more useful to try to get them focused on specific events or facts which will lower their distress. This is not to say you need to be completely unempathic, only that you need to help them focus. For example, you might say *'I can see it's really upsetting – is there anyone I can call at home to come and be with you?'*

**ACTIVITY 18.3**

- Think about a time when you were really upset about something important.
- When someone was sympathetic did it make you more or less upset?