

Managing the difficult consultation

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ABSTRACT – Patients are more likely to develop psychological problems if their concerns are unresolved and their information needs unmet. However, many health professionals are uncertain how to elicit patients' concerns or tailor information appropriately. These difficulties may also lead to psychological problems for the health professional. Feeling inadequately trained in communication skills has been linked to burnout amongst senior doctors working in cancer. Clinicians find that some consultations are particularly hard to manage; for example, when patients are highly distressed, angry, withdrawn or in denial. Barriers to effective communication are patient-led as well as doctor- or nurse-led but relevant training can help overcome those barriers. The article described one training model that is effective in improving health professionals' skills. Specific strategies are suggested that can help in the more difficult consultations and so enable clinicians to talk to patients about their concerns and worries more freely.

KEY WORDS: affective disorder, burnout, cancer, communication, communications skills training, consultation

Introduction

When doctors and nurses are inadequately trained to manage consultations with patients, both patients and health professionals are more likely to develop

psychological problems. This article reviews factors that contribute to communication problems and suggests strategies for managing difficult encounters.

Eliciting patients' concerns

The number and severity of patients' concerns as measured by a questionnaire administered after a cancer diagnosis predicted how emotionally distressed patients were six months later.¹ A two-year longitudinal study of over 600 newly diagnosed cancer patients found that the number and severity of their concerns, assessed using a 14-item checklist, also predicted which patients developed clinical anxiety, major depressive disorder or an adjustment disorder.² So, it is obviously important that patients' major concerns are elicited by the medical and nursing staff caring for them. However, up to 60% of cancer patients' concerns remain undisclosed, even in hospices where there are fewer problems caused by staffing levels and high patient turnover.³

When doctors and nurses are presented with this evidence, they admit that their training has not equipped them with the skills necessary to elicit their patients' main concerns (whether they be physical, social, psychological or spiritual in nature) and associated feelings.

Identifying patients' information needs

Communication problems have also been found in relation to information giving. A study of women undergoing surgery for breast cancer found that the key determinant of women's psychological adjustment over the next two to three years was their perception of the adequacy of information given at the time of diagnosis. Those who felt they were given too little or too much information were at greater risk of developing a major depressive illness and/or generalised anxiety disorder.⁴ Yet many doctors and nurses admit that they are unsure how to identify what patients want to know. Instead, they take refuge in ritual and predictable ways of giving information. While they give information caringly and pace it appropriately, they make little attempt to tailor what they say to meet individual patients' preferences. For example, one surgeon said he always insisted that women look at their mammograms. He felt they should do so because he wanted them to understand

Key Points

Patients with important but undisclosed concerns and information needs are likely to become clinically depressed and anxious

Only a minority of patients' concerns and information needs are elicited in practice and affective disorders often go unrecognised and untreated

These communications problems arise because few doctors have had any systematic communication skills training

In particular, doctors have not acquired strategies that would enable them to deal effectively with difficult communication situations like talking with very angry or distressed patients

Practical ways of dealing with these difficult situations are described

the extent of their disease and the need for the treatments being offered. What he had not realised was that when one woman, untutored in looking at mammograms, looked at the cancer ('a white spot') she saw her whole breast as white and concluded that it was riddled with cancer which may have spread throughout her body. The idea that the nature and amount of information given to patients should be negotiated and tailored to what they are ready to know or able to understand appears novel to many experienced doctors and nurses.

Prevalence of affective disorders

Because of these continued problems in eliciting patients' concerns and tailoring information to their individual needs, it is not surprising that 30% of cancer patients develop affective disorders.^{5,6}

Despite this high prevalence, only half of those with an affective disorder are recognised and treated appropriately.⁷ Doctors and nurses feel uncomfortable about exploring patients' psychological reactions and asking specifically about symptoms of depression and anxiety. They are especially reluctant to ask if patients have felt so low that they have felt life is not worth living and have contemplated suicide.

This difficulty in eliciting key problems is not limited to psychological aspects. For example, pain of moderate to severe degree is reported by 30–70% of cancer patients. However, the quality of the assessment of the nature and extent of pain is often inadequate and pain control poor.⁸

Problems with burnout

So far, the arguments for training doctors in communication skills have concentrated on patients' needs. A landmark study by Ramirez and colleagues in 1996 reported data on over 800 senior cancer doctors who completed the Maslach Burnout Inventory.⁹ This measured how exhausted they were feeling emotionally, their level of detachment and depersonalisation, and the extent to which they felt they were achieving worthwhile results. Twenty-five per cent of the senior doctors scored high on emotional exhaustion, high on depersonalisation and detachment, and felt they were accomplishing little. They attributed their problems, in part, to a lack of training in communication skills. They worried about whether they had handled consultations as well as they should and how patients and relatives were coping.

Professional barriers to communication

Objective studies of communication between doctors and patients, and nurses and patients, have found that when patients try to communicate their concerns and associated feelings, they are met by strategies that inhibit further disclosure. Doctors are used to encountering distress when patients are diagnosed as having cancer or are told there is no more treatment. They tend to habituate to this and explain any distress away as normal. This discourages patients from disclosing their underlying concerns.

Doctors and nurses go into their professions because they

want to help patients and carers resolve their problems. When they have to break bad news or give unpalatable information they want to ensure that patients and carers maintain hope. The moment they perceive that a patient or carer is becoming distressed they offer reassurance, regardless of individual need. For example, in one case, saying to a young woman with breast cancer, 'Your lump is very small and is localised. I think we can get away with less aggressive treatment' was premature because the doctors had not elicited this patient's concerns. Had they done so, they would have found that the young woman with a small breast cancer was terrified she would die like her sister who had an equally small breast cancer but died from cancer three years before.

This need to 'fix' things by offering advice and reassurance is a common problem in medicine. A study of New York general practitioners found that the doctors offered new patients advice and reassurance within 18 seconds of them mentioning the first problem.¹⁰ This stopped patients disclosing the full nature and extent of their first problem. They also failed to disclose their other problems at follow-up.

Distancing strategies are often used 'on automatic' and the doctors or nurses concerned do not realise what they have done. For example, a consultant talking to a man dying of lung cancer asked him a useful question ('How have you been since I saw you two days ago?'). The patient responded by asking, without warning, 'Am I dying?' The consultant responded by enquiring, 'How has your breathing been?' He did not realise he had done this and was horrified when he heard the audiotape replay of this encounter.

When health professionals notice that patients look gloomy they can find this hard to tolerate, so they try to jolly the patient along. Thus, a man had gone to surgery, believing that his stomach pain was due to a gastric ulcer which would be excised. At laparotomy it was found he had an inoperable gastric carcinoma. When he woke up from the operation, the surgical registrar told him what had been found. The patient was devastated. As the ward sister walked along the ward she noticed he was looking distressed. She cajoled him by saying, 'Come on, Mr Smith, there's no need to look so upset, the sun's shining'. This stopped him disclosing his concerns and feelings about the news he had received.

Since most doctors and nurses are dedicated to patient care, a key question is why they use these distancing strategies and identify only a minority of their patients' concerns, information needs, and mood disturbances.

Reasons for distancing

Systematic interviews with doctors and nurses have revealed that they take a pessimistic view of how patients are affected if they are encouraged to talk about their emotional reactions to bad news, and their concerns about their illness and treatment. Health professionals worry that such enquiries will unleash strong emotions, and that they will not be able to 'put the lid back on'. They also think that eliciting strong emotions will make it harder for patients to cope. However, there is no

scientific basis for these worries. If patients are encouraged to talk about their concerns and associated feelings when they wish to, they are more likely to put things in a better perspective and cope more positively.

Other reasons doctors and nurses offer for distancing are realistic. When patients or carers sense that the doctor or nurse is seeking to understand their predicament and elicit their concerns, they may trust them with difficult questions like 'Why haven't you been able to cure me?', 'Why hasn't the chemotherapy worked?' or 'Why was the problem not diagnosed?' These questions are difficult to answer and health professionals fear that they will take up too much time. They are also concerned that if they allow patients to talk about their worries they will identify with the patient's situation and be upset by it. They may then become concerned about their own emotional survival.¹¹

Patient-led barriers

Patients sometimes hold back from disclosing their concerns and problems because they wrongly believe that little can be done to help them. Time spent mentioning social and psychological problems could jeopardise their chances of survival because less time will be spent on discussion of their disease and treatment. Other patients are loathe to admit problems with coping, anxiety and depression because the doctors they have come to like and respect may regard them as 'pathetic or inadequate'. They may decide not to report adverse effects of chemotherapy because they could be seen as complaining and this might cause treatment on which their life depends to be reduced or stopped.

Patients and relatives notice that doctors and nurses utilise distancing strategies. They interpret this as meaning that it is not legitimate to mention their feelings, psychological or social concerns. They also notice that doctors and nurses attend selectively to cues about physical rather than psychological matters.¹¹ In the following example, an oncologist attends selectively to side effects of chemotherapy:

Oncologist: How have you been getting on?

Patient: I've been getting more sick and tired with the chemotherapy. I've been worrying the cancer is back. I've been so irritable with the family – they don't deserve it.

Oncologist: Let's focus on your chemotherapy then. Tell me about your sickness and tiredness.

The oncologist does not, at any point in the consultation acknowledge the cues 'worrying' and 'so irritable'. So, the patient says no more about his deteriorating mood state.

Development of appropriate training methods

To promote disclosure of patients' and relatives' concerns, health professionals need further training in key communication skills.

Residential workshops were established to help doctors and nurses acquire key skills and overcome their fears of effective

communication.¹² A major aim of the workshops was to help doctors and nurses acquire the specific skills necessary to elicit patients' concerns, identify patients' information needs and check how they were adjusting psychologically.

It soon became apparent that their ability to elicit patients' concerns, reactions and information needs was seriously affected when they encountered the more difficult communication situations listed in Box 1.

The workshops were, therefore, reorganised so that they would consider basic assessment skills initially and then help participants learn how to deal with these more difficult situations.

After they had practised basic assessment skills in role

play, the communication tasks they found especially difficult were worked through in order of increasing difficulty. The groups were asked to suggest strategies that might help the interviewers manage each difficult task on the agenda. Strategies were tried out and participants asked to feed back to interviewers what they liked about what they had done, what might have been done differently, and how they believed the strategies had affected the 'patient', 'relative' or 'colleague'.

From this experience, the strategies most likely to help doctors manage these difficult situations were identified. These are described below.

Managing difficult situations

Handling patients' or relatives' anger

It is best to avoid taking it personally when a patient or relative is angry with the doctor. It is tempting to become defensive and argue that everyone has done their best or suggest that the patient or relative has misunderstood the circumstances. Being defensive only serves to fuel the patient's or relative's anger. Instead, the anger should be acknowledged by saying, 'You seem angry' and by explaining that it would be helpful to explore how angry they are and the reasons for this. While they are explaining their reasons they should not be interrupted. This should be followed by an enquiry as to whether there are any other reasons. When their anger is aimed at someone, it is important to be empathic without taking sides about who is right and who is wrong ('I can understand you feel angry since you believe there was a serious delay in diagnosis'). As the anger, its intensity and the reasons for it are explored, there should be a clear sense that the anger is becoming less intense.

Then there should be a noticeable transition between anger and the mention and expression of other emotions, for example, sadness at the potential loss of a loved one or despair that they will ever cope without them. It is important to check then if they are willing to discuss their concerns and feelings about their predicament.

Box 1. Key issues.

- Handling angry patients and relatives
- Dealing with despair/distress
- Demanding/manipulative patients or relatives
- Withdrawn patients
- Partners or relatives in denial
- Confronting colleagues

When the anger remains intense despite the doctor's best efforts, it is important to explore whether there have been past experiences that explain why the patient or relative is so angry, for example by asking, 'Is there anything else making you angry – maybe something that relates to things you have experienced in the past?'

For example, a patient had not got over the death of his first wife from cancer. His second wife was then diagnosed as having terminal cancer. She had a stormy illness and treatment was unsuccessful. This left him feeling bitter and angry. When he was asked to reflect why he was still so angry despite talking about it and the reasons, he said he could not believe it was happening to him again. He was full of rage that he had lost two-much loved wives from the same disease in terrible circumstances. He was then able to identify that his key problem was despair at being on his own again. He also admitted he had strong guilt feelings that he had not been assertive enough in ensuring that his second wife got better treatment.

Handling despair/distress

As soon as it is clear that a patient is despairing or distressed, again it is best to acknowledge this. It signals that it is legitimate for patients to feel like that. It is never possible to guess whether a patient or relative will find it too painful to talk about why they are distressed or despairing. So, this can be negotiated by asking 'I can see that you are very distressed, can you bear to talk about it?' When patients or relatives say no, this should be respected and other topics introduced. However, most patients or relatives will say that they are willing to talk about it. It is then important to warn them that if their feelings get too painful or threaten to overwhelm them they should ask the doctor to stop. This helps them feel confident in that they can try and talk about very distressing feelings and experiences but have permission to stop if they sense it is too difficult.

When they are willing to talk, the doctor should emphasise that s/he wishes to know all the concerns that are contributing to the distress and other associated feelings. If eliciting their experiences and associated feelings does not lessen the intensity of their emotions, it is important to check whether they are suffering from clinical depression or anxiety.

Withdrawn patients

Doctors and nurses find it especially difficult to deal with withdrawn patients. They start off trying to establish a dialogue but find the patient is unforthcoming or monosyllabic. It is important to consider likely reasons why patients might be reluctant to talk (Box 2).

First, the doctor's difficulty should be acknowledged by saying, 'We seem to be finding it difficult to get into a conversation about how you are, can you bear to explain why?' Patients will usually give clues that signal which reasons (shown in Box 2), apply. For example, a patient may say, 'I can't be bothered, there is no point'. On clarifying why s/he feels like that s/he may say, 'I am just too low' or 'I can't see any future' or 'I can't

be bothered to talk, it's too much of an effort'. S/he might say, 'There is no point in talking, it won't make any difference to what is going to happen'. If a patient gives the latter reason, it is important to acknowledge that this could be the case. Although talking will not change the patient's chances of physical survival, it might make a difference to how s/he feels. The doctor should check whether the patient is prepared to continue. If not, s/he should be left alone and an arrangement made to come back and check how s/he is in a day or so. Most withdrawn patients, unless they are very confused or in stupor because of severe depression, will thus be helped to enter into a useful dialogue.

Box 2. Reasons for withdrawal.

- Anger
- Collusion
- Guilt feelings
- Shame about not coping
- Paranoid ideas
- Collusion by relatives
- Confusional state
- Psychotic illness
- Depression/hopelessness
- Introverted personality

Demanding, manipulative patients and relatives

Sometimes there is an obvious discrepancy between the observed behaviours of patients and the demands they make on staff. Thus, patients may complain that they are experiencing serious pain and are noticed to be writhing around. At other times, they are observed by other staff to be relaxed and pain free. Patients may complain that they are not getting enough care and attention but in fact objective evidence shows they are getting just as much help as other patients on the ward. When such discrepancies occur and discussion within the team confirms this, it is important that somebody acknowledges these behaviours with the patient and explores the reasons for them. Such behaviours are often due to anxiety, fear or depression. If their behaviour continues to be difficult, and some staff are taking the side of the patient while others are becoming hostile, it is worth considering referral to a clinical psychologist or psychiatrist.

Managing denial

In considering how to deal with patients in denial, it is important to acknowledge that true denial is a necessary defence against intolerable emotional pain. So, attempts to broach it should not be made unless there are compelling reasons, like refusal of treatment or preventing a family dealing with important and unfinished business. The strategies suggested here aim to explore whether denial is complete or partial.

The first strategy is to tentatively reflect back to patients inconsistencies between their apparent beliefs and illness experiences. For example, a man who had had chemotherapy for cancer of the stomach was insisting he was cured, but he was continuing to lose weight and felt very tired. He explained these symptoms away as the aftermath of chemotherapy. His wife was concerned because they were about to embark on an expensive cruise. She sensed that he wasn't well enough to go and there was a danger that it would put them into debt.

The doctor talking with him asked him how he felt he was getting on. He explained he thought he was cured because of chemotherapy and was looking forward to his cruise. The doctor then said, 'You are very positive that you are cured but you say you are continuing to lose weight and feel even more tired. How do you explain that?' When the patient replied by saying, 'It was down to chemotherapy', the doctor said, 'But your chemotherapy finished three months ago. So might your tiredness and weight loss be due to anything else?' The patient began to cry and said he realised that things looked bad. He admitted he had been trying to deny what was happening because the thought of premature death was so painful and he did not want to leave his wife behind. The couple were then able to discuss together their key concerns.

If asking patients to reflect on inconsistencies in their situation fails, one other strategy is worth trying. Even when patients appear to be in denial it may be that at least at some time of the day or night they have doubts about the status of their illness. So, it is worth saying, 'I understand that you feel positive that you are fine at the moment and that things are going to work out. Can I ask you if there is any time in the day or night when you have any doubts?' This question often reveals that patients have doubts. The doctor should then ask, 'Can you bear to talk about these doubts?' In talking about these doubts, patients will indicate whether they are able to enlarge their awareness and face the reality or need to go back into denial by saying, for example, 'Oh, I am just being silly, I am sure I am going to be all right'.

Patients should not be confronted aggressively in a bid to eradicate denial, as the following example illustrates. I (PM) was called to a ward for an urgent psychiatric opinion. A patient who was terminally ill with a brain tumour had summoned up enough energy to throw a plant pot at a social worker. The social worker had insisted the patient face the fact she was dying, because the social worker needed to talk with her and her family in order to deal with 'unfinished business'. The patient was not ready to face this reality and found the pressure intolerable. In a bid to stop the social worker she threw the plant pot. Fortunately, it missed.

When I assessed her, it was clear that she found facing the reality of dying intolerable because of her two young children and husband. I advised the team that it might be a few days before she faced the reality and only then if there was further deterioration in her health. Her health deteriorated and she acknowledged that she was dying. This allowed a sad but vital and constructive discussion with her husband to take place.

Confronting colleagues

Before confronting colleagues about undesirable behaviours that need to be changed (for example, a reluctance to be honest with patients about their prognosis when asked directly), it is important to have strong and unequivocal evidence. Throughout the confrontation, the focus should be on the consequences for the patient and/or relative of this behaviour. Attempts to personalise it should be avoided.

At the outset, the colleague should be told that the reason for the meeting is serious. There should not be any attempt to soften it by having a chat before the 'bad news' about undesirable behaviours is broken. It should be made explicit from the beginning that the person has been called because there is something serious to discuss concerning their patients or patients' relatives. The evidence should be presented succinctly, followed by a pause and an invitation to respond.

Next, an enquiry should be made about reasons for their behaviour. This will usually reveal that they have had adverse experiences from telling people the truth in the past which has made them wary of doing so. Alternatively, at a personal level, they may find it too painful and wish to avoid it whenever possible.

When the undesirable behaviour represents a change from past behaviour, it is important to acknowledge this and to ask if they are prepared to consider if there could be any reasons for the change, like a developing drink problem or problems within the family, like a loved one having cancer. It also helps to acknowledge common ground, namely, a wish to ensure high-quality care.

The action to be taken should then be made explicit and a timetable and review dates agreed to see if the behaviours which are the focus of concern have been modified. So often, in daily practice, the confrontation of colleagues is delayed because it is an unpleasant task and fraught with potential difficulties. However, delay in dealing with these behaviours increases risks to patients, the doctor concerned, relatives and the team.

Conclusions

Physicians need further training to help them to acquire key skills that will help them to elicit patients' concerns and associated feelings and identify their information needs. They will be unlikely to do this effectively unless they are also helped to deal with difficult communication situations that arise commonly in clinical practice. They need to learn the specific strategies that will help them manage these difficult situations and a chance to practise them both within workshops and their work situations.

Feedback from the many doctors and nurses who have attended our workshops has confirmed that they gained confidence in handling these difficult situations. Without this training, doctors continue to take refuge in distancing tactics and detachment.

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