Responding Effectively to Patient Anger Directed at the Physician

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Background and Objectives: *Patient anger because of a long wait is a common occurrence, but few studies have looked at how the anger should be addressed. This study determined patient levels of satisfaction, rating of importance, and preference for a variety of approaches for addressing anger being directed toward a physician.* Methods: *A video trigger tape of an angry patient and 12 physician responses to the angry patient were shown to 130 participants who then rated the physician responses based on four approaches, alone or in combination (apology, explanation, self disclosure, and acknowledgment) for satisfaction and importance of the response. Participants also evaluated four physician follow-up questions.* Results: *An apology combined with an explanation was rated highest in satisfaction and importance and individually ranked as the best approaches for physicians to use. "I apologize for your long wait" was rated significantly higher than "I am sorry you have been kept waiting." Although gender and prior high anger with clinicians affected the ratings of some responses, participants consistently preferred an apology and/or an apology combined with explanation as the best response. Participants also preferred physician follow-up questions that facilitated segue to the medical interview rather than questions that explored patient feelings.* Conclusions: *Participants clearly indicated that they would like a physician to apologize, explain the reason for the delay, and then quickly move along with the interview.*

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Communicating with angry patients is a familiar experience for physicians, yet little research has been conducted to help clinicians deal with patients' angry feelings. Recommendations to physicians on how to deal with angry and emotional patients are often based on inference or extrapolated from the social and psychological sciences.[1,2] Acknowledging and openly discussing anger has been recommended,[3] but there is little evidence that this is effective. Rather, medical students and residents typically learn how to communicate with angry patients through observation of attending physicians, with little or no consideration being given to evidence supporting or refuting their approach.

Patient anger can have many effects on medical care. Angry patients may not be able to effectively communicate their concerns and may instead express dissatisfaction through noncompliance with medication or diet regimens.[4] Virshup et al[5] argue that many malpractice suits are the result of patient anger regarding some negative aspect of the patient-doctor relationship and not because of malpractice or the quality of medical care. Angry patients are more likely to sue,[6-8] and effectively addressing patients' anger may decrease the frequency of lawsuits.

Videotape technology is commonly used for medical training, but its use is primarily limited to presenting didactic lectures, providing feedback in teaching patient relationship skills, and in clinical decision making.[9-12] The study of patient preferences using videotapes is a more recent phenomenon in medical education.[13,14] The study reported here evaluated different modes of response by physicians to patient anger, using video trigger tapes to test how patients react to different physician behaviors.

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Methods

Participants and Setting

The Institutional Review Board of East Tennessee State University approved this study. Research participants were recruited from two family practice residency practices in Northeast Tennessee. After patients had arrived at our clinic either before or after they completed their clinic visit, a medical student assistant approached them and asked to speak with them privately to discuss the purpose and voluntary nature of the study. Patients who were just arriving at the clinic were given the option of participating prior to or following their physician visit and were assured that the time with their doctor would not be delayed. About half of this group chose to participate following their physician appointments, and only a few declined to participate. Of patients who were approached following their visit with the physician, a higher number (up to eight patients per day) declined participation, mostly citing limited time or conflicting appointments.

Participants took an average of 15 minutes to complete the study; the range was between 10 and 30 minutes. According to the student research assistant, older patients took longer because "they liked to chat."

Procedures and Data Collection

Videotape Viewing. Consenting patients viewed a videotape depicting a female patient telling a female physician that she (the patient) was angry at being kept waiting. Participants were asked to imagine or pretend that they were the patient. Participants then evaluated 12 videotaped responses by a female physician to this angry patient. Table 1 defines each of the responses. These responses were based on four approaches (apology, explanation, self disclosure, and acknowledgment) alone or in combination with one or another (eg, explanation with acknowledgment).

Participants rated each videotaped response separately before going on to the next response. Ratings were accomplished by having participants score their level of satisfaction with the physician's response on a 7-point Likert scale (1=not at all satisfied to 7=very satisfied). They also rated the statement "How important would it be that the doctor make a statement like this?" on a 7-point Likert scale (1=not at all important to 7=very important). Two questionnaire forms and the videos were presented in varying order to reduce the potential effects of primacy and recency.

Next, participants viewed a single example of each approach (apology, explanation, self disclosure, and acknowledgment) and ranked them from the "least important" to the "most important" statement that the doctor should make, using a 4-point scale (1=least important, 4=most important).

To evaluate physician follow-up questions, participants again viewed the angry patient, followed by a physician's response, incorporating all four approaches. Participants then rated four follow-up approaches that either returned the interview focus back toward the medical issues or allowed the patient and clinician to continue to discuss the anger (Table 2). Subjects rated their satisfaction with each approach using the 7-point satisfaction scale and also ranked from 1 to 4 the "worst" to "best" approach the doctor could take. Finally, each participant was asked about his/her own experience with anger at a physician. They rated prior anger on a 7-point scale from 1 ("barely angry") to 7 ("the greatest anger I can imagine").

Written Responses. Participants were asked to write down what they would like the doctor to say if they were the patient in the videotape. To control the effect of our own questions and statements, half of the participants wrote their statements prior to viewing physicians' responses while the other half gave their written statements at the end of the questionnaire. Written statements of participants' suggested responses for the physician were independently classified by three of the authors into 10 response categories and three follow-up categories. Response categorization was made when at least two of the three reviewers agreed.

Data Analysis

For statistical analysis, Likert scale results were treated as continuous data, and means were compared using paired *t* tests, analysis of variance, and multivariate analysis of variance as appropriate. Rank scores were compared using the Wilcoxon signed rank test. Written responses are reported as percentages.

Results

A total of 130 adults, with ages ranging from 18 to 81, consented to participate in the study. About 36% (36.2%) of the sample were in the 18–40 age group, 40.8% in the 41–60 group, and 23.1% in the greater than 60 group. This is similar to our clinic population, in which 37.4% of adult patients are 18–40 years, 37.4% are 41–60 years, and 25.2% are older than 60. Gender distribution (66.2% women in the study) was also representative of the clinic population (66.7%). Table 3 reports education levels and ethnicity in the study sample. While our administrative database does not include education levels and ethnicity, we can't be sure how precisely these variables were similar in our subjects and our entire patient population, but they generally reflect those found within our geographical region.

Ratings of Physician Responses

Patient Satisfaction and Importance of Responses. Participants' ratings of how satisfied they would be in hearing the various physician responses are shown in Table 1. Of the individual responses, an apology, "I

Table 1

Satisfaction and Importance Ratings of Physician Responses to Patient Anger

		*Satisfaction**		*Importance**	
Research Type	*Response*	*Mean*	*SD*	*Mean*	*SD*
Apology (with ownership)	I apologize for your long wait.	5.25	1.85	5.48	1.78
Apology (without ownership)	I'm sorry you've been kept waiting.	4.18	2.00	5.12	2.06
Explanation A	It's been a hectic morning! Some of the patients have needed extra time.	4.79	1.87	5.20	1.81
Explanation B	We've been swamped! I have had some difficult patient problems to deal with.	4.68	2.00	4.89	2.03
Self disclosure	I know it upsets me when I am kept waiting.	4.38	2.06	4.61	2.19
Acknowledgment	I can see that you are upset.	4.05	2.12	4.26	2.11
Apology (without ownership)/ explanation	I'm sorry you've been kept waiting. It's been a hectic morning! Some of the patients have needed extra time.	5.28	1.77	5.65	1.60
Apology (without ownership)/ self disclosure	I'm sorry you've been kept waiting. I know it upsets me when I am kept waiting.	4.88	1.88	5.22	1.81
Apology (without ownership)/ acknowledgment	I'm sorry you've been kept waiting. I can see that you are upset.	4.51	1.94	4.91	1.91
Explanation/acknowledgment	It's been a hectic morning! Some of the patients have needed extra time. I can see that you are upset.	4.80	1.85	5.19	1.86
Explanation/self disclosure	It's been a hectic morning! Some of the patients have needed extra time. I know it upsets me when I am kept waiting.	4.66	1.93	5.12	2.03
Acknowledgment/self disclosure	I can see that you are upset. I know it upsets me when I am kept waiting.	4.55	1.98	4.80	2.00

SD—standard deviation

* Ratings were on a 7-point Likert scale. Multivariate comparison was done using Wilks' Lamba $P<.001$.

1=not at all satisfied, 4=neutral, 7=very satisfied
1=not at all important, 4=neutral, 7=very important

apologize for your long wait," was rated highest in satisfaction (x=5.25, standard deviation [SD] ± 1.85), followed by explanation A, "It's been a hectic morning! Some of the patients have needed extra time." (x=4.79, SD ± 1.87), explanation B, "We've been swamped! I have had some difficult patient problems to deal with." (x=4.68, SD ± 2.00), and self disclosure, "I know it upsets me when I am kept waiting." (x=4.38, SD ± 2.06). Acknowledgment, "I can see that you are upset" was rated lowest (x=4.05, SD ± 2.12) in satisfaction.

Of the two individual apologies evaluated, "I apologize for your long wait" (apology with statement of implied clinician responsibility—ownership—for the wait) was the highest-rated individual response. "I'm sorry you've been kept waiting" (apology without ownership) was rated next to lowest (x=4.18, SD ± 2.00), compared with other responses.

Table 2

Satisfaction with Follow-up Approaches

	Follow-up Question	*Mean*	*SD*
Request/segue	Shall we get started? What brings you in today?	4.99	1.90
Suggestion/segue	Let's get started. What brings you in today?	4.93	1.93
Address feelings	Would you like to talk more about how you are feeling about this?	4.41	2.10
Non-directed facilitation	How do you think we should proceed now?	4.0	2.18

SD—standard deviation

1=not at all satisfied, 4=neutral, 7=very satisfied

Table 3

Demographic Characteristics of Participants

	#	(%)
Gender		
Women	86	(66.2)
Men	44	(33.8)
Age (mean=46, range=18–81)		
<40 years	47	(36.2)
40–60 years	53	(40.8)
>60 years	30	(23.1)
Education		
< high school graduate	34	(26.7)
High school graduate	43	(33.9)
> high school graduate	50	(39.4)
Ethnicity		
White	121	(93.1)
African American	6	(4.6)
Hispanic	1	(.8)
Native American	1	(.8)
Other (Egyptian)	1	(.8)

Six combination responses were constructed from four individual approaches (apology without ownership, explanation A, self disclosure, acknowledgment.) Among the 12 total responses, the combination response of apology (without ownership) and explanation A, ("I'm sorry you've been kept waiting. It's been a hectic morning! Some of the patients have needed extra time.") was rated highest in satisfaction overall (x=5.28, SD ±1.77), and the apology with ownership was rated as second. The ratings for these two responses were not statistically different from each other.

When participants were also asked "How important was it that a statement like this be given?" the rated importance of various responses was similar to the ratings for satisfaction (Table 1). An apology combined with explanation was rated most important (x=5.65, SD ± 1.60), followed closely by the apology with ownership (x=5.48, SD ± 1.78). Acknowledgment (x=4.26, SD ± 2.11) and self disclosure response alone (x=4.61, SD ± 2.19) were rated the least in importance.

An "apology" was ranked as most important, followed by "explanation" when participants ranked the four individual approaches separately (Wilcoxon signed rank test, $P<.05$).

Age and Gender. Each response rating was compared to the age group and gender of the participant. Age was not associated with their ratings of importance; in only 1 of 12 ratings for satisfaction ("It's been a hectic morning! Some of the patients have needed extra time.") was satisfaction associated with the age of the participant. Gender was not associated with participants' satisfaction ratings of physician responses. However, women rated 5 of 12 responses as more important than men (Table 4). Despite demographic differences in ratings, an apology with ownership and/or the combination of apology and explanation were always among the highest ratings for each classification of age or gender.

Prior Anger. Although 100 participants (77%) reported a prior history of anger with a health professional, this was not associated with their ratings of satisfaction or importance at physicians' responses in the videotapes. The 44 participants who were classified as having had "high anger" (Likert scale 5–7) reported significantly lower satisfaction on 4 of 12 physician responses and significantly lower importance ratings on 5 of 12 physician responses when compared with participants who had lower ratings or no prior anger with health professionals (Table 4). However, patients' prior feelings of high or low anger did not influence the fact that an apology combined with an explanation was among the highest-rated responses.

Follow-up Questions. The results of patients' ratings of their satisfaction with four videotaped follow-up approaches by the physician are shown in Table 2. Participants preferred questions that facilitated a segue to the medical interview, such as "Shall we get started? What brings you in today?" (x=4.99, SD ± 1.90) or "Let's get started; what brings you in today?" (x=4.93, SD ±1.93). Focusing on the patient's anger, with comments such as "Would you like to talk more about how you are feeling about this?" (x=4.41, SD ± 2.10) or using a non-directed facilitation such as "How do you think we should proceed now?" (x=4.00, SD ± 2.18) were rated as less-preferred responses. Satisfaction with follow-up questions was not associated with age or gender.

Written Responses. Sixty-four of the written responses about what patients would like a doctor to say were elicited before evaluating the videotaped physician responses. Sixty-two were elicited after seeing and evaluating the physician responses. There was no significant difference between responses elicited before or after the videotape evaluation. The vast majority (77%) preferred an apology, and 47% preferred an explanation. Seventeen participants preferred a promise or commitment to do something tangible in the future, such as alerting the patient prior to the encounter if the physician was running late. Five written responses indicated a desire for some reassurance by the physician of providing them the appropriate time and quality of care. Only 21 participants spontaneously mentioned a follow-up response, and 18 of these mentioned a quick transition to the interview. One participant suggested

that the physician should address the patient's feelings.

Table 4

Covariates of Satisfaction and Importance With Physician Responses to Patient Anger

	Satisfaction With Response		*Importance of Response*	
	Gender	*High Anger*	*Gender*	*High Anger*
Apology (with ownership)	NS	.01*	NS	.001*
Apology (without ownership)	NS	.04*	.03*	.02*
Explanation A	NS	NS	NS	.001*
Explanation B	NS	NS	NS	NS
Self disclosure	NS	NS	NS	NS
Acknowledgment	NS	.02*	NS	NS
Apology (without ownership)/explanation	NS	.04*	.03*	NS
Apology (without ownership)/self disclosure	NS	NS	NS	.03*
Apology (without ownership)/acknowledgment	NS	NS	.006*	NS
Explanation/acknowledgement	NS	NS	.03*	.001*
Explanation/self disclosure	NS	NS	NS	NS
Acknowledgment/self disclosure	NS	NS	.02*	NS

NS—not significant

P values from ANOVA

* Statistically significant at $P<0$

Discussion

Our results offer some guidance to those teaching communications skills to clinicians about patients' preferences for ways that clinicians might respond to patients when patients are angry with them. Participant preferences for responses and questions indicate they would like the doctor to apologize, explain the reason for the delay, and then quickly move along with the interview. Less preferred were responses in which the doctor merely acknowledges their anger or tries to identify with their feelings by disclosing that he/she also does not like to be kept waiting.

In follow-up questions, participants preferred not to dwell on the anger. Rather, they preferred apologies in which the physician takes ownership for the problem. For example, "I apologize for your long wait" is preferred over "I'm sorry you've been kept waiting." The latter response may come across as "passing the buck"—no personal responsibility is taken, while "I apologize for your long wait" may connote more personal responsibility. Although an explanation alone did not appear as satisfying to participants, an apology combined with an explanation was the overall preferred response. The acknowledgment "I can see that you are upset" was the least-preferred response. The results of this study also suggest that the interview need not be delayed by focusing on the anger.

Limitations

This study has limited generalizability to all patient populations because 93% of the patients in our study were Caucasian. Other potential limitations include the voice tone of the physician on the videotape, which could have had an effect on participant's ratings. However, it should be noted that great care was taken in the development of the video with repeat recordings of each response or question to ensure capturing a consistently neutral emotional tone. Another potential limitation could be the exclusive use of a female physician. Nonetheless, observations from a previous study[15] with a much more gender sensitive issue (interviewing about sexual practices) found no difference in participants' evaluations of interviews, regardless of gender of the physician on the videotape.

Implications for Future Research

The feasibility of using video trigger tapes to explore doctor-patient communication was demonstrated in this study, and useful information regarding responses to patient anger was obtained. An advantage of the video trigger tape method is that it permits a great deal of consistency and control in the way that statements are presented to study participants. Both the emotional tone and body language are held constant, and all participants are presented with identical stimuli. This technique may also help survey preferences of patients who have reading ability that limits their ability to use regular questionnaires. One potential limitation of the method, however, may be the time required for inquiry. Participants have commented that using this technique was more time consuming than written questionnaires. However, the method did assure that participants spend similar amounts of time for each area of inquiry.

Concern about the validity of the method is that it may not simulate real-life emotion and communication. However, results of the participants' own suggested responses yielded identical findings to the results of the questionnaire, thus demonstrating a measure of validity.

Conclusions

The findings of our study may help guide teachers who work with students and physicians in addressing patient anger during clinical encounters. Angry patients may not be able to communicate their health concerns effectively, are more likely to be noncompliant, and may

be more likely to sue over minor mishaps. Dealing with angry patients with an apology, an explanation for the problem encountered, and then moving on with the encounter seems to be the best approach.

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