Case History

Mdm W was a 57-year-old woman who suffered from metastatic cancer of cervix. She was found to have pelvic recurrence at six months after commencement of chemotherapy and radiotherapy. She was referred to our palliative care consultative service because of difficult pelvic pain control, and later transferred to our palliative care ward after stabilization for massive per vaginal bleeding.

Mdm W was widowed, and she lived with her elder son. She was a traditional Chinese herbal medicine dispenser, but retired with onset of her disease.

Her elder son, Mr T, was single and left home in his teens when he had serious behavioral problems. He moved back to live with his mother after she was diagnosed to have cancer. He was the main caregiver of the patient and he was unemployed. The second son was married and worked in a pharmacy as dispenser.

Mdm W had poor compliance to medical treatment and complained of intolerance to multiple analgesics, making pain control difficult. She had always been skeptical about western medicine. Instead, she preferred to take the over the counter herbal medication brought to her by Mr T daily.

She developed acute renal failure with anuria, and ultrasound revealed bilateral obstructive uropathy resulting from the pelvic tumor mass. An urgent transfer to acute hospital was arranged and percutaneous nephrostomy was performed subsequently. Her sons were interviewed on several occasions before the transfer, and grave prognosis was communicated. During the interviews, they appeared upset, while hoping the herbal medication might help, they realized she was deteriorating and agreed with do-not-resuscitate decision.

Despite a partial recovery of her renal function post operatively, she was febrile with severe metabolic acidosis and post obstructive diuresis. Her general condition was further compromised, and she was bedbound, lethargic, anorexic, and had acidic breathing. Intravenous fluid replacement, bicarbonate infusion and antibiotics were given.

As Mr T was confronted with patient’s deterioration, our nurses started to report problems with his behaviour in ward. He became overwhelmed, and was very emotional and agitated. He would demand the nurses to give immediate attention to his mother with the slightest signal of any change in his mother’s physical state. Despite the irreversible organ failures, the patient appeared calm and sleepy most of the time. However, any frowning or noise from breathing would trigger a huge emotional response in Mr T.

On one occasion, in the middle of the night, Mr T yelled and shouted in the ward, requesting immediate transfer of patient to a private hospital. He thought her mother should be under better care. However, the patient was too ill for transfer and he did not have any specific ideas in his mind. Eventually he settled down and he was interviewed again with an attempt to align the goals of care. On another occasion, the focal muscle twitching of patient was interpreted as a major seizure by Mr T. He yelled and appeared furious; he scolded the nurse who attended the patient immediately. The nurse felt threatened and intimidated by his emotions and behaviour. The doctor immediately came to assist to explain that the muscle twitching was related to uraemia and calmed Mr T down.
Dealing with Anger in Palliative Care Setting

All these episodes of emotional outbursts and verbal violence created great tension in the ward. Our palliative care team members were scared of Mr T, felt threatened by him and work stress was building up. Many staff felt exhausted and had poor morale at work. Some felt burnt out and a few cried because of the unjustified hostility directed towards them from Mr T.

Various team members, including nursing specialist, clinical psychologist and doctors, further explored the background. Mr T had a poor relationship with his family as he left home since teenage. Being the eldest son of the family, he felt obliged to move back home and looked after his mother. As he was unemployed, he spent all his time in caregiving and developed strong emotional attachment yet ambivalent relationship with his mother. Besides, Mr. T perceived the doctors had abandoned her mother. As curative oncological treatment was no longer feasible, he thought that the western medicine had failed her mother. Therefore, he relied on the traditional Chinese herbal medicine that he gave to her mother because he had heard of successful stories.

In dealing with his anger, we tried to mobilize other family members to engage in caring for patient. The other family members, including patient’s younger son, patient’s brothers and sisters from China came to accompany Mr T so that he felt more secured, and the team was able to calm him down more easily. We, as doctors, proactively conveyed timely, consistent and clear patient’s progress daily and Mr T had a chance to express his concerns. The senior nursing staff held debriefing sessions with the affected staff to allow ventilation and sharing. The verbal violence was reported to the hospital management through the Advanced Incident Reporting System.

With the relatives from China around, Mr. T remained calm and was more receptive to information from staff as the others would try to reassure him by acknowledging the facts. When at end-of-life, patient was given low dose subcutaneous morphine for pelvic pain and shortness of breath. Patient finally died in peace and this was very much appreciated by Mr T.

Discussion

Being aware of the emotional responses of ourselves as well as others allowed us, as health care workers, to cope with challenging situations involving difficult communication. In dealing with highly expressed emotions, this is especially important. In the Satir Model of personal iceberg, a congruent coping stance that takes care of one’s self, others, and the context facilitates good communication and anger resolution.

Mr T’s coping stance of blaming others and expressing anger rooted from incongruence within the personal iceberg - unmet expectation and unfulfilled yearning with low self esteem.

Figure 2: Mr. T’s iceberg - Blaming
Dealing with anger in palliative care setting

Staff, when challenged with a difficult relative, had their own coping stances which could be different from Mr. T. Feelings of being unhappy, being hurt and scared might be rooted from unmet expectation of respect from others and out of touch with one’s inner self. This was again originated from incongruence in the iceberg and such coping might not be sustainable. (Figure 3) Some of the staff might adopt the coping stance of being super-reasonable and ended up in arguing with the angry son, which would not be helpful in dealing with difficult emotional scenes.

Dealing with anger is common in palliative care. Anger was recognized as one of the essential stages in grieving as described by Kubler-Ross. Prevalence of anger emotions ranged from 9% to 18% in cancer patients and their families in various descriptive studies.\(^1\) Verbal abuse in palliative care is also not uncommon. In Australia, a survey in 2005 showed 62% of doctors had been verbally abused in the previous 12 months.\(^2\)

In a descriptive qualitative study on a focus group in an acute hospital palliative care team, various aspects of anger were analyzed. Source of anger was often shared between patient and the family. Source of anger from patient might arise from perceived neglect or abandonment from doctors, delay in diagnosis and accusation of doctors giving too much or too little information, or even in the wrong style. Family members’ guilt towards patient might also be expressed as anger.\(^3\) Negative impact of anger on medical staff could be significant. Staff confidence and self efficacy might be undermined. Staff may feel exhausted with repeated efforts to engage patient or the relatives, rendering staff difficult to show empathy and establish rapport further. Staff often feel threatened, and may become defensive or even angry themselves, with a spiral down effect as anger escalates. The long term effects on nursing staff included absenteeism, sub-standard care and reduced job satisfaction. Dealing with anger might distract time of staff from other aspects of patient care. Last but not least, anger emotion often blocks effective communication.

Practical tips in dealing with anger

Practical tips for communication in the challenging scenario of dealing with anger are suggested.\(^4\) (Figure 4) It is important to acknowledge the anger and demonstrate that you have grasped what the client is angry about. It is also important not to ‘dismiss’ the anger as part of an adjustment process. Always take the source of the anger seriously (e.g. waiting room delays, or other expectations not being met), even if the response seems out of

![Figure 3: Staff’s iceberg - Placating](image-url)
proportion. If anger persists, one can try to get
the patient to see that, no matter how justified
the anger is, it is beginning to affect him
adversely. If he needs help, then simple anger
management techniques can be taught
(relaxation training, distraction activities, limiting
rumination).5

In conclusion, anger emotion is not
uncommon in palliative care. In the busy acute
wards, staff often tends to avoid interactions that
may lead to expression of anger. However, in
providing holistic palliative care, anger emotion
should be treated as something that requires
exploration, expression and understanding. It
can lead to blockade in communication and
adversely affect patient care and staff morale
and team spirit. Anger may induce violence, be
it physical or verbal. Understanding patient as
well as our own emotional response, with high
self awareness, laid the foundation for dealing
with such difficult situations. Mutual support
within the team is of utmost importance. There
would be tremendous satisfaction when anger is
transformed into more constructive emotional
response following intervention by the team.

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Figure 4: Some practical tips in handling anger emotion

Consider limits
• Frequent and unreasonable demands for physician time by family may be limited to regular
updates at agreed occasion
• Family meeting, involve more family members

Support of team
• Debriefing and regular meetings

Independent broker
• An alternative independent voice maybe provided by a family representative or advocates

Preparation
• Private room, indicating uninterrupted attention
• Seated, sense of time
• Power inequality conferred by height difference is reduced

Listen
• Allow to tell the story, uninterrupted, avoid defensiveness or give explanation
• Repeat and rename emotion (anger --> upset)
• Common position, goals of care negotiated

Involve others
• Single staff handling anger, limited by tiredness aand burntout
• If anger persists, shift of focus from attempting to resolve the anger to support of the team

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