REBELS: An approach to communication challenges in the consultation

Susan J Hawken, Richard Fox, Renske van den Brink and Fiona Moir

Correspondence to: s.hawken@auckland.ac.nz

ABSTRACT

There is ongoing interest and research on how to manage communication challenges in the consultation. A new model, REBELS, developed for the New Zealand context, is presented as a framework for managing challenging situations in health care consultations. It consists of a sequence of helpful strategies to follow during the consultation. This model has been found to be useful in enhancing practitioner skills in a variety of settings and at different levels of experience. Tips are given on creating a successful teaching session using the REBELS model.

Keywords

Communication challenges; challenging interactions; the consultation

*

Introduction

Even the most ordinary day in practice can bring through the door the angry patient, the demanding patient and the unrealistic patient. Sometimes we feel under pressure from people seeking drugs or medical certificates. If we can approach such consultations with a higher level of communication skills and helpful strategies, then the consultation will go more smoothly, be less emotionally draining on us, and have a better outcome for the patient.

Challenging practitioner–patient communication is a well documented area[1-6] that has been of interest for over 30 years.[7] Historically the focus was first on the patient, often described as 'hateful',[7] 'difficult', or 'heartsink'.[8] Next, attention was given to the characteristics of the doctor,[6] and then, more recently, to the nature of the interaction between the patient and the doctor.[4,9] In addition to the more generalised work on the doctor–patient encounter, different approaches to specific challenging interactions have been outlined. These include strategies that emphasise the doctor's role in managing the patient's behaviour by, for example, scheduling regular visits, keeping

Back row, from left: Richard Fox, Renske van den Brink
Front row, from left: Susan Hawken, Fiona Moir

Susan J Hawken *is a Senior Lecturer in the Department of Psychological Medicine at the University of Auckland teaching medical students communication and professional skills. Her research interests include medical education and cross-cultural communication.*

After 15 years of rural general practice, ***Richard Fox*** *re-trained in counselling and psychotherapy. He now has a psychotherapy practice in Auckland's Ponsonby.*

Renske van den Brink *was a general practitioner in Auckland for 10 years. More recently she has focused her interest in the 'Mind Body' area completing a Diploma in Counselling using the Psychosynthesis model which supports her work as a counsellor and mind body therapist in Mt Albert.*

Fiona Moir *is a Senior Tutor in Mental Health and Communication Skills in the Department of General Practice and Primary Health Care at the University of Auckland. She is the Programme Director for The Goodfellow Symposium, and has an interest in multi-disciplinary learning. Her research interests include self-care and resilience for health professionals.*

visits short and focused, and setting more limited objectives.[9] There are also some coping suggestions for clinicians, for example, the CALMER model which offers ways to reduce the affective distress clinicians feel when interacting with challenging patients.[10] Currently there is an increased focus on the issues of patients with medically unexplained symptoms.[11,12] It is clear that some consultations continue to be more challenging than others and that there is active interest expressed by practitioners in how to manage these interactions most effectively.

As teachers of undergraduate and postgraduate students across several disciplines (medicine, nursing and pharmacy) we have developed REBELS, an approach to managing challenging consultations. REBELS allows students/practitioners to learn a framework for approaching challenging situations which enables them to better manage consultations in practice by exploring and reflecting on related issues. We propose that the REBELS model be used by teachers to assist health practitioners and students to develop their skill level in working with challenging interactions.

This paper will firstly outline the REBELS model and then present 10 teaching tips associated with using this in a successful teaching format.

REBELS model

*R – **Recognise** there is a problem*

The starting point for these communication strategies is that the problem is clearly recognised early in the consultation. The recognition is usually easy, particularly when we are aware of our own responses to challenging patients, but the next step is to acknowledge to the patient that there is a problem. This is a helpful strategy as then you are both able to focus on the issue and explore it rather than wasting time by not confronting it. Often the acknowledgement is as simple as stating *'you're really angry'*, or *'I can see you have a long list there'* or *'you are not too keen on that idea'*. Once the problem is stated then it is 'out there' and can be dealt with better.

*E – **Express Empathy***

Expressing empathy is the crucial part of the approach to challenging patients.[13] Often these are the patients that we feel less able to empathise with or they are the ones who really 'push our buttons'. By first recognising our own reaction, and then really trying to empathise, we can improve the relationship, and can begin to see the situation more clearly from the patient's perspective.

To express empathy, it helps to have conscious awareness of one's own non-verbal behaviour and to use as much verbal reflection of feeling as possible. The stronger the emotion the more important it is to reflect this back to the patient. For example, if the patient is in a situation in which they feel no one understands them or gives them what they want, this can be reflected back by stating *'so you really feel that no one hears you or gives you what you need'*. You can then wait for a response and reflect back the next feeling. Repeating this process several times over will help the relationship considerably as the patient starts to feel that you really understand them. Summarising the patient's point of view can be particularly helpful at the end of this stage.

*B – Establish clear **Boundaries***

It is important early on to establish clear professional and interpersonal boundaries. Boundary-setting and assertiveness are important for safe, ethical and professional practice. Stating that legally or ethically you cannot, as a health professional, undertake a particular action allows the patient to see that you will not be persuaded into doing something you consider inappropriate. If your boundaries are being challenged, phrases such as *'We have a practice policy...'*, or *'Legally I cannot sign a form till I have enough information ...'* can be useful. If the patient continues to challenge your boundaries then simply stay calm, and re-state your boundaries – being a 'cracked record' is a useful strategy. Obviously if tension escalates, calling for assistance is prudent.

*E – **Emphasise** the patient's best interest*

By emphasising the patient's best interest you place them at the centre of the interaction and it helps to avoid the argument from the patient that you are not doing anything or offering them any solutions. The kinds of statements that are helpful at this point are *'It's really important that we take the time to sort this out properly for you...'* or *'We need to make sure we get the best results.'*

*L – Use inclusive **Language***

It is very easy to become unaware of how our language influences the consultation, particularly when we feel defensive or under threat in an interaction. We can quickly alienate patients by using technical or distancing language. Responses that begin with words like 'why?' and 'but' (e.g. *'Why do you want me to...?'* or *'But I can't do that...'*) are divisive in this context. So being more aware of actively using inclusive language, e.g. 'We', 'both...and' is useful. For example statements like *'We need to find a way'* or *'So BOTH are true, you need some strong pain relief, AND I cannot prescribe morphine...'* are useful to have in your repertoire.

*S – Focus on **Solutions***

The strategy now is to move from the problem and the patient's needs to solutions. If you have been empathic and highlighted the patient's best interest then you have hopefully obtained a reasonable rapport. So you move from their needs to being able to look at possible solutions, e.g. *'I can't give...AND you need strong painkillers, so how about we try...'*

Encourage the patient to think of solutions themselves and generate possible ways forward together, e.g. *'what has worked best for you before?'* Sometimes this strategy can seem to backfire and you may need to go back and be clear about your boundaries again. If the patient (e.g. drug seeker) persists in challenging your boundaries it may be that despite your best efforts they are not prepared to look at other solutions, and they may choose to end the consultation.

Teaching tips

In our experience this model can be used successfully across health practice disciplines, and in multidisciplinary settings from undergraduate to postgraduate levels. We have facilitated sessions on 'Challenging Situations' in many contexts and they have resulted in busy health practitioners actually attending and finding the approach a useful one. Practitioners interested in teaching these skills to others may be interested in our experience in facilitating these sessions. We recommend working in a group size of eight to 12 preferably, with a maximum of 20. The following 10 tips will help to make a successful learning session:

1. Promotion

Use 'Challenging Consultations' in the title to whet the appetite of your prospective participant. Avoid referring to 'challenging or difficult patients' as this implicates patients rather than the combined interaction as being the source of the problem. Also avoid mentioning role-plays in case this is off-putting for potential participants.

2. Set-up and ground rules

Select an enthusiastic and skilled health practitioner facilitator and a conducive, pleasant learning environment. Generate some ground rules for the session (e.g. cell phones off, constructive feedback, confidentiality of cases and individuals, giving it a go).

3. Glean participants' experiences

Ask the participants to think of scenarios they have had to handle and then invite them to describe these situations briefly in pairs. This encourages everyone to get involved and interact early. Each pair then has the opportunity to feedback to the wider group and the scenarios are written on the whiteboard. The facilitator can then ask the participants to vote with a show of hands the scenarios they would most like to work on.

4. Professional actor

Involve a professional actor. The actor needs to be able to pick up a role quickly, as in theatre sports. Likely scenarios can be discussed with the actor prior to the session, e.g. the angry patient always comes up as does the drug-seeker. Using an actor stimulates far more interest in the group, realism in the role-plays, and also means the anxiety about 'playing a patient role' is removed from the group. A well trained actor familiar with this type of work can also give really useful feedback from the patient's perspective which which helps participants understand the patient position.

5. Demonstrate

Initially the facilitator takes the health practitioner's role and tries out suggestions from the group on managing the challenging interaction. Once the group is warmed up the facilitator can invite participants to take the health practitioner's role, trying out their own, or the group's ideas. The facilitator should reassure the group that nobody has to take part – but that participants will get more from it if they do.

6. Keep it interactive

Ask the facilitator to keep the discussion crisp so that preference is given to role-plays rather than talking about situations, e.g. If a participant says what he would do, invite him up to demonstrate. Talking too much about situations, 'aboutism', can be very time-consuming and can quickly degenerate into participants complaining about patients and comparing stories.

7. Try new strategies

Encourage the participants to utilise the cognitive structure/communication strategies of the REBELS model – which can be left up on a whiteboard or overhead for participants to refer to. Sometimes the strategies are not part of the health practitioner's current practice and so the attitude of 'giving it a go' to see what happens can be adopted.

8. Role-play

If the group warms up, is very interactive, and feels safe, then it can be useful to encourage a health practitioner to take on the role of a particular patient that they struggle with – this allows them to develop more insight into the patient's perspective and develop more empathy for them.

9. Debrief

After each scenario a debrief is useful, and also some action to let go of that scenario, e.g. 'shake the patient out' literally shaking your body to release emotional/physical tension. This is important both for the actor and the group in order to be able to move on to the next scenario.

10. Take-home points

To finish off the facilitator invites each of the participants to offer one sentence on what they learnt. These learning points can be whiteboarded if desired. This is a good way to involve everyone at the conclusion and hopefully to cement the main learning points! Finally the facilitator thanks everyone for getting involved – especially those who came out the front.

Where participants have completed evaluations of our teaching, we have found that role-plays are always highlighted as a helpful learning tool despite the fact that

many people are initially hesitant about them.

In conclusion, the REBELS model can be used successfully to enhance the teaching of how to approach challenging interactions in healthcare settings at all levels of experience. It is a useful model for a wide variety of situations in daily clinical practice.

RF had the original idea and all authors are involved in using the model in teaching health practitioners.

Competing interests

All four authors are partners in *Connect Communications* that offers coaching and seminars on communication skills for health professionals.

References

1. McDonald PS, O'Dowd TC. The heartsink patient: a preliminary study. Fam Pract 1991 Jun; 8(2): 112-6.
2. Smith S. Dealing with the difficult patient. Postgrad Med J 1995 Nov; 71(841): 653-7.
3. Crutcher JE, Bass MJ. The difficult patient and the troubled physician. J Fam Pract 1980 Nov; 11(6): 933-8.
4. Wilson H. Reflecting on the 'difficult' patient. N Z Med J 2005 1; 118(1212): U1384.
5. Hawken SJ. Strategies for dealing with the challenging patient. N Z Fam Physician 2005; 32(4): 266-9.
6. Mathers N, Jones N, Hannay D. Heartsink patients: a study of their general practitioners. Br J Gen Pract 1995 Jun; 45(395): 293-6.
7. Groves JE. Taking care of the hateful patient. N Engl J Med 1978 20; 298(16): 883-7.
8. O'Dowd TC. Five years of heartsink patients in general practice. BMJ 1988 20-27; 297(6647): 528-30.
9. Gillette RD. 'Problem patients': a fresh look at an old vexation. Fam Pract Manag 2000 Jul-Aug; 7(7): 57-62.
10. Pomm HA, Shahady E, Pomm RM. The CALMER approach: Teaching learners six steps to serenity when dealing with difficult patients. Fam Med 2004 Jul-Aug; 36(7): 467-9.
11. Mann B. Generalism – the challenge of functional and somatising illnesses. N Z Fam Physician 1997; 34(6): 398-401.
12. Hatcher S, Arroll B. Assessment and management of medically unexplained symptoms. BMJ 2008; 336: 1124-8.
13. Halpern J. Empathy and patient-physician conflicts. J Gen Intern Med 2007 May; 22(5): 696-700.