Physician Anger

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During the past 5 years, we have studied the topic of anger in physicians. Based on our review of the literature on anger, interviews with many physicians, and our own experience, we have found that anger can disrupt behavior, cloud judgment, and interfere with communication.[1–4] Reciprocal exacerbation of anger and mistrust can adversely affect the physician-patient relationship,[5–7] leading to negative patient behaviors, such as failure to comply with a prescribed medical regimen, changing physicians, or malpractice suits[8]; and the potential harm from anger and hostility may be *the* significant risk factor in the relationship of the type A behavior pattern to coronary heart disease and hypertension.[9–12]

Despite the weight of the evidence cited above, anger in physicians remains a neglected subject. We do not mean to imply that the topic of anger in physicians has never been discussed in the medical literature. Physician anger has been described as a byproduct of stress,[13–15] mentioned in studies of malpractice suits,[8,16–17] and included in discussions of physician characteristics,[6,18] particularly as they relate to angry and "hateful" patients.[5,7] Observations by physicians made over 100 years apart illustrate that the practice of medicine both in the past and today includes built-in provocations to anger.

The first observation was part of a valedictory address by Sir William Osler at the 1889 graduation of the University of Pennsylvania School of Medicine.[19] He cautioned the students and faculty about the need for "coolness and presence of mind under all circumstances."[19(p4)] He then introduced the term *aequanimitus*, which he defined as "a calm equanimity."[19(p5)]

According to Sir William, "One of the first essentials in securing a good-natured equanimity is not to expect too much of the people amongst whom you dwell. . . . In matters medical the ordinary citizen of today has not one whit more sense than the old Romans, whom Lucian scourged for a credulity which made them fall easy victims to the quacks of the time. . . . Deal gently then with this deliciously credulous old human nature in which we work, and restrain your *indignation* . . . [italics added]."[19(pp5,6)]

One hundred years later a surgeon wrote as follows for his 50th Harvard Medical School class reunion booklet[20]: "And what are my hopes for the future? I do hope that the public—particularly the lawyers, the politicians, the judges, the insurance executives, and the patients themselves—will have more respect for physicians. When I began practice, I felt as though I were 'Captain of the Ship'; now I feel that I am a consultant making recommendations to numerous individuals about how to care for my patients. . . . The mountains of paper work which I must endeavor to move. . . . The number of professional liability cases and the amounts of the awards for such cases are truly making us practice defensive medicine."[20(p46)]

And one of his classmates added, "I'm glad I went into medicine when I did and retired when I did. I don't think I would like being a 'provider' of medical care and working for a large group of bureaucrats and trying to avoid law suits."[20(p119)]

In addition to institutionalized provocations, there are patient behaviors that arouse feelings of anger in physicians, ranging from mild annoyance (being late for appointments) to rage (malpractice suits). Most physicians will admit to feelings of helplessness and frustration when a patient fails to improve despite a correct diagnosis and rational treatment, and to impatience felt during the care of the incurable patient when suffering is prolonged; but these feelings could, irrationally, turn to anger toward the "uncooperative" patient.[2]

Intermingled with all of the above is the disenchantment of the physician's family arising from canceled plans, late dinners, cash-flow problems, and other disruptions that turn what should be a haven of comfort into another venue for reciprocal anger.

In short, the exasperation seemingly inherent in the

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ISSN 0094-3509

learning and practice of medicine may threaten the composure of the most even-tempered and objective physician. Indeed, it might have been very instructive to observe the degree of Sir William's equanimity while he was dealing with Medicaid, or with a nonphysician at an insurance company who argued to limit the hospital stay of one of his patients.

Recent articles in this journal[21,22] have pointed out the importance of family medicine residents and physicians counseling their patients on coronary risk factors. Anger and hostility should be added to the list of alertable risk factors,[9–12] and physicians should apply to themselves what they teach to their patients.

We also believe that the risk can be minimized. Cognitive-behavior therapy (CBT)[23–31] offers practical, proven approaches to anger management that can be learned, practiced, and applied in the course of everyday activity by patients and physicians alike.[28,31] Three CBT approaches to anger management are described below.

Relaxation Skills

Tension-control and relaxation skills are useful in countering anger problems that arise when the cumulative effects of a series of relatively minor provocations are superimposed on an underlying high level of stress.[2–3]

One such technique is Benson's "relaxation response," which is " . . . the counterpart of the fight or flight response."[25(p140)] This 20-minute meditation is particularly effective if practiced early in the day when it will act as a buffer that reduces excessive responses to minor stressors.

A second relaxation technique is Stroebel's "quieting reflex."[30] This five-step, *6-second* technique is designed to be used promptly after each stressful, anger-provoking event has occurred. By keeping the buildup of stress and irritability within controllable levels, the quieting reflex decreases the likelihood of a disproportionate "last straw" response.

It is often the latter response that leads to a feeling of disbelief and dismay that so minor an incident could lead to such a disproportionate reaction. As a result, concentration may be broken for several minutes, or even longer, with potentially serious effects on diagnostic accuracy and treatment decisions.[6]

Self-instruction Techniques

In addition to the general relaxation skills outlined above, there are CBT techniques that can be used specifically for anger management. These techniques facilitate the expression of negative feelings to others in ways that lead to successful conflict resolution rather than merely escalating antagonisms.[3,28,31]

It is recognized that anger has adaptive as well as maladaptive functions. Tavris points out that "anger is . . . an emphatic message: *Pay attention to me. . . . Restore my pride. . . . Give me justice.*"[4(p47)] In the usual anger scene, however, there is generally reciprocal shouting of more and more extreme statements, leading to a total breakdown of communication.

Imagine yourself in a "discussion" with an on-call colleague who had failed to inform you that he had admitted one of your patients yesterday with a serious condition.

In this situation it might be possible to break the cycle of anger escalation by preparing in advance a series of self-instructions[3,24,26–28,31] to be used in anger situations. For example: "We seem to have a problem, let's work on it together" is more constructive than pointing out that your colleague has acted like an idiot. By developing and practicing a series of self-instructions it is possible to restructure an antagonistic situation into a more neutral one before it gets out of hand. You might respond to the recognition of your own anger or someone else's anger by asking yourself "What is provoking my (their) anger?" Another example would be to ask: "Is my anger *disproportionate* because I'm too irritable, and I need to use the quieting reflex right now?"

Self-instructions can also be combined with the use of "time-outs"[28] of a few seconds to several hours, which are very useful periods for practicing self-instructions and/or tension-control techniques.

Stress-Inoculation Training

Finally, we all face situations which we *anticipate* will produce considerable tension and anger. The anticipation may be based on similar previous experiences (eg, an upcoming encounter with the health care bureaucracy, or a difficult patient returning for a complex examination); or on knowledge that the circumstances are likely to be antagonistic (eg, being called up before a peer review board, or a tax examination).

The third CBT anger-management technique, stress-inoculation training (SIT),[27] is designed to train individuals to remain calm while imagining and mentally "walking-through" possible similar future situations. In SIT, it is assumed that the trainee is already skilled in tension/relaxation control and self-instruction techniques, which are applied in preparing for the future situation. SIT is also very useful for dealing with obsessive anger resulting from a prior provocation by allowing one to focus on problem-solving rather than on thoughts of revenge.[26]

Conclusions

Our objective in presenting this editorial is to alert physicians in practice to the dangers of anger, and to interest them in learning more about the subject, as a contribution to their own well-being and that of their patients.

Several excellent books and journal articles have been written on anger management.[1–4,12,25,28–31] If a severe anger-hostility problem exists, particularly in individuals exhibiting type A behavior, a counselor skilled in behavioral techniques for anger management and stress reduction may provide the most effective assistance.[29]

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