

The 'difficult patient' as perceived by family physicians

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Steinmetz D and Tabenkin H. The 'difficult patient' as perceived by family physicians. *Family Practice* 2001; **18**: 495–500.

Objectives. The aim of this study is to understand in depth the experience of the family physician faced with the patient that he perceives as 'difficult'. This was done by means of the 'long interview' as a method of qualitative research.

Method. We interviewed 15 randomly selected Board-certified family physicians, with five or more years experience as specialists, employed in the northern district of the 'Clalit Health Services', the major sick fund in Israel.

Results. The participants stated that the 'difficult' patients are not those with difficult medical problems but rather those who are violent, demanding, aggressive, rude and who seek secondary gain. Patients with multiple non-specific complaints and those with psychosomatic problems are also difficult for the family physician. Appropriate use of patient–doctor communication skills and an effort to improve relations with the patient through empathy, tolerance and non-judgmental listening were suggested by the physicians as ways of making the difficult encounter easier.

Conclusions. Family physicians acknowledge their responsibility for the 'difficult' patient, and seek innovative and creative ways to cope with the difficult medical encounter. The more experienced the doctor is, the less he perceives patients as 'difficult', as he learns to accept greater diversity of behaviours in his patients.

Keywords. Difficult patient, family physician, qualitative research.

Introduction

The medical encounter usually constitutes a source of mutual satisfaction. There are, however, patients who evoke in us physicians negative emotions, such as anger, guilt, hatred and even depression.¹ These patients visit their doctor more frequently than average, with a variety of acute and chronic problems, receive more prescriptions, have more tests run and are referred more often to obtain a 'second opinion' or counselling from various specialists.² Some call them 'heart sink' patients.³ Many of these patients have a 'thick file' in the doctor's office.⁴

Throughout the years, various attempts have been made, some of them in studies of different kinds, to describe the difficult patient. Groves¹ has defined four types of difficult patients: the demander, the manipulator, the denier and the self-destroyer. Other researchers have reported patients with symptoms of somatization

as being difficult, i.e. those patients for whose problem doctors do not find an organic basis.^{2,5,6}

Various social and medical conditions were found to be difficult for physicians. Mental disease, alcoholism, drug use, obesity and muscular skeletal diseases were the most difficult medical conditions for physicians, while dirty, smelly people, aggressive behaviour, anger and hostility, lack of co-operation in treatment and exploitation of the health system were the most difficult social conditions.⁷

More and more physicians acknowledge that the problem is the medical encounter, the interaction between the doctor and his patient, and not just the patient himself.^{8–12} The difficulty may derive from the doctor's personality, from his work style and belief system, from cultural gaps between him and his patient, from the character and behaviour of the patient and from external circumstances that affect the encounter.^{2,8,9}

Various studies published on the subject of the difficult patient have examined different aspects through research based on questionnaires, in which physicians were asked to rate different situations or traits of patients, on a scale, according to the degree of difficulty for the doctor. A special questionnaire, which doctors filled out, was

Received 15 October 2000; Revised 5 March 2001; Accepted 4 May 2001.

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designed to examine difficult physician–patient relationships. Attempts were also made to analyse, on the basis of interviewing or of observing an interview with a difficult patient, the difficulties of the physician, with the purpose of coping better through a ‘corrective experience’. Furthermore, anecdotal accounts on the subject appeared.^{5,7,10,12} Many of the studies were conducted in a psychiatric setting or were written by psychiatrists.^{1,2,5,6,10} Fewer studies were conducted and written in primary care clinics.^{7,9,13}

In this study, we attempt to reach a deeper understanding of the family physician’s experience in coping with what is, for him, the difficult patient, as well as looking at the solutions and means of coping that the physician has developed in order to improve the problematic medical encounter.

Subjects and methods

Fifteen experienced family physicians (>5 years as specialists) constituted the population of this study. All of the doctors work in the northern district of the Clalit Health Services. The doctors were selected randomly from all the experienced specialists working in the district. We did not want to have a bias by selecting doctors according to our familiarity with them. Only physicians who work with the Jewish population in the area were selected, so as to maintain cultural uniformity, as much as possible. All of the doctors selected consented to participate in the study.

The study was conducted as qualitative research, implementing the method of ‘the long interview’.^{15,16} A questionnaire was designed, based on the literature on the subject and the interests of the researchers. The interview was structured, and the interviewees were asked six open-ended questions. The interviewer read the questions aloud, so as to maintain uniformity when presenting the subject, and encouraged the interviewee by using words from a list of encouraging words and phrases which was composed, in advance, for this purpose. The interviews were tape-recorded in their entirety.

The first two interviews constituted a ‘pilot’, and following them slight modifications were made to the questionnaire and to the interviewing method. At the beginning of the study, the two researchers prepared a list of topics that constituted the basis of encoding and analysing the interviews. The first two ‘pilot’ interviews were analysed separately by each of the two researchers, and in a joint meeting they decided which topics would be used for the rest of the interviews and for the analysis. (It is notable that there was an 86% agreement between the researchers, *vis-à-vis* the encoding of the interviews and topics, as defined in advance.)

In the next stage, an additional and final compatibility analysis was done on the code-book for analysing the results. The method described here is conventional and

has been described previously by various researchers.^{15–20} The tape-recorded interviews were transcribed verbatim. A horizontal reading and division of all printed material was conducted manually.^{18,19}

The researchers determined six categories of interview analysis, but, after receiving and summarizing all of the results, it was decided to analyse the interviews according to three categories only, due to the overlap of topics, and to add comments. The three categories are:

- (i) Who is the difficult patient?
- (ii) Means of coping.
- (iii) The effect of the physician’s character on the encounter.

Results

In this study, 10 of the physicians were males and five were females. Their ages ranged from 39 to 53 years. All of the doctors had 5–17 years experience as specialists in family medicine.

The data regarding the first two topics (‘Who is the difficult patient?’ and ‘Means of coping’) were written in a table in descending order of frequency. This relative frequency can be misleading because certain physicians emphasized different aspects in different ways, and the researchers surveying the material obtained a subjective impression from the power and quality of the text and gave their feelings weight without precise numbering or numerical averages. This is an accepted method in the analysis of the results of qualitative research.¹⁸

Who is the difficult patient?

Patients with a broad range of ‘behavioural problems’ are the most difficult ones for the majority of family physicians interviewed (Table 1). In this definition, the patients who were mentioned were mainly violent, aggressive, verbally rude, manipulative, lying, demanding, ‘boundary busting’ and exploitative of the doctor, seeking secondary gain, ‘a pain in the neck’, and those who are angry at the doctor. We can add to this group the drug addicts who, in most cases, behave bluntly or violently.

“... I don’t feel that he wants to ask for my medical advice. He doesn’t need me as a doctor at all. Actually, I’m just a tool in his hands.”

The second group of difficult patients are either those that have repetitive complaints, mainly without clear clinical significance, and strange unsolved complaints, or those who visit the doctor with multiple complaints—‘a shopping list’. Here we can also add a subgroup of patients for whom ‘everything hurts’. In this group, the visits last a long time, usually much longer than the average, and the patients tire out their doctors.

“It starts with the fact that the complaints are never specific. There are always complaints that paint you

TABLE 1 *Types of difficult patients (in descending order of relative frequency)*

1.	Violent, aggressive, verbally abusive
2.	Unsolved repeated complaints
3.	Multiple complaints—'shopping list'
4.	Psychosomatic patients
5.	Complaining, never satisfied
6.	Seeking secondary gain
7.	Manipulative, lying
8.	'Everything hurts'
9.	Having a high anxiety level
10.	'Pain in the neck'
11.	Demanding, boundary-busting, exploiting the doctor
12.	Angry at the doctor
13.	Unco-operative
14.	Difficult psychiatric patient
15.	Drug addict

TABLE 2 *Means of coping with the difficult patient or encounter (in descending order of frequency)*

1.	Empathy
2.	Non-judgemental listening
3.	Patience and tolerance
4.	Direct approach
5.	Defining limits of time and content in advance
6.	Referral to various consultants, laboratory and simulated tests, alternative medicine, mental health services
7.	Confrontation with the patient
8.	Recommendation for transfer to another doctor
9.	Use of humour
10.	Involving the patient's family
11.	Sharing some of the doctor's personal experiences with the patient
12.	Ignoring the patient's feelings

into the corner, such as weakness, dizziness, etc . . .
Their visits last above and beyond your expectations."

The third group of difficult patients are those with 'psychiatric' disorders of some kind, such as psychosomatic disturbances. These patients, who suffer from a high level of anxiety, return repeatedly to the family physician. In most cases, a comprehensive organic examination reaps no findings. The solutions we have to offer them are extremely limited.

Patients with a 'hysterical' personality and those with difficult psychiatric illnesses are experienced as difficult patients by some of the physicians.

"A female patient with conversive personality disturbance complains at every visit about 'intolerable pains'. The hardest part is that she always transmits 'man-eating' sexuality, sitting too close to me, etc., and the visit is oppressive."

Means of coping

We can divide the means of coping into a number of areas (Table 2).

Correct use of communication and improving doctor-patient relations

- (i) The most common and, apparently, most effective means of coping is the use of empathy. The ability to be empathic toward the difficult patient makes the encounter much easier. "First of all, what I have learned with the years is being empathic toward them."
- (ii) Patient, non-judgemental listening. A number of physicians noted that they have learned to listen to the patient and accept his words without

judgement. Two examples are: "I concede more, am patient, listen and resign myself to the situation" or "I relate [to the difficult patient] with a great deal of patience, even more than to the others."

- (iii) Establishing a clear framework for the encounter, trying to plan ahead of time the encounters with the difficult patient, with a set and defined time frame, while giving explanations about what to expect in the encounter. In this encounter, the doctor "concentrates and focuses on the most disturbing problem at that moment."
- (iv) Directness. The doctors try to take a direct approach, to speak in clear language that cannot be interpreted differently, to control the course of the meeting. For example: "I am very direct and make it clear to the patient who is 'running the show'. I put the patient in his place."
- (v) Use of humour. For instance, one of the female doctors said, "Many times I use humour. It really makes it easier. I mean, even about the complaints I say something funny and sometimes that's what helps."
- (vi) Confrontation with the patient. Some of the doctors are not put off confronting their patients and feel that confrontation sometimes contributes to better and healthier relations. This approach is employed especially where secondary gain is concerned, such as: demands to receive 'sick notes' for a prolonged absence, confirmation for social security benefits, etc.
- (vii) Co-operating with and involving the difficult patient's family in the treatment, on condition, of course, that they are willing to co-operate and that the patient consents.

Use of consultants, referrals, tests and transferring the patient

These patients have more examinations than necessary, are referred more often to various medical consultants and specialists, have more simulated tests conducted and use the services of social and community workers. All of these are means of coping with these patients' difficult demands, on the one hand, and the doctors' helplessness, on the other hand. For example: "There are some people I simply don't like, so with them I am very cautious. I prefer that someone else see them, that we do more tests, just to be sure". Or "And I use alternative medicine and send them to really bizarre [treatments]; sometimes you need a totally unorthodox idea . . .".

In case all of these do not help, there are some doctors who recommend that their patient transfer to the care of another doctor. Physicians noted that this suggestion often meets with resistance on the part of the patient, even when the doctor-patient relationship has been undermined.

Sharing with the difficult patient the difficulties in the life of the doctor

Doctors sometimes choose to share with these patients their personal experiences and try to turn the difficult encounter into a more personal, intimate and social one. "I share personal things with these patients and, by doing so, create a more personal and intimate relationship. I am seen as a human being, so we are more forgiving toward one another, and this narrows the distance and removes barriers."

Coping techniques that doctors developed

- (i) Relaxation before this kind of encounter: "I breathe deeply before the encounter."
- (ii) Resigning yourself to the situation: "That's life and this is part of my job."
- (iii) Artificial use of emotions and behaviours: "I'm nice in an exaggerated way."

The effect of the doctor's character on the encounter

Doctors mentioned their different character traits as helping or hindering the encounter with the difficult patient. Only a small minority of the doctors believe that there is nothing in their character that may contribute to the encounter being difficult or experiencing the patient as difficult.

Of the traits that make the encounter harder, doctors noted their personal anxieties, their being a pressured type of person, having an overly critical and judgemental character, the need to be loved constantly by the patients, having a defensive personality and being overly nice.

"I, also, as a doctor carry a sack of anxieties from home, my problems, and if this threatens me, it probably contributes to the encounter."

"There is something in me, that I want to please people . . . it's important for you to do things so that people love and rely on you, things that are not always appropriate."

Of the helpful traits, doctors mentioned openness, feeling comfortable at work, ability to interact and learn lessons, ability to make concessions, tolerance and patience, a sense of humour, an empathic ability and the ability to love patients.

"In the past I was more tough and stubborn, and this contributed to the difficulty, since I was less open to the patient and concentrated more on the purely medical side. This has changed a lot, and now I'm more understanding, open and tolerant, and this helps me."

Or the doctor who said, "I reached a point of real anger in the medical encounter. I felt that I could not go on with a certain patient. I tried to reach an understanding with myself about what was happening, and later I reached an understanding with the patient about this barrier that was stuck between us."

Discussion

This qualitative research study finds that the older and more experienced the doctors are, the fewer difficult patients they testify to having, and that they are capable of coping better with a wide variety of patients and their problems, including in the emotional domain.

This was a qualitative study but, in comparison with other studies, our results suggest a slightly different profile of the difficult patient. Patients with behavioural problems, and particularly those who behave violently and aggressively, are at the top of the list of patients who are difficult for physicians. In many of the previous publications on the subject, it was the mentally ill patients who topped the difficult patient list. In one of the studies, for example, it was found that 15% of the family physician's medical encounters were defined as difficult. Of these, many of the patients had mental disorders.²¹ Personality disorders were found to be most frequent among difficult patients and especially a dependent personality disorder.²² The difference in the type of difficult patients can derive from the study population and the research methodology. While many studies were conducted by researchers in a psychiatric setting, our research was done with family physicians. A high percentage of the primary physician's patients have complaints from the area of 'soft' psychiatry, and family physicians are highly skilled in treating a variety of problems of this kind.

Most doctors feel that they do not receive real help from mental health authorities for their difficult patients and must learn on their own how to treat and relate well

to these complaints. The main help received from consultants in the mental health field is in cases where the patients have a 'hard' psychiatric disorder, such as schizophrenia or bipolar affective disorder. These patients are not perceived as difficult by most family physicians.

Similarly to other reports, the physicians who took part in our study have a hard time with patients who frustrate them; those patients for whom every attempt to treat them is met with resistance, lack of co-operation with the doctor's recommendations and a constant expression of dissatisfaction. Also, patients who arrive with repetitive complaints that are never solved or when one problem is solved and another one immediately appears, greatly frustrate the family physician. Therefore, these patients are perceived as being difficult.

The patients who arrive at every office visit with a long list of complaints put pressure on the overloaded doctor whose time is limited and who cannot possibly finish the encounter on time and provide satisfactory solutions. Moreover, the patients defined as 'psychosomatic', for whom many tests are run to determine the reason for their illness, but the tests always return 'normal' and yet the complaints go on and on, are perceived as difficult patients by the doctors.

It is encouraging to reveal that the physicians do not disown these difficult patients, but rather attempt to find solutions to improve the difficult medical encounter. Most of the solutions are found in the realm of correct communication and improving doctor-patient relationships. Doctors acknowledge the importance of empathy, non-judgmental listening, patience and tolerance. Solutions of this kind are the most common, as they were suggested as means of coping with difficult situations in the medical encounter in general, and with difficult patients in particular.^{23,24}

Setting a clear framework of time and content of the conversation are likely to make the encounters with difficult patients much easier. Due to the limited time allotted to each patient, especially in our overburdened public medicine, it is important for the doctor to inform the patient at the outset what the length of the session will be, and to be strict about ending the encounter on time, even if the patient has much more to say or request. The doctor can always suggest an additional time-limited session at a later date.

Since physicians often feel frustrated by these patients and feel that they are not really helping them, they frequently refer them to numerous consultants and various specialists. The patients are then returned respectfully to their family physician without a real solution to their problem. At this point, the family doctors' imagination and creativity are put to the test: referrals to a wide variety of caregivers in the field of complementary medicine, various physical treatments, body-mind aspects, healing and organic treatment, all in accordance with the patient's personality and ability.

Doctors offered a number of additional ideas for improving and coping with the difficult encounter.

- (i) Get the patients to meet medical students and interns to let them get more deeply involved, to get well acquainted with the patient and his family and to present the 'difficult case' as an oddity and as learning material for the students.
- (ii) Videotape the difficult encounters and get the doctor to sit with a colleague or a behavioural scientist to analyse the interview and learn from it.
- (iii) Learn and accept tools for coping with anger, tantrums, rejection, etc.
- (iv) Learn relaxation techniques.

Most doctors think that their personality and character traits play a part in the fact that they perceive their difficult patients in the way that they do. That is why it is appropriate to talk about the difficult encounter and not just the difficult patient. A difficult patient for one doctor may not necessarily be difficult for another.^{2,9,25} Doctors with poorer psychosocial skills perceive more of their medical encounters as difficult.²¹

Little has been written to date about the family physicians' means of coping with the difficult patient. This qualitative research study describes numerous and various means of coping, which are suitable and can be implemented.

Mathers *et al.* recommended that primary care doctors find ways to increase their satisfaction with their work, and undergo relevant postgraduate training, mainly in the field of communication, so as to reduce their load of difficult patients.²⁵ Our research suggests that doctors are willing to keep on treating 'difficult patients'. Therefore, it may be advisable to share their means of coping with the entire population of family physicians.

Furthermore, participating in support groups with colleagues, groups for personal growth, such as Balint,^{26,27} or a joint meeting with people who deal with the behavioural sciences, and analysing the difficult cases, can all contribute greatly to the doctor's understanding of his difficult patient's problems and can improve the problematic medical encounter.

Acknowledgements

This study was supported by Grant no. 4923 from the Chief Scientist's Office of the Israel Ministry of Health.

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