The Problem Patient as Perceived by Family Physicians

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Views of family physicians, in training and in practice, were obtained on problem patients. Both groups identified problem patients by the presence of vague complaints of a functional nature and the presence of psychiatric symptoms. Views of problem patients did not change with age of physician or length of time since training. Neither group identified problem patients by the type of physician-patient relationship, a finding that probably contributes to increased difficulties with this group of patients.

There are many good people who are not what I call good patients.

Oliver Wendell Holmes

Patients and physicians have forever evaluated each other according to real or imagined attributes. Regrettably, negative evaluations for either group are more often memorable than positive ones. Appellations like "quack" and "turkey" have developed from reciprocal pejorative assessments and grown into common usage. This investigation examines the physicians' view of a group of patients that by definition receives negative evaluation: "problem" patients. Most physicians can identify a few individuals whose conduct as patients has contributed to a frustrating physician-patient relationship.

Definitions of problem patients have arisen from multiple perspectives. Von Mering,[1-3] an anthropologist, defines the problem patient as a person who is stigmatized by a variety of diagnostic labels which vaguely define his/her condition. Although the condition tends to be functional and nonfatal, it is often partially or wholly incapacitating. Such patients seek far more medical care than the average person and usually undergo more expensive diagnostic procedures. Von Mering stresses that such patients are problems because they do not fit the medical model which is inappropriately applied to them. Steiger,[4,5] a psychiatrist, emphasizes communicational difficulties between physicians and troublesome patients. These usually result in such adverse affective responses in the physician as anxiety, anger, sympathy, or guilt. He notes that the physician-patient relationship, rather than the nature of the problem, arouses these feelings. Kaywin,[6] a physician-in-training, defines the problem patient as uncooperative and a poor historian with few objective findings and an unusual number of complaints and demands. Lorber,[7] a sociologist, finds the problem patient a person with deviant attitudes in the areas of trust, cooperation, complaints, and demands. Other workers have emphasized that problem patients suffer character and personality impairments which contribute to distorted interpersonal relationships with all others.

Condensing the above, we may define problem patients as a group with problems of treatment outcome not ascribable to the severity or complexity of their disease state. Factors contributing to poor treatment outcome include the following. Problem patients usually present with vague complaints which are functional and changing. Problem patients often have underlying psychiatric symptoms or syndromes that complicate treatment. Lastly and perhaps most importantly, problem patients create difficulties in the process of developing and maintaining a normative physician-patient relationship. Poor treatment outcome leads to unmet expectations on both sides and often to termination of the physician-patient relationship.

Since the definitions of problem patients represent disciplinary approaches, we decided to investigate the

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problem patient by examining the perceptions of a group of family physicians. We wished to know if family physicians perceive problem patients according to the composite criteria given above. We were particularly interested in their view of physician-patient relationships occurring with different types of problem patients; we wanted to know whether they would identify subgroups of problem patients on the basis of type of physician-patient relationship. We also studied the effects of the physician's age and experience on his/her view of problem patients.

Table 1
Mean Scores of the 24 Process Terms

Term	Mean Score
frustrating	4.30
manipulating	4.15
depending	3.98
demanding	3.96
insisting	3.87
suffering	3.68
challenging	3.53
provoking	3.06
resenting	2.98
controlling	2.87
blaming	2.87
influencing	2.83
urging	2.77
commanding	2.38
malingering	2.23
competing	2.20
symbolizing	2.19
withdrawing	2.13
touching	2.04
sacrificing	2.00
flirting	1.91
minimizing	1.87
condescending	1.87
secluding	1.75

Methods

Fifty-three subjects were drawn from two family practice training programs and from private practice in the community. The sample included 27 family practice residents and 26 trained physicians in either private or academic practice.

The test instrument contained demographic data concerning age, sex, amount of medical training, whether in training or in practice, and the estimated number of problem patients seen by the physician since he/she concluded medical school. Problem patients were defined by exclusive criteria only. Physicians were instructed not to include patients who were problems because of difficulty in diagnosis or disease state. Physicians were requested to rank the three most frequent presenting complaints they saw in problem patients and to rate whether these presenting complaints were perceived as functional or organic. They were then asked to check whether they entertained psychiatric diagnoses or symptoms in their problem patients. If they did, they were asked to identify and rank the top three categories. The instrument included terminology from the major psychiatric diagnostic categories in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) to ensure uniform diagnostic nomenclature.*

Assessment of the physician-patient relationship was obtained by presenting 24 terms (Table 1) which could describe the relationships between physicians and several types of problem patients. Physicians were requested to rate each descriptive term from one to five according to how poorly or how well each term characterized different transactions between themselves and problem patients. The terms selected were based on Kahana's and Bibring's model of personality types (Table 2) under the stress of medical problems.[8] Kahana and Bibring defined seven personality types occurring in normal individuals based on dynamic factors of personality which become exaggerated under the stress of medical difficulties. Such individuals are likely to react to a physical illness as an emotional crisis, impairing their relationships with all individuals but especially with health-care professionals. Three to four process terms were selected to characterize the transaction occurring between physicians and each of the seven personality types that could react as problem patients under the stress of medical illness. Twenty-two process items were selected to fit the seven personality categories. Two additional process terms, "malingering" and "manipulating," were added to the test instrument since they are so frequently used to describe physician–problem-patient transactions. These latter two terms, however, were not felt to be associated with any one personality pattern. One term, "minimizing," was used in two personality categories. All 24 terms were placed in random order.

Several hypotheses were formulated based on whether or not physicians would score process terms into clusters forming common factors. These common factors could represent different types of physician–problem-patient relationships. Several statistical results were possible. First, physicians might cluster the process terms according to the Kahana-Bibring model and thus empirically confirm that model. Secondly, physicians might cluster terms differently than the Kahana-

*Committee on Nomenclature and Statistics: Diagnostic and Statistical Manual of Mental Disorders (DSM-II). Washington DC, American Psychiatric Association, 1968.

Bibring model thus invalidating the model, but nevertheless, demonstrating the physician's ability to perceive different types of problem patients based on the processes occurring between the physician and the problem patient. Thirdly, physicians might not score any of the process terms into clusters. Although many conclusions could be reached from this third finding, one plausible conclusion is that physicians tend to evaluate problem patients on criteria other than processes occurring in the transactions between themselves and problem patients.

Results

The principal components analysis revealed there was only one significant factor which was associated with the clustering of three of the 24 terms. This factor accounted for 21 percent of the total variance and was associated with the terms "flirting," "competing," and "symbolizing." These three terms were consistently clustered together by our sample of physicians. In Kahana and Bibring's model these three terms describe the dramatizing, emotionally involved personality. None of the other terms significantly factored together.

Neither age nor years of practice significantly altered physicians' responses. With the problem patients characterized by "flirting," "competing," and "symbolizing," residents and established physicians perceived these patients alike. Using an analysis of variance, residents vs established physicians were compared on 42 variables, including process terms. The single term which reached statistical significance ($P = .01$) was "resenting." A greater number of established practitioners than residents rated problem patients as having significantly higher resentment toward them.

The most highly scored terms were "frustrating," "manipulating," and "depending." It should be remembered, however, that these terms did not vary together.

The most frequent initial complaint of problem patients was headache. The second most frequent complaint was abdominal pain. Seventy-five percent of the sample felt that both of these complaints were functional. Obesity, fatigue, low back pain, dizziness, and nervousness followed in order of frequency, and again three fourths of the physicians saw these complaints as functional.

Only three physicians of the total sample did not consider psychiatric diagnoses or symptoms in their problem patients. Eighty percent of the physicians who did entertain psychiatric diagnoses picked as their first choice depression and/or anxiety. The remaining 20 percent were equally divided among alcoholism, personality disorders, and psychophysiological reactions.

For our sample, 6.8 years was the average number of years in practice, including residency time. The average total number of problem patients estimated to have been seen by each physician was 154. A Pearson Product-Moment Correlation was performed on all 44 items on the questionnaire. The number of years in practice correlated highly with the number of problem patients seen ($r = .71$). Modest correlations were noted between age and some of the scores for the process terms. The highest correlation was the relationship between age and the term "touching" ($r = .42$). The older the physician, the more likely that "touching" was a term describing the relationship with the problem patient.

Discussion

Physicians in our sample confirmed that problem patients present with diffuse problems of a functional nature. The majority of our physicians also perceive that problem patients have some psychiatric symptoms. A most significant finding was that physicians failed to cluster process terms into types of transactions occur-

Table 2. Personality Types Under the Stress of Medical Problems†

Personality type	Process terms	
1. **Dependent, overdemanding person**	depending	
	demanding	
	frustrating	
2. **Orderly, controlling person**	controlling	insisting
	influencing	urging
3. **Dramatizing, emotionally involved person**	*flirting	*competing
	*symbolizing	touching
4. **Suffering, self-sacrificing person**	suffering	
	minimizing	
	sacrificing	
5. **Guarded, querulous person**	blaming	
	provoking	
	resenting	
6. **Superior, narcissistic person**	condescending	challenging
	commanding	
7. **Uninvolved, aloof, shy person**	withdrawing	
	secluding	
	minimizing	

†Personality categories likely to react to physical illness as an emotional crisis.[8] Listed with each category are process terms describing potential patient-physician transactions producing "problem patients."

*Terms that significantly factored together in the principle component analysis.

ring between them and the problem patient. The only exception to this was the histrionic patient who sets the transaction of flirting, symbolizing, and competing, which was recognized by virtually all physicians in our sample. Failure of physicians to cluster process terms into transactional types may be interpreted in a variety of ways. One explanation is that the test instrument was faulty and did not allow the physicians enough choices to formulate problem patient types or that the intent of rating the process terms was not clear. Another explanation is that physicians in our sample can identify one set of processes occurring between themselves and the histrionic problem patient but, in general, do not identify problem patients by the processes that are occurring in the transactions.

Neither the age of the physician nor the length of time since completion of training had any significant influence on responses. We conclude that physicians form impressions of problem patients early in their training and this remains unchanged throughout their years of practice. The ways physicians learn to identify problem patients remain unclear but probably occur in early clinical experiences. Training in identification and management of transactions occurring between student and problem patient would be one implication for medical education.

From our study, physicians appear to identify problem patients on the basis of functional and changing presenting complaints plus psychiatric symptoms. This is followed by poor treatment outcome, by which time it would seem that many problems in the relationship between physician and problem patient will have become fixed. Neither party may recognize this until the relationship is strained by the patient's failure to improve. At that stage, the patient or the doctor may terminate the relationship and the patient will move on to another physician to reenact the chain of events. The physician may, in fact, end the relationship through a type of referral commonly called "dumping."

Not all patients entering treatment with vague functional complaints and psychiatric symptoms will inevitably have a poor treatment outcome. In order to detect problem patients early, the physician must be aware of the nature of the transaction occurring between them. Physicians develop expectations as to how most patients respond to specific illnesses. When a patient falls outside these personal norms, the physician must alert him- or herself to the fact that the relationship may not proceed smoothly. Patients who seem to be more frustrating, dependent, or manipulative may indicate an impending physician—problem-patient relationship.

Although not the focus of this discussion, there are problem physicians as well as problem patients. Physicians with a low tolerance of frustration, dependency conflicts, and difficulty with control issues such as manipulation will "find" more problem patients than a physician without these difficulties. A few of the physicians in our sample indicated that they had seen thousands of problem patients. We suspect that a problem patient for them may not necessarily be a problem patient for most physicians.

Management

From this study some definite recommendations about the management of potential problem patients may be drawn.

1. Physicians should attempt to detect problem patients early by using familiar standards of physician-patient relationships to evaluate the patient relationships that appear to be increasingly frustrating, dependent, or manipulative.

2. When a patient gives an "organ recital" of multiple vague complaints, the physician should confine initial treatment to the one complaint that appears most treatable. An early success will be valuable in establishing a good relationship.

3. The physician should avoid dichotomizing patients' complaints into functional or organic etiologies, but rather should remain open to physical as well as psychosocial factors which may be obscured by the flood of vague complaints. The physician should promote awareness of the physical *and* psychosocial aspects of the illness to the patient.

4. The physician should make the patient aware of the physician's treatment goals and, if necessary, redefine the patient's treatment expectations more realistically. The physician should respond directly to patient expectations that the physician feels he/she cannot meet at all.

5. The physician should avoid early referrals to multiple specialists for apparently intractable problems. The problem patient will often view this as a measure of the physician's frustration and rejection.

It is well to remember Dr. Holmes' remarks and maintain a humanistic attitude to the person even if he or she is becoming a "problem patient." With the stress of perceived illness, all of us are less of what we wish and choose to be as noted in John Donne's verse:

> *In poverty, I lack but other things; in banishment, I lack but other men; but in sickness, I lack myself.*

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