The Difficult Patient and the Troubled Physician

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Some patient encounters may produce a variety of unpleasant reactions such as guilt, anger, frustration, or dissatisfaction in the physician. These troubling feelings may arise from various sources and can affect the outcome of medical care. Twelve community physicians who had similar training and practice locations evaluated a total of 722 patient encounters in their offices for the presence of these troubling emotions. Just under 30 percent of these encounters were troubling to the physician, but psychosocial problems and lower social class patients produced a significantly greater frequency of troubling. More experienced physicians had significantly fewer troubling encounters.

It is evident from the recent medical literature that unpleasant feelings are commonly evoked by patients in health care providers. The emotions have been variously labeled as hate, aversion, guilt, and malice but feelings like worry, anxiety, and frustration are also present. At times, these reactions can have a certain diagnostic and therapeutic value. Groves has suggested an empiric but useful set of behaviors for physicians based on their feelings towards patients.[1] Goodwin and others found that a group of patients with lupus erythematosus who were rated as "least-liked" by their physicians, also contained all the patients with signs of organic brain damage and suicidal ideation.[2] An editorial on that paper called this tool "Helpful Hate."[3]

At other times, these unpleasant feelings may trigger behaviors that may not benefit the physician-patient relationship. The results may be detrimental when a physician starts ". . . becoming angry or more demanding, referring the patient, pursuing further diagnostic studies, or trying new medication to display his own method of dealing with the frustration and guilt. . . ."[4]

But whether the outcome is beneficial or destructive, troubling encounters seem to arise from an interaction between the patient's problem or behavior and the physician. In many cases, the uncertainty inherent in the problem challenges the health care provider. As McWhinney points out, "A physician always likes to achieve certainty in the diagnosis. In many situations, however, certainty is not attainable. This is particularly so when dealing with undifferentiated medical problems, in which serious disorders are often indistinguishable from minor ones."[5] Several studies have shown that these undifferentiated problems are common. One researcher investigated 1000 consecutive ambulatory patients with puzzling or undiagnosable complaints who underwent a thorough history, physical examination, and laboratory investigation by specialists; over 81 percent had no organic illness.[6] Thirty percent of the ambulatory population in another study presented with puzzling problems. Among these patients, less than two thirds of their complaints were clearly and usefully diagnosed according to the traditional

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rules of medical evidence.[7] This struggle with uncertainty is succinctly summed up in Knight's triad.[8] Physicians may be caught between (1) uncertainty in current knowledge, (2) uncertainty from their own personal limitations, and (3) the inability to distinguish between these two uncertainties.

Physicians are also troubled by the behavior of patients. In a recent survey, over 450 general practitioners described their most troubling patients.[9] Those classic patients were perceived to be women who present with vague symptoms that are hard to label and treat; their visits tend to be inappropriate and time consuming; their personality lacks trust and gratefulness; and their behavior is seen as demanding, critical, and uncooperative. Other behaviors may provoke unpleasant feelings in the provider when, "The patient-child has to put himself in the hands of the powerful doctor-parent, and because he must become dependent and has fears of being so, often makes his needs felt by the doctor by showing pain, and distress in a forceful way, like a child screaming."[10]

Of course, the role of a physician confronted with the problems or behaviors of patients cannot be overlooked. One researcher found that physicians responded with increased anxiety and frustration, and decreased comfort and satisfaction when faced with patients of lower social classes, and those with psychosocial problems.[11] In another study, 53 physicians were asked to associate problem patients with a list of descriptive adjectives.[12] A significant relationship was found in the use of the terms "flirting," "competing," and "symbolizing" for problem patients. Since this response was the physicians' perception of the problem patient, the study tells us more about physicians than patients.

Regardless of the source of these troubling encounters, the current studies do not answer some questions that are relevant to the practicing clinician. Very little is known about: (1) the rate of troubling encounters; (2) factors in the problem, patient, or physician that influence this rate; and (3) factors in the problem, patient, or physician that influence the intensity of the troubled feeling.

This paper describes a study to answer these questions. Hopefully, this research will lead to an enhanced understanding of physicians' feelings as a diagnostic and therapeutic tool in the physician-patient relationship.

Methods

Twelve family physicians, all of whom had successfully completed residency training at the Department of Family Medicine, University of Western Ontario, and who practiced within 30 miles of London, Ontario, were chosen to participate in this study. The physicians were selected with an intentional stratification for the years of practice experience and sex. Selection began with the most recent graduates, and proceeded to the older graduates. An equal number of male and female physicians were recruited, and all physicians approached for this study agreed to participate. During the study, the physicians kept a record of each patient visit for three different periods of office activity on a special encounter form. This form had been developed during a fellowship and was shown to be a valid and reliable measure of troubling encounters.[13] After each patient encounter, the physician was asked to record four impressions on this form:

1. the age, sex, and perceived social class of the patient. (The perceived social class was simply the physician's impression of whether the patient was "white collar," "blue collar," or not classifiable);

2. the main problem for the encounter. (The visit was coded in one of three ways: organic if the majority of the visit dealt with physical ailments; psychosocial if the visit was primarily focused on problems of living and counseling; or mixed if both of the above modes were involved);

3. the presence or absence of a troubled feeling in the physician. ("Troubled" is defined as an unpleasant emotion during or after the encounter. The feeling may be, but is not limited to, emotions like worry, anxiety, guilt, anger.);

4. and if troubled, the intensity of this feeling on a one to five scale. (Each physician was asked to think of troubling patients who caused the most intense reaction, give them a five rating, and compare the intensity of feelings in the current encounters to that scale.)

Chi-square analysis was used to compare troubling encounters with the years practice experience, the sex of the physician, and the age, sex, and perceived social class of the patient. Possible interactions between confounding factors were identified using Pearson's correlations, and any interactions were controlled for in the analysis by using the Mantel-Haenszel chi-square test.[14]

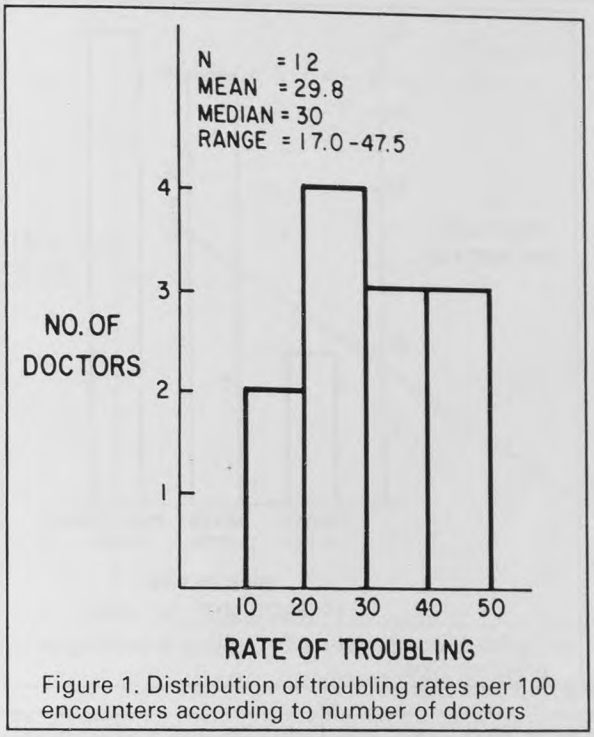

Figure 1. Distribution of troubling rates per 100 encounters according to number of doctors

Results

Half of the participating physicians (two males and four females) had had two or less years of practice experience after their residency training with a range of one to nine years of experience. A total of 722 unselected patient encounters were evaluated by the participating physicians and a group practice profile was developed: 69 percent of all the encounters were with female patients; three quarters of all patients were 44 years old or less; and almost half of the patients were perceived as having white collar status. By far, the majority of encounters were for predominately organic problems (70.8 percent); problems that were primarily psychosocial contributed only 6.8 percent of the total encounters; the remainder were mixed problems. In general, female physicians tended to have significantly more female patients, while older, more experienced physicians saw older patients.

There were 215 of the 722 encounters that were labeled as troubling, and the overall troubling rate for 12 trained family physicians was 29.8 troubling encounters per 100 office visits. Figure 1 displays the frequency distribution for the rate of troubling of the 12 physicians. The mean, the mode, and the median are all around 30 troubling encounters per 100 visits. However, this rate can be influenced by several important factors in the problem, the patient, and the physician. The important factor in the problem was the psychosocial aspect. The rate of troubling encounters was significantly higher for problems that were perceived to be predominately psychosocial or mixed, than for problems that were perceived to be primarily organic (Figure 2).

Of the three patient factors, social class and age significantly affected the rate of troubling. Physicians were troubled more often by encounters with patients who were perceived to be blue collar workers and who were older (Table 1). However, no relationship between the sex of the patient and the rate of troubling encounters could be found.

Like the sex of the patient, no association between the sex of the physician and rate of troubling could be found. Male physicians had an average troubling rate of 29.1 per 100 encounters and female physicians had a rate of 30.7 per 100 encounters ($P>.05$). Other than the sex of their patients, there were no other statistically significant differences between these two groups of physicians. However, there is a significant inverse correlation ($r = -.83$) between the years of prac-

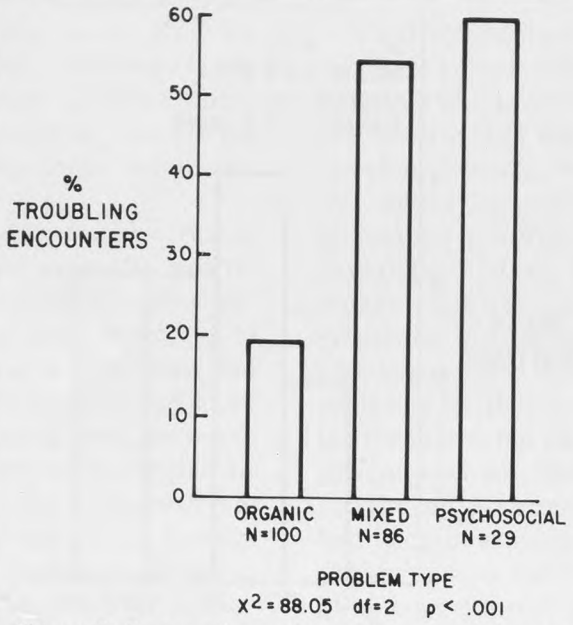

Figure 2. Comparison of troubling according to problem type

Table 1. Rate of Troubling According to Patient Factors

Patient Factor	Total Number of Patients	Rate of Troubling Per 100 visits	Significance
Age (years)			
0-14	157	16.6	$x^2=33.82$
15-44	379	27.7	$P<.001$
45-64	101	45.5	df=3
65+	82	43.9	
Age unknown*	3		
Sex			
Male	215	33.6	$x^2=1.06$
Female	486	29.4	$P>.05$
Sex unknown*	20		df=1
Social Class			
White Collar	329	25.9	$x^2=4.27$
Blue Collar and Unemployed	284	33.8	$P<.05$
Other or class unknown*	109		df=1

*Not used in the analysis of this patient factor

tice experience and the rate of troubling (Figure 3). The more experience the physicians have, the less likely they are to be troubled.

Finally, the intensity of the feeling of being troubled depended only on the sex of the physician; male physicians were significantly more troubled than female physicians (Table 2), even though the rate of troubling between them was the same. There was no relationship between intensity and the problem type, the age, sex, and social class of the patient, or the years of practice experience of the physician.

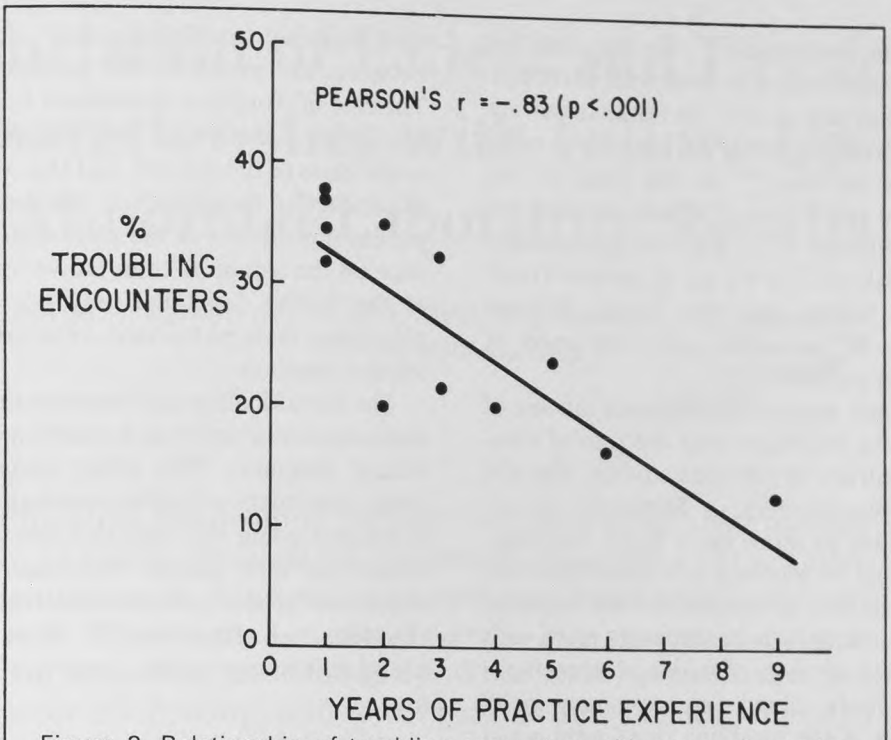

Figure 3. Relationship of troubling encounters with years of practice experience for each participating physician

Table 2. Association of Intensity of Troubling and Sex of the Physicians

Physician Factors	Number of Troubling Encounters	% High Intensity*	Significance
Sex			
Male	114	53.5	$x^2=11.37$
Female	87	28.7	$P<.001$
Intensity unknown	14		

*High intensity was a rating of 3 or more on a scale of 1 to 5

Discussion

All participating family physicians were residency trained, certificated by the Canadian College of Family Physicians, and had been in the London area since starting practice. The findings in this study will not necessarily apply to graduates of other programs, non-residency trained physicians, or those who are mobile.

The strong, positive relationship between psychosocial problems and troubling encounters was expected. Dungal found a similar association and Brennan used the ease of handling psychosocial problems as a measure of physician satisfaction[11,15] The association of social class and troubling encounters has also been found in other studies. When Stimson did a retrospective survey of general practitioners in England, the occupation of their patients was mentioned along with other reasons for feeling troubled.[9]

Although the association between psychosocial problems and troubling is clear, the reasons for this relationship are not. Perhaps, as one British physician points out, "The doctor may feel annoyed that he is called upon to solve what are

essentially social problems. . . . He may feel that he is not only unqualified to deal with such matters, but that they are outside his terms of service and that it is unreasonable for his patients to make these demands on him."[16] At the base of this annoyance may rest a fear of failure. In these patients, the physician ". . . has the exceedingly complicated task of first trying to relieve symptoms, perhaps failing, and then having to cope with the resultant frustration, guilt, and anger of his own and his patients."[17]

The lack of any association between the sex of the patient or the physician and the rate of troubling seems contrary to previous studies. The 450 male general practitioners in Stimson's survey mentioned women as more likely to be troubling. This finding could be ascribed to a sexual bias that does not exist on this continent, but the explanation for this discrepancy probably rests more with overall frequency of visits of men and women patients. In this study, about twice as many visits were by women; if the troubling rates were equal for both sexes, twice as many women would be called troubling. In a retrospective questionnaire like the one used by Stimson, physicians may be more likely to remember women as troubling, because they cannot do rate adjustments in their head. The lack of association between sex and troubling seems true for patients and physicians alike, and may help ease some of the popular controversy about sexual biases in a male dominated profession.

There are several possible explanations for the significant inverse correlation between years of experience and troubling encounters. As physicians gain more experience and skills, they may become more confident, and feel less troubled. Or, patients who trouble physicians may also feel troubled themselves, and may seek out another physician with whom they are more comfortable. Finally, busy, experienced physicians may have less time to inquire about problems of living or other psychosocial problems that are concomitant with the presenting problem. Regardless of the reasons, the correlation is strong, and experience seems to play a role in troubling encounters.

Conclusions

Troubling encounters seem to arise from one or a combination of three main sources. The physician may feel troubled because of an interaction between the problem, the patient, and himself. The rate of troubling encounters is affected by the psychosocial nature of the problem, the age and social class of the patient, and the years of practice experience of the physician. Neither the sex of the patient nor the sex of the physician had any influence on the troubling rate. However, the intensity of the feeling depended only on the sex of the physician; male physicians experienced the more intense reaction.

The identification and enumeration of troubling encounters can serve as a useful measure of physicans' reactions. This study suggests that troubling encounters are quite common, and that residents just going into practice can expect a good number of their patient encounters to cause an unpleasant reaction. Some understanding of these reactions, and preparation for them can serve as a useful adjustment to the "real world" after training.

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