Patient Characteristics that Elicit Negative Responses from Family Physicians

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Responding anonymously to a questionnaire asking them to list medical conditions and social characteristics of patients that evoked negative responses, 439 family physicians specified 1,846 medical conditions and 1,519 social characteristics. Of the medical conditions, the largest category (60 percent) represented conditions for which medical treatment offered little or no likelihood of cure or alleviation. Of the social characteristics, the largest category (33 percent) involved behavior that violated the physician's personal norms, even though it had little or no bearing on the patient's health.

It appears that the responses accurately reflect the Protestant Ethic value system characteristic of Western Europe and the United States, but this constellation of values is accentuated in physicians by their selection and their professional training. Although negative responses to patient characteristics do not inevitably lead to inferior treatment of the negatively perceived patient, negative feelings might be reduced through changes in both the undergraduate and graduate levels of medical education.

It has been generally recognized that physicians, like other professionals, do not experience the same emotional response to all their "cases"; they react to certain illnesses and to certain types of patients with feelings of discomfort, distaste, or hostility that they do not experience when treating other illnesses or other types of patients.

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The relationship between negative attitudes and actual discriminatory behavior is not clear-cut, and patients who evoke negative responses from physicians do not inevitably receive substandard treatment. But because negative attitudes, regardless of whether they influence treatment, can have deleterious effects on both physician and patient, a number of efforts are under way in both undergraduate and postgraduate medical education to modify such attitudes, if not eliminate them entirely. If such efforts are to be effective, however, the specific patient characteristics that evoke negative responses need to be precisely identified.

Although negative feelings toward patients have been reported introspectively by physicians and medical students[1-5] and experientially by nurses

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and by patients,[6-7] relatively few studies have systematically identified both the patient characteristics that evoke such feelings and the physician characteristics that are associated with negative responses. Studies of physicians' negative feelings have taken several approaches, each of which has its own limitations and all of which have limitations that they share in common.

One type of study examines the ways in which physicians cope with "difficult" patients.[8-10] Such studies often fail to specify either the illness or other characteristics of patients that cause them to be perceived as "difficult"; hence, they fail to identify personal or social characteristics of either the patient or the physician that may contribute to the physician's perception of difficulty.

Another type of study examines physicians' negative attitudes toward a specific diagnostic category (eg, mental retardation[11]) or toward specific social characteristics of the patient (eg, seeking abortion[12,13]) and specifies the implications or consequences of such attitudes for the treatment of the patient. Such studies, by concentrating on one specific diagnostic category or social characteristic, do not provide an array of data broad enough to permit generalizations about why the negative feelings are aroused or about other medical conditions or social characteristics that might also arouse them.

A third type of study traces the experience of a group of patients with a specific medical condition (eg, kidney failure[14]) or social characteristic (eg, low income[15]) in order to discover whether this group encounters negative attitudes or discriminatory treatment at the hands of physicians and other providers of health care. These studies provide evidence that certain illnesses or certain social characteristics are, indeed, stigmatized, but because the studies are limited to a single condition or characteristic, they fail to identify the factors that distinguish them from nonstigmatized illnesses or characteristics.

One British study attempted to overcome these limitations by seeking to identify, through a questionnaire survey of physicians, the types of patients who cause them "the most trouble" and "the least trouble."[16] Although this study produced a substantial and useful response, it was beset by two limitations. First, as the author acknowledged, the term "trouble" was variously interpreted by the respondents. Second, the physician population consisted entirely of National Health Service physicians, whose motivations and attitudes may differ significantly from those of physicians working in other professional contexts.

The present study, like the foregoing one, attempts to identify specific patient characteristics that evoke negative responses from physicians. Instead of using the ambiguous word "trouble," however, the questionnaire more specifically queried each respondent about conditions arousing feelings of "discomfort, reluctance, or dislike."

Underlying the study were two assumptions: (1) the responses would not be idiosyncratic but would reflect some degree of consensus among physicians, and (2) the various "disliked" conditions and characteristics could be grouped into categories that relate to attitudes and values which physicians as a group hold strongly.

Methods

On a questionnaire to be filled out and returned anonymously each respondent was asked to list five diagnostic entities and five social characteristics of patients that aroused in him or her "feelings of discomfort, reluctance, or dislike." The only incentive provided the respondent for participating was the offer of a complimentary copy of the completed study. To preserve anonymity, a postcard was included for requesting the study.

The questionnaire was sent to a 66.7 percent random sample (1,000 practicing physicians) of the 1,493 current members of the Michigan Academy of Family Physicians. This group was chosen because family physicians presumably treat the broadest spectrum of patients and because the membership of the academy seemed reasonably representative of American family physicians with respect to age, rural-urban distribution, and type of practice and patient population.

Results

The total number of responses to the initial mailing and to a reminder mailing dispatched a month later was 450, a response rate of 45 percent. Only 9 of the 450 respondents listed no diagnostic or social items and stated that they experienced no negative feelings either toward any medical condi-

Table 1. Medical Conditions Negatively Perceived

	Number	Percent
Psychiatric conditions, mental illness	249	56.7
Alcoholism, drunkenness, alcohol abuse	245	55.8
Drug addiction, abuse, overdose	185	42.1
Obesity	147	33.5
Musculoskeletal pain, chronic back pain	121	27.6
Sexual behavior related conditions, including unwanted pregnancies; excluding homosexuality	115	26.2
Headaches	74	16.9
Malignancies, cancer, neoplasia	63	14.3
Hypochondriasis	54	12.3

Table 2. Social Characteristics Negatively Perceived

	Number	Percent
Dirty, smelly, poor hygiene	197	44.9
Aggressive, angry, hostile, passive-aggressive	114	26.0
Noncompliant	104	23.7
Demanding	91	20.7
Medicaid, welfare, and Workmen's Compensation patients and system abusers (not examinations)	87	19.8
Dishonest, lying, sneaky	57	13.0

tions or toward any social characteristics. Three respondents listed no items and simply provided the demographic data that the questionnaire requested, and 11 responded that they were retired.

The remaining 427 respondents specified both diagnostic categories and social characteristics of patients to which they responded negatively, although not all respondents listed the five of each that the questionnaire called for. In addition, some diagnostic entities (eg, alcoholism, homosexuality) were listed by some respondents as a medical condition and by others as a social characteristic. The perception of alcoholism, homosexuality, or obesity as a social characteristic or a medical condition is presumably related to the respondent's opinion as to whether its cause is somatic or environmental. But the categorization by some respondents of such entities as premarital pregnancy, child abuse, workmen's compensation cases, and malingering as medical conditions lends support to the contention that physicians tend to perceive a wide array of phenomena through a "medical window."

Tables 1 and 2 list, respectively, the medical conditions and the social characteristics specified by at least 10 percent of the respondents. Responses listed by fewer than 10 percent have been omitted because of space limitations. In compiling each of these tables, different responses that obviously signified the same condition have been combined: for example, "COPD" and "emphysema" were considered synonymous, and such responses as "dirty," "filthy," and "smelly" were combined under "poor personal hygiene." By means of this condensation process, 1,846 "medical" responses were reduced to 82 response categories, and 1,519 "social" responses to 74 response cate-

gories. Small distinctions, however, have been retained when they appear to be significant.

Two points are worth noting in connection with Tables 1 and 2. First, respondents specified more negatively perceived medical conditions than negatively perceived social characteristics. The mean number of responses for medical conditions was 4.2 compared with 3.5 for social characteristics. Second, there was a greater consensus on medical conditions than there was on social characteristics. Among the medical responses, two were specified by more than 50 percent of respondents and six by more than 25 percent; among the social responses, none was specified by 50 percent of the respondents and only two by more than 25 percent.

Tables 1 and 2 tabulate the responses in a raw form, which offers no clues as to their cause. In the hope of developing some meaningful patterns, both the medical and the social responses were organized into a series of categories, some of which were suggested by the literature on physician-patient relationships, others of which stem from sociological and anthropological research.

Tables 3 and 4 represent, respectively, attempts to recategorize the medical and social responses into a meaningful framework reflecting a basis for the responses. Judgment in relating specific responses to one or another of the categories is, of course, inevitably subjective, but it was based largely on the response data. For example, placement of alcoholism in a medical instead of a social category was dictated by the fact that 194 respondents considered it a "medical condition," whereas only 51 labeled it a "social characteristic."

It is possible, of course, that the responses might fit an entirely different set of categories, but such an alternative framework would be preferable only if it accounted for a larger percentage of the responses than the present one. The medical categories used in Table 3 account for 97.2 percent of the medical responses, and the social categories used in Table 4 account for 99.9 percent of the social responses.

Discussion

The relationship between prejudice (or negative attitudes) and overt discriminatory behavior is complex.[17] Prejudice has been found to be neither a necessary nor a sufficient condition for discrimination. A physician may, for example, dislike blacks intensely but nevertheless give them excellent medical care. Conversely, a physician who is entirely unprejudiced toward blacks may discriminate against that group if the institution of which he is a part practices discrimination. Thus, for example, the physician whose practice and hospital affiliation are located in an exclusively white suburb is in effect withholding his services from blacks, regardless of his own lack of prejudice.

Nevertheless, there is some evidence[7,10,13] to indicate that a physician with negative attitudes is more likely to withhold treatment from or to provide inferior treatment to the negatively perceived patient than a physician with neutral or positive attitudes. Furthermore, regardless of whether they directly affect the quality of patient care, negative attitudes seem to produce some psychic stress in physicians who hold them. (There was considerable anger reflected in some of the unsolicited comments that some respondents made in justifying or elaborating their listings of dislikes.) In any event, it would seem desirable to reduce these negative reactions, but before this can be accomplished, it is essential to identify their origins.

One possible explanation is that the negative reactions reflect the Protestant Ethic,* a value system characteristic of Western Europe and more particularly the United States. The relationship between the negative responses and this value system may be seen in the following listing in which the components of the Protestant Ethic as identified by anthropologists and sociologists[18] are linked with the categories under which the responses were organized:

1. *A strong faith in the ability of applied science (including medical science) to solve mankind's problems.* The responses grouped in Tables 3 and 4 under categories M1, M2, and S1 reflect the physician's frustration by illnesses or patient behaviors that negate or challenge this faith.

2. *A stress on hard work, self-sufficiency, and achievement.* Achievement is measured not only in terms of skillful performance but also in terms of economic success. Categories M2, M3, S1, S3, and S4 include responses to illnesses or patient behaviors that threaten the physician's self-

*The Protestant Ethic, so-called because it stemmed from Calvinism at the time of the Reformation, is no longer peculiar to Protestants but has become the dominant value system in almost all modern industrial societies.

Table 3. A Conceptual Framework For Responses On Medical Conditions (Total 1,846 responses)

	Number	Percent
M1—Conditions for Which No Cure Exists		
Malignancies, cancer, neoplasia	63	14.3
Severe mental or physical handicap	42	9.6
Chronic obstructive lung disease, emphysema, asthma	38	8.6
Geriatric patients, senility	34	7.7
Terminal states, premorbidity	24	5.5
"Insoluble problems"; "can't help"; wasting diseases	11	2.5
Others (under 10 mentions each)	11	
Total	223	
M2—Conditions with Low Probability of Cure		
Psychiatric conditions	249	56.7
Alcoholism	245	55.8
Drug abuse	185	42.1
Obesity	147	33.5
Cardiovascular disorders	30	6.8
Diabetes (controlled)	17	3.9
Arthritis, joint diseases	14	3.2
Others (under 10 mentions each)	15	
Total	900	
M3—Conditions Challenging Physician's Competence or Diagnostic Skill		
Back pain, musculoskeletal pain	121	27.6
Headache	74	16.9
Hypochondriasis	54	12.3
Fatigue, weakness, inanition	34	7.7
Gastrointestinal disorders	33	7.5
Chronic vague pains and functional problems	24	5.5
Skin disorders	19	4.3
Dizziness	19	4.3
Workmen's Compensation disability examinations	17	3.9
Psychosomatic diseases	14	3.2
Multiple physical problems	13	3.0
Nosebleed	10	2.3
Others (under 10 mentions each)	37	
Total	469	
M4—Conditions for Which Patient or Others Are Perceived Culpable		
Sexual behavior related (excluding impotence, homosexuality)	107	24.4
Child abuse and neglect	30	6.8
Accidents, motor vehicle; other trauma	23	5.2
Suicide attempts, self-inflicted injury	14	3.2
Others (under 10 mentions each)	29	
Total	203	
Unclassified	51	

Table 4. A Conceptual Framework For Responses On Social Characteristics (Total 1,518 responses)

	Number	Percent
S1—Characteristics That Threaten or Impede Therapy		
Noncompliant	104	23.7
Overbearing, arrogant, domineering	37	8.4
Habitual smoking, will not stop	34	7.7
Overdependent, timid	31	7.1
Suspicious, doubting, inquisitive	25	5.7
Apathetic, uninterested, negligent	20	4.6
Irresponsible, undisciplined	14	3.2
Helpless, self-destructive, self-pitying	14	3.2
Others (under 10 mentions each)	13	
Total	292	
S2—Characteristics Threatening Physician's Authority or Prestige		
Demanding	91	20.7
Complaining, whining, querulous	40	9.1
Manipulative	38	8.7
Snobbish, aloof, VIP, flaunting wealth	34	7.7
Doctor shoppers	29	6.6
Self-diagnosing, demanding specific treatment	26	5.9
Negativistic, impatient, never satisfied	20	4.6
Overfamiliar, gushing, obsequious	15	3.4
Litigation-prone, suit-conscious, medical sharpist	14	3.2
Medical faddist, health nut	11	2.5
Specialist or hospital oriented, wanting other opinions	10	2.3
Others (under 10 mentions each)	24	
Total	352	
S3—Characteristics Impeding Physician-Patient Communication		
Aggressive, angry, hostile, passive-aggressive	114	26.0
Dishonest, lying, deceptive, unreliable	57	13.0
Selfish, inconsiderate, egocentric	33	7.5
Garrulous, verbose, boring	27	6.1
Know-it-all, opinionated	26	5.9
Stupid, low intelligence, uneducated, ignorant	23	5.2
Immature, adolescent, emotional	6	1.4
Total	286	

sufficiency and achievement. Categories M4 and S5 consist mainly of negative reactions to patients who are themselves neither self-sufficient nor high achievers socially or economically. Responses in categories S1, S3, and S4 deal with patients who jeopardize the physician's professional or economic performance.

3. *Stoicism and persistence in the face of adversity, and an obligation to exert rational efforts to improve one's situation.* Categories M4, S1, S3, and S5 all include negative reactions against patients who are not stoical or rational or fail to make

Table 4. Continued

	Number	Percent
S4—Characteristics Impeding Physician's Economic Efficiency		
Nonpayers, deadbeats, chiselers	28	6.4
Misses appointments, habitually late	17	3.9
Brings long list of symptoms, extra patients	11	2.5
Others (under 10 mentions each)	17	
Total	78	
S5—Characteristics That Violate Physician's Personal Norms		
Dirty, smelly, poor hygiene	197	44.9
Welfare, Medicaid and Workmen's Compensation abusers and patients	87	19.8
Malingerers	40	9.1
Chronically unemployed, no ambition, lazy	30	6.8
Loud, rude, vulgar, foul language	24	5.5
Homosexuals, effeminate	24	5.5
Promiscuous, poor morals, seductive	18	4.1
Child behavior problems, spoiled brats	17	3.9
Religious bigots, fanatics	10	2.3
Others (under 10 mentions each)	52	
Total	499	
Unclassified	12	

(from the physician's point of view) persistent efforts to alleviate their plight.

4. *An emphasis on austerity, self-denial, self-discipline.* Most of the reactions included under categories M4 and S5 refer to patients who lack these characteristics.

5. *A high regard for the profession of medicine.* For decades both the general public and the medical profession have ranked "physician" as the profession highest in occupational prestige.[19] Category S2 includes reactions against patients who challenge this belief.

Although the foregoing values are widely held by the American population, especially by the middle class, they may be held with particular intensity by physicians for several reasons. Because they come from predominantly middle class families, most medical students are socialized to this value system from childhood. The value system is strongly reinforced, moreover, by an education system which regards strong adherence to the Protestant Ethic as essential for achieving the level of academic success necessary for admission to medical school. Medical school admissions committees, in turn, embody these values in their admissions criteria in the belief that those candidates who demonstrate them are most likely to be successful in medical school and subsequently in practice. The four years of medical schooling can do much to reinforce this value system.[20]

In fact, these values appear to be highly functional in a profession that requires (both during training and in practice) a high level of performance, often under adverse conditions, a high regard for scientific rationality, considerable self-discipline and self-denial, and a strong sense of self-sufficiency and autonomy, especially in the face of uncertain diagnoses and therapies. One consequence of this value system, however (as the response data indicate), is that those who adhere to it tend to show little tolerance for patients who violate it or, indeed, for themselves when faced with situations in which the values are not functional—as with the terminal patient, for example.

This intolerance for patients who violate the physician's personal standards of behavior is reflected in the finding that by far the largest category of negatively perceived social characteristics

(category S5), comprising 32.8 percent of the social responses, consists entirely of behavior that has no medical significance but was simply distasteful to the respondent. As categorized, medical conditions linked to behavior that is distasteful to the physician (category M4) account for only 11 percent of the responses, but if alcoholism, obesity, and drug abuse had been included under category M4 instead of M2, as could be justified, the percentage would have increased to 42.3 percent.

The physician's intolerance of what he perceived as his own or the profession's limitations (categories M1 and M2) accounted for 60.8 percent of the medical responses.

Attempts to eliminate or reduce the intolerance that is reflected in negative reactions to patients might proceed in two directions. First, medical schools might experiment with the admission of candidates who have a less tenacious hold on the value system described. Given the strong belief that the value system is functional, however, it seems very doubtful that those responsible for medical school admissions will attempt so radical a departure from tradition.

A second direction would involve the introduction into the medical curriculum of both didactic and clinical experiences specifically designed to help students understand both their own value orientation and the reasons why many, if not most, patients do not share it with the same intensity. Medical schools that have attempted this approach through courses with a strong anthropological and sociological orientation, systematic programs of sensitivity training, and clerkships that involve the student in all aspects of the community report some small success in reducing negative reactions,[21-23] although evaluations of these programs usually conclude that a change in admissions criteria would be more effective. Nevertheless, the effectiveness of medical school experiences in extinguishing negative reactions in students has been observed by almost every faculty member who has followed student progress through the traditional anatomy course.

If medical school experiences are effective in extinguishing these very common and often intense disgust reactions, it would seem that properly designed courses and clinical experiences could do much to reduce negative reactions toward patients who violate the students' value system and to clarify to students the circumstances under which a generally functional value system can become strongly dysfunctional.

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References

1. Cartwright A: Patients and Their Doctors. New York, Atherton Press, 1967, p 74
2. Dungal L: Physicians' responses to patients: A study of factors involved in the office interview. J Fam Pract 6:1065, 1978
3. Ford AB, Liske RE, Ort RS, Denton JC: The Doctor's Perspective: Physicians View Their Patients and Practice. Cleveland, Case Western Reserve University Press, 1967, p 84
4. Hornung CA, Massagli M: Primary-care physicians' affective orientation toward their patients. J Health Soc Behav 20:61, 1979
5. Martin W: Preferences for types of patients. In Merton RK, Reader GG, Kendall PL (eds): The Student Physician. Cambridge, Mass, Harvard University Press, 1957, p 189
6. Davis A, Horobin G: Medical Encounters. New York, St. Martin's Press, 1977
7. Lorber J: Good patients and problem patients. J Health Soc Behav 16:213, 1975
8. Groves JE: Taking care of the hateful patient. N Engl J Med 298:883, 1978
9. Kasteler J, Kane RL, Olsen DM, Thetford C: Issues underlying prevalence of doctor-shopping behavior. J Health Soc Behav 17:328, 1976
10. Lipsitt DR: Medical and psychiatric characteristics of "crocks." Psychiatr Med 1:15, 1970
11. Kelly NK, Menolascino FJ: Physicians' awareness and attitudes toward the retarded. Mental Retard 13(6):10, 1975
12. Nathanson CA, Becker MH: The influence of physicians' attitudes on abortion performance, patient management and professional fees. Fam Planning Perspec 9:158, 1977
13. Wolff JR, Nielson PE, Schiller PJ: Therapeutic abortion: Attitudes of medical personnel leading to complications in patient care. Am J Obstet Gynecol 110:730, 1971
14. Fox RC, Swazey JP: The Courage to Fail: A Social View of Organ Transplants and Dialysis, ed 2. Chicago, University of Chicago Press, 1978
15. Rushing WA, Miles S: Physicians, physicians' assistants and the social characteristics of patients in southern Appalachia. Med Care 15:1004, 1977
16. Stimson GV: General practitioners, "trouble" and types of patients. In Stacey M (ed): The Sociology of the National Health Service. Keele, England, University of Keele, 1976, p 43
17. Merton RK: Discrimination and the American creed. In MacIver RM (ed): Discrimination and National Welfare. New York, Harper & Row, 1949, p 99
18. Eitzen DS: In Conflict and Order. Boston, Allyn & Bacon, 1978, p 77
19. Hodge RW, Siegel PM, Rossi PH: Occupational prestige in the United States, 1925-63. Am J Sociol 52:286, 1964
20. Becker HS, Geer B, Hughes EC, Strauss A: Boys in White. Chicago, University of Chicago Press, 1961
21. Fletcher CR: Study of behavioral science teaching in schools of medicine. J Med Educ 49:188, 1974
22. Kauss DR, Robbins AS, Abrass I, et al: The long-term effectiveness of interpersonal skills training in medical schools. J Med Educ 55:595, 1980
23. Rezler AG: Attitude changes during medical school: A review of the literature. J Med Educ 49:1023, 1974