

# Medical Care and Demographic Characteristics of 'Difficult' Patients

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*This pilot study describes the medical care and demographic characteristics of "difficult" patients as compared with randomly selected patients of a community-based family practice center. Ninety-two difficult patients were identified by asking physicians to indicate those patients whose care they considered difficult. Charts of 166 randomly selected patients were then compared with those of the difficult patients. The difficult patient group was older, more often divorced or widowed, and had a higher percentage of women than the random patient group. The difficult patient group also had more acute problems, chronic problems, medications, x-ray examinations, blood tests, physician referrals, and visits to the family practice center. After covariance analysis adjusting for age and sex, significant differences remained between the two groups for chronic problems, blood tests, medications, and visits to the family practice center. The two patient groups did not differ significantly in household composition, payment status, or provider continuity. The data suggest that, although there are different types of difficult patients, there may be certain medical and demographic features that are common to many of them. Many physicians suspect that difficult patients suffer from a "thick-chart syndrome," a syndrome confirmed to exist by this study.*

Patients known as "difficult" have been studied with regard to their personality traits and physician interactions, but little is known of their demographic or medical care characteristics. Difficult patients have been described mostly from a psychiatric or deviant personality perspective,<sup>1-3</sup> as if being a problem patient is solely the patient's problem. Little is known about why physicians label certain patients as difficult or how this labeling may influence the care of the patient. This study was designed to test certain generally accepted assumptions about the demographic and medical care characteristics of these patients, specifically the medical care utilization of these patients. The differences between randomly selected patients and difficult patients with regard to their medical care and demographic characteristics can be used as a starting point for further research regarding the reasons both patient and physician behaviors might lead to the labeling of patients as difficult.

## METHODS

An audit form was designed to collect quantifiable demographic and medical care data found in the usual outpatient chart. The form was tested and revised to ensure uniform measurement of the selected variables and to ensure that all measurable variables in the chart were included. Audit reliability was checked by separate reviewers and found to be acceptable. Charts were collected from a university-operated family practice center in a community with a population of about 10,000. This faculty-resident practice is community based and mimics a private practice in its patient population demographic characteristics. (For this study, random patients are chosen as a control group because the definition of a population of not difficult patients is unclear. Are these patients necessarily satisfying or not frustrating? Until more is known about what makes patients difficult, the selection of an appropriate control group for research remains a problem.) The random patient sample (n = 200) was generated by selecting two charts at random from each of the 100 subsections of the medical records system. The difficult patient sample (n = 95) was generated by asking faculty and senior resident physicians in the practice to choose up to five patients that they considered to be difficult from a list of all the

Submitted, revised, March 10, 1987.

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**TABLE 1. MEDICAL CARE AND DEMOGRAPHIC CHARACTERISTICS OF RANDOM VS DIFFICULT PATIENTS**

Characteristic	Random Patients (n = 166)	Difficult Patients (n = 92)	P
Age (years)	37	53	<.001
Sex (% female)	60	72	<.07
Marital status (%)			
Married	52	47	<.005
Not now married	11	27	
Never married	29	16	
Unknown	7	10	
Payment status (%)			
Medicare	2	7	NS
Commercial	78	74	
Self-paying	10	8	
Medicaid	4	10	
Other/unknown	6	2	
Adults in household*	2.1	1.9	NS
Children in household*	1.2	0.9	NS
Acute problems	4.3	5.5	<.02
Chronic problems	2.2	4.1	<.001
Chronic medications	1.9	4.0	<.001
After-hours visits	2.7	3.8	NS
X-ray examinations	4.3	6.8	<.005
Blood tests	4.7	8.1	<.003
Physician referrals	5.7	8.8	<.01
Total visits (from 1/82)	11	21	<.005
Visits per year (from 1/82)**	3.7	6.8	<.005
Provider continuity (%) (for visits from 1/82-7/85)	56	59	NS

NS, not significant  
 \* Random n = 79, difficult n = 34  
 \*\* Random n = 160, difficult n = 87

patients they had seen in the past two weeks. The word "difficult" was not defined for the physicians in this study because of a desire to not bias the study with a personal or stereotypical definition of the difficult patient. Physicians were allowed to define for themselves which patients they considered to be difficult. Follow-up open-ended interviews with all physicians indicated that all patients selected were picked because of the physician's frustration with the physician-patient relationship or the patient's health care-seeking behavior. None were selected because of medical complexity or difficulty.

The random and difficult patient charts were audited and coded with regard to the patient's date of birth; sex; payment or insurance status; marital status; household composition; date of first visit; date of last visit; number of acute problems; number of chronic problems; number of chronic medications, after-hours visits, x-ray examinations, blood tests, and physician referrals; and provider

continuity (for total visits made from January 1982 to July 1985). Certain characteristics were specifically defined for the purposes of this study. The number of blood tests counted was the number of discrete results listed on the laboratory data sheet. The number of physician referrals was measured by counting the correspondence to or from separate physicians concerning the patient.

To assure comparability of the two samples and to allow meaningful computation of continuity and time-related measures, all analyses were restricted to patients who had visited the clinic at least two times. With this restriction, the sample sizes of the two groups were 92 for the difficult patient group and 166 for the random group. Two-way cross-tabulations were used to compare categorical data, such as sex and payment status. The significance of the comparisons was assessed with the chi-square test. A two-sample Student's *t* test was used to compare analytical data such as the number of acute problems or the patient's age. Additionally, covariance analyses were performed on the analytic variables to compare the random and difficult patient groups, adjusting for age (with linear and quadratic terms in the model) and sex.

**RESULTS**

The comparisons without adjusting for age or sex are summarized in Table 1. The difficult patient group was older, more often divorced or widowed, and had a higher percentage of women than the random patient group. The difficult patient group also had more acute problems, chronic problems, chronic medications, x-ray examinations, blood tests, physician referrals, and visits to the family practice center. The two patient groups did not differ significantly in after-hours visits, household composition, payment status, or provider continuity. As age or sex might explain many of the differences between the two groups found by univariate analysis, covariant analysis was done, adjusting for age and sex. The results are displayed in Table 2. Significant differences persisted for a number of chronic problems, chronic medications, blood tests, total visits, and visits per year to the family practice center.

**DISCUSSION**

Physician anecdotes about difficult patients have described a thick-chart syndrome. In this study the increased utilization of medical care resources created on the average a much thicker chart for each patient. The difficult patient was usually older than the random patient. There was an almost total absence of children in the difficult patient

group compared with the random patient group. Children are evidently rarely considered frustrating or difficult. Because elderly patients often have many more health problems than younger patients (although they may report fewer complaints per problem), either the increased rate of complaint or the lower level of health may be a source of frustration to the physician, leading to labeling the patient "difficult." Since physicians reported that patients were not selected for this study due to medical complexity, presumably physicians are frustrated with an increased rate of complaints or with the care of patients with many chronic problems that are usually not cured. As differences in number of chronic problems and number of visits persisted after adjusting for age and sex, the health care-seeking behavior of patients and the chronic nature of the patient's illness that never is cured, rather than the age of the patient, may be what cause physicians to feel frustrated.

The greater number of divorced or widowed patients in the difficult patient group suggests that lesser levels of social support predisposed the patient to be perceived as difficult. While household composition did not differ significantly between the two groups, the specific types of social network support may be important. For example, elderly patients living with an adult child may be less well supported and make greater demands on (ie, make more visits to) the medical care system than do elderly patients living with a spouse. Family determinants of utilization and health care-seeking behavior are strong,<sup>4</sup> and excessive utilization may lead to being labeled difficult. This issue requires further study.

With regard to medical care for patients labeled as difficult, physicians saw the patient more frequently, ordered more tests, prescribed more medication, and made more referrals than for randomly selected patients. Difficult patients had significantly more acute and chronic problem diagnoses than random patients, which may have contributed to their increased utilization of such medical care resources as medications, laboratory tests, x-ray procedures, and physician referrals. It was interesting that, despite the difficult patient label and the increased referral rate, difficult patients did not differ significantly from the random patients in provider continuity. One might expect a pass-the-patient style of care, but such an approach was not seen in this study. A simple measure of continuity was used, the percentage of total visits made to the dominant or primary provider, but more complex measures<sup>5,6</sup> would likely show the same result. Apparently, physicians and difficult patients are about as committed and connected to one another as are physicians and other patients not so labeled. After adjusting for age and sex, random and difficult patients differed with regard to chronic problems but not to acute problems. A source of frustration to physicians may be seeing patients frequently and feeling

**TABLE 2. COVARIANCE ANALYSIS—ADJUSTING FOR AGE AND SEX OF MEDICAL CARE AND DEMOGRAPHIC CHARACTERISTICS OF RANDOM VS DIFFICULT PATIENTS**

Characteristic	n = 258*	
	Estimated Difference Difficult—Random	P
Acute problems	.24	NS
Chronic problems	.63	<.05
Chronic medications	.83	<.02
After-hours visits	1.3	NS
X-ray examinations	.30	NS
Blood tests	1.8	<.01
Physician referrals	.74	NS
Total visits (from 1/82)	7.4	<.0001
Visits per year (from 1/82)**	3.7	<.002
Provider continuity (%) (for visits from 1/82)	2.9	NS

NS = not significant  
 \* Random n = 166, difficult n = 92  
 \*\* Random n = 160, difficult n = 87

unable to reach any closure in their acute medical problem solving.

Past studies of difficult patients have emphasized different personality types that caused difficulties in the physician-patient interaction. The data from this study suggest that all of these personality types may have underlying interpersonal or communication features that result in certain common demographic and medical care characteristics. This finding supports the hypothesized notion that being a difficult patient is not a patient problem that should appear on the chart's problem list. A more accurate designation might be to describe a generic difficult physician-patient relationship<sup>1,7</sup> that involves many different physician and patient personalities but has certain generic demographic features and medical care outcomes. The authors are currently pursuing this issue with studies that more clearly delineate behaviors and characteristics of patients perceived to be difficult, and how these behaviors are associated with certain physician characteristics.

This study was limited by the usual inadequacies of chart audits: incomplete data sets, variables difficult or impossible to quantify, and discrepancies between actual and charted care. A high level of confidence exists, however, about the high proportion of total care captured by this chart-audit technique because of the number of patient visits recorded for a 2.5-year (30-month) period of time. Random patients visited an average of 3.7 times per year. This rate approaches published utilization rates in national data sets.<sup>8</sup> Difficult patients sought care an average of 6.8 times per year, or nearly twice the national average.

A potential inadequacy, that of time standardization, proved not to exist. Certain variables such as the number

of medical problems, x-ray examinations, and referrals were measured from the time these were first recorded in the patient's chart. A potential bias is that the difficult patient group might have been treated at the family practice center for a longer period of time than the random patient group, so values for these variables might be artificially inflated. This bias was at most small. The average length of time the difficult and random patients received care was 130 and 116 months, respectively.

Several opportunities for further research are suggested by this study. Physicians in specialties other than family practice may find patients with different characteristics to be difficult. The reasons for the increased utilization of medical care resources by the difficult patient group might also be investigated, including a study of the financial costs of this overutilization. Recent studies of patient populations with characteristics similar to the difficult patient group of this study show that brief psychiatric interventions have a marked beneficial effect on overutilization behavior.<sup>9,10</sup> How might this intervention apply to the patients identified here? Are patients difficult because of undiagnosed psychiatric illness? Ultimately, this research might lead to a more careful delineation of patient and physician behaviors that may lead to a cycle of mutually unmet needs and expectations, increasing frustration, pejorative labeling, and unpleasant financial and legal ramifications.

## CONCLUSIONS

Physicians may have many reasons for classifying patients as "difficult," but those patients whom they so classify appear to have certain common medical care and demographic characteristics that distinguish them from

randomly selected patients. Patients labeled as difficult are older, more likely widowed or divorced, and have more problems, medications, tests, office visits, and physician referrals. Several of these differences persist when analyses are adjusted for age and sex. These findings have implications for further research and educational interventions designed to reveal the "difficult" patient as a problem of the physician-patient relationship, with attendant implications for physician behavior.

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