Physician and Patient Determinants of Difficult Physician-Patient Relationships

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In an effort to account for the effects of both physician and patient characteristics in understanding difficult physician-patient relationships, family physician participants in the Michigan Research Network, a practice-based research network in the state of Michigan, were assessed for their perceptions of "difficult" patients. Twenty-two family physicians responded to a mail survey in which they selected from among their respective practices a sample of patients whose care they considered to be particularly difficult. This sampling procedure resulted in a total of 205 difficult patients. Physicians' perceptions of these patients were obtained through ratings of the applicability of 40 behavioral and physical characteristics drawn from the literature. Factor analysis of these data resulted in the identification of two factors underlying physicians' perceptions of difficult patients: medical uncertainty, characterized by particularly vague, difficult to describe, undifferentiated medical problems; and interpersonal difficulty, reflected in a perceived abrasive behavioral style. In addition, physicians self-rated the importance of various motivations for practicing medicine. The top six ranked mean ratings indicate that the primary motivations for practicing medicine were satisfaction derived from solving medical problems and the desire to help people. The interaction of these physician and patient characteristics is offered as a partial explanation for the development of difficult physician-patient relationships.

The difficult physician-patient relationship can be of frequent concern to the practicing physician and to many patients as well. For the physician such relationships are characterized by patient encounters that result in negative feelings toward the patient and a perception of the patient as being "difficult."[1,2] Furthermore, the mutually frustrating nature of difficult physician-patient relationships can result in poor health care delivery and ultimately in patient dissatisfaction. This undesirable outcome may prove medically, socially, financially, and legally detrimental to the physician's practice.

Unfortunately, there is little in the medical literature that would help physicians better understand the interpersonal dynamics of a difficult physician-patient relationship. Similarly, there is little help for educators who wish to teach students and residents how to deal better with such relationships. The literature that is devoted to this topic focuses almost exclusively on the characteristics of patients who have been labeled as difficult. Much of it is anecdotal, in which physicians describe their personal experiences with patients who are difficult for the physicians. In addition, much of this literature originates from the specialty of psychiatry, which emphasizes the study of personality characteristics of so-called difficult patients, implying these patients have psychiatric or personality disorders that cause difficult physician-patient relationships.[3] Consequently, remedies are aimed at adapting physician behavior to cope with difficult patients,[4] for example, through improving interviewing skills, or to substitute more appropriate referral. In either case, the solution is based on the assumption that the patient is the root of the problem and the physician must do something with respect to the patient who is difficult.

The utility of an approach that focuses exclusively on understanding and adapting to the personal characteristics of difficult patients to deal with difficult physician-patient relationships is limited. Such an approach ignores the role of physicians in what is a dyadic relationship. Both phy-

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sician and patient bring to the clinical setting unique personal and social characteristics that may not be complementary. In fact, physician and patient characteristics may interact to produce both negative health and negative interpersonal outcomes. The dyadic nature of the physician-patient relationship requires the examination of both physician and patient characteristics,[5] particularly when this relationship is a difficult one.

The study reported here examined the characteristics of physicians and patients, as perceived by physicians who are involved in difficult physician-patient relationships. The data include physicians' self-evaluations as well as evaluations of their difficult patients. While the patient is viewed from the physician's perspective, this study is unique for its inclusion of physicians' self-evaluations. The specific aims of this study were to do the following:

1. Develop a descriptive model of the perceived characteristics, as reported by a group of practicing family physicians, of patients labeled as difficult
2. Describe the self-perceptions of this sample of physicians in terms of their motivations for practicing medicine
3. Examine how perceptions of self and patients might interact to produce a difficult physician-patient relationship

METHODS

Sample

The current sample of family physicians was drawn from the members of the Michigan Research Network (MIRNET), a practice-based research network of 25 family physicians with practices established throughout the state of Michigan. The survey achieved a response rate of 88 percent without follow-up. MIRNET is composed of residency-trained, board-certified family physicians in private practice who practice primarily in towns with populations of less than 50,000.

Instrument

Two questionnaires, both to be completed by the physician, were developed for this study. The first questionnaire focused on physician characteristics and self-ratings on motivations for practicing medicine. Items included in this questionnaire were drawn from past work identifying the usual motivations of physicians for practicing medicine.[6–8] Physicians rated the degree of importance of the 14 motivations for practicing medicine on a five-point scale. The values on this scale ranged from 1 (not at all important) to 5 (extremely important).

The second questionnaire focused on physicians' perceptions of difficult patients drawn from each practice. This questionnaire contained 40 statements about the patient's medical problems (eg, The patient's medical problems are difficult to solve), behavior (eg, The patient ignores my advice), and the effect the patient has on the physician (eg, The patient causes me to feel frustrated). These items were drawn from the literature focusing on difficult patient behavior.[3] Physicians rated these patients with respect to the degree of applicability of each of the 40 statements on a five-point scale. Values on this scale ranged from 1 (not at all applicable) to 5 (very applicable). In addition, a global rating of difficulty was made based on a referent. Physicians were requested to rate the difficult patients they selected in relation to all other difficult patients in their practice. Ratings were made on a scale that ranged from 1 (less difficult than usual difficult patients) to 5 (far more difficult than usual difficult patients). Physicians were also requested to note the sex of each patient they rated. In all cases the sex of the patient and the global rating of difficulty were noted prior to completion of the 40 statements.

Procedure

Each of the 25 members of MIRNET received a packet through the mail that consisted of a cover letter explaining the intent of the study, one physician questionnaire, ten copies of the difficult-patient questionnaire, and an addressed, postage-paid return envelope. Participants were instructed to complete the physician questionnaire and then to select one patient on each of ten consecutive practice days "whose care [they] experienced to be most difficult that day." Physicians were instructed to complete a difficult-patient questionnaire for each patient they selected.

Analysis

Multivariate techniques were applied in analyzing the 40 difficult patient items to construct a multidimensional model of physician's perceptions of the difficult patient. This multidimensional perspective was adopted as a data reduction and summary technique.

Four steps were taken during the analysis of physicians' perceptions of difficult patients. The aim of this analysis was to develop a general descriptive model of difficult patients in a family practice setting rather than a model specific to any one patient group. In the first step all difficult-patient questionnaire items on which sex differences emerged through univariate one-way analysis of variance (ANOVA) with sex as the two-level single factor were eliminated from subsequent analysis. This elimination

procedure was done to make the model as general (ie, non-sex-specific) as possible. In the second step, Pearson correlation coefficients between each of the remaining patient questionnaire items and the global measure of difficulty were calculated; items with coefficients less than 0.3 were eliminated from subsequent multivariate analysis. The cutoff of 0.3 was selected as a means of further reducing the number of items and for ensuring that construct-relevant items were included. In the third step, a correlation matrix was generated among the remaining items; one of two items with coefficients greater than 0.7 in this matrix was eliminated to avoid reciprocal causality among the items included in the final factor analytic solution. In the fourth step, a principal components analysis was conducted on all remaining items to identify the number of factors to extract. These same items were then factor analyzed and the resulting solution rotated utilizing the varimax algorithm.

TABLE 1. MOTIVATIONS FOR PRACTICING MEDICINE RANKED ACCORDING TO MEAN PHYSICIANS' RATINGS OF IMPORTANCE (N = 21)

Motives for Practicing Medicine	Rank	Mean	Standard Deviation
Desire to help people	1	4.38	.97
Enjoy solving problems	2	4.19	.93
Professional challenge	3	3.95	.80
Dedication to humankind	4	3.86	.91
Love of science	5	3.53	.81
Desire to pursue scientific knowledge	6	3.48	.87
Autonomy in decision making	6	3.48	1.08
Respect of other professionals	8	2.95	.92
Desire to gain control over illness	9	2.86	1.15
Financial reward	10	2.81	.68
Special identity	11	2.57	1.03
Expectations of parents, spouse, or family	11	2.43	1.36
Community prestige	12	2.33	1.02
Desire to gain control over death	13	2.14	1.20
Expectations of friends	14	2.10	1.22

RESULTS

Physician Characteristics

Of the 22 participating physicians, five were female, 16 were male, and all but one were board-certified. One physician did not provide an indication of his or her sex. The mean age of this sample of physicians is 35 (SD = 3.3) years. Male and female physicians did not differ with respect to age ($F = 1.7$, $df = 1, 19$, $P < .2$). Ten physicians practiced within communities with populations of less than 10,000, three physicians served populations of 10,000 to 50,000, one physician served a population of between 51,000 and 100,000, and seven physicians served populations of more than 100,000.

Physician Motivations

Table 1 displays motivations for practicing medicine ranked according to the mean self-ratings of importance. The top six ranked items indicate that a desire to help people and the intellectual and problem-solving challenges specific to the practice of medicine are the main motivations for practicing medicine among this sample of family physicians. In contrast, financial reward, social desirability, and prestige are relatively unimportant factors underlying the desire to practice medicine.

Characteristics of the Difficult Patient

This sample of physicians selected and rated from their respective practices a total of 205 difficult patients. Two thirds of this sample of difficult patients were female and one third were male. The mean global rating of difficulty for both male and female patients is 3.4 (SD = 1.0; $F = .04$, $df = 1,169$, $P < .9$). Both male and female patients were evenly distributed among 18 to 39 years, 40 to 69 years, and 70 years and older ($\chi^2 = 0.18$, $df = 2$, $P < .9$).

General Model of Physicians' Perceptions of "Difficult" Patients

Two factors emerged from the analysis of the combined male and female difficult patient data that together account for over 35 percent of the total variance. These factors and their item loadings are presented in Table 2.

The first factor to emerge appears to reflect physicians' frustration that is derived from the especially complex and apparently ambiguous nature of the medical problem associated with these patients. In addition, this factor reflects the difficult patient's inability to contribute toward a definition of the medical problem.

The second factor to emerge reflects the physician frustration that results from the difficult patient's behavior in response to the physician's advice, as well as the demands made by the patient upon the physician. Thus, it appears there are two sources of physicians' frustration with difficult patients: the apparent ambiguity of the medical problem (medical uncertainty) and the perceived abrasive behavioral style of the patient (interpersonal difficulty). Having the physicians' frustration item load on both (uncorrelated) factors suggests two things. The first is that physicians' frustration is the key affective result of treating difficult patients. The second is that physicians' frustration

TABLE 2. FACTORS AND ITEM LOADINGS FOR THE GENERAL MODEL OF DIFFICULT PATIENTS (N = 205)

Medical Uncertainty	Item Loadings	Interpersonal Difficulty	Item Loadings
The patient's medical problems are difficult to solve	.71	The patient demands things of me that I cannot give	.61
The patient has many problems	.63	The patient ignores my advice	.57
The patient causes me to feel frustrated	.49	The patient causes me to feel frustrated	.43
The patient is unable to clearly tell me his/her problem	.42		
The patient ignores my advice	.36		
The patient's complaints have no apparent cause	.32		
Percent variance accounted for by each factor	20.8%		14.5%

can result from medical uncertainty and interpersonal difficulty separately or in combination.

DISCUSSION

The results of the factor analysis indicate there are two domains of difficult patient characteristics that act as sources of frustration for physicians: the uncertainty of the medical problem and a perception of the patient as having an abrasive behavioral style. These two perceptual components of difficult patients are in apparent conflict with the chief motivations for practicing medicine reported by this sample of physicians. These physicians report that medical problem solving, a sense of closure, and a desire to help people are the principal motivations for practicing medicine. The unusually complex and ambiguous nature of the medical problem, as well as the perceived abrasive style of behavior associated with these difficult patients, however, denies the physician satisfaction from the practice of medicine. A model of difficult physician-patient relationships emerges then in which such relationships are marked by the unmet expectations of both physicians and patients and are reflected by low levels of both physician and patient satisfaction.

The emergence of medical uncertainty and interpersonal difficulty as factors descriptive of difficult patients is consistent with other work examining the characteristics of patients labeled as difficult. Crutcher and Bass[9] described two basic characteristics of difficult patients found in a review of the literature. The first is based on the assumption that physicians feel the need for certainty[10] in managing patients' problems, and that uncertainty in the diagnosis causes difficulty for the physician. Toward this end they cite a number of studies documenting the high incidence of undifferentiated diagnoses that can be found in a variety of patient care settings. None of these studies, however, differentiated difficult from nondifficult patients. Consistent with the relevance of undifferentiated diagnoses to difficult patient status, John et al[11] found that patients who were identified by physicians as being difficult required more medical care than matched controls who were not identified as being difficult. In this study, the charts of both difficult and nondifficult patients were audited. It was found that difficult patients made more office visits, underwent more laboratory tests, and received more x-ray examinations and physician referrals than controls.

The second patient characteristic identified by Crutcher and Bass is the difficulty physicians have in dealing with the patient's behavior. Citing a study of general practitioners' descriptions of troubling patients by Stimson,[12] Crutcher and Bass conclude that such patients behave in ways that show no appreciation of the difficulty of the medical problem the physician is faced with or the effort the physician has gone through in trying to deal effectively with it. Indeed, their own study of troubling encounters between physicians and difficult patients suggests that physicians attribute their difficulty to patient characteristics that are both medical and psychosocial in nature.

No doubt patients with complex and ambiguous medical problems alone would be characterized as being difficult. Without an accompanying perceived abrasive behavioral style, however, such a reference would most likely be attributed to the medical problem as a difficult medical case. Alternatively, patients with relatively simple or acute medical problems whose behavioral style the physician finds abrasive are also likely to be labeled as difficult. With infrequent contact or with problems that are readily solved, however, these patients are not likely to be a major source of difficulty for the physician. A patient is unlikely to be labeled as difficult or particularly troublesome based on either one of these factors alone. The patients who present with complex and ambiguous medical problems in combination with a perceived abrasive behavioral style are those who characterize this sample of difficult patients.

A few points about these results should be noted here. The purpose of the multivariate analysis was to construct a general model of physicians' perceptions of difficult patients in a family practice setting. Thus, factors potentially relevant to physicians' perceptions of difficult patients, such as race or socioeconomic status, were viewed as topics

TABLE 3. ITEMS ELIMINATED FROM STEP 2 OF MULTIVARIATE ANALYSIS BASED ON SEX*

Items Eliminated	Male Patients		Female Patients	
	Mean	SD	Mean	SD
Seeks disability or compensation benefits that are not deserved	1.83	1.32	1.37	.78
Pursues remedies that are quackery	1.55	1.14	1.28	.58
Is too emotional	1.72	1.08	2.4	1.28
Has religious/personal beliefs that interfere with proper medical treatment	1.06	.25	1.5	1.02
Symptoms change frequently	1.45	.8	2.0	1.13

** All items differ significantly at or less than P = .04*
SD—Standard deviation

for study in a prospective fashion utilizing the current results as a guide in selecting appropriate items for analysis. Although male and female patients differ on some items, they too are not germane to the purpose of this study. These items are displayed in Table 3. While it is likely that the composition of the final factor analysis would change if these items were included, the results would be confounded because of the sex specificity of the items in Table 3. Finally, while the percent of variance accounted for by the model appears low (35 percent), its magnitude is along the lines of results in other field studies utilizing factor analysis.

Despite these precautions, the current results would appear to have significant educational implications for physicians. Physicians clearly have greater responsibility for rectifying faulty physician-patient relationships than do patients. Awareness of personal characteristics that underlie affective responses to certain difficult patients along with the development of skills for recognizing and understanding this process can aid in the prevention of difficult physician-patient relationships. In addition, the prevention of difficult physician-patient relationships appears to require that physicians (1) improve communication skills for understanding patient needs and expectations, (2) further develop interviewing skills for taking difficult medical histories,[4] (3) develop better patient rapport skills for dealing with adverse patient behavior, and (4) improve their medical problem-solving skills for dealing with particularly vague symptom complexes, with particular attention to the possibility of undiagnosed depression and common somatiform disorders.[13]

SUMMARY

It is important to reiterate that in this study the patients themselves are not difficult. Rather, physician-patient relationships can be and frequently are difficult. This study has illustrated how physician and patient expectations can interact in such a way as to produce mutually negative outcomes under conditions of extreme medical uncertainty and interpersonal difficulty. Recognition of the physician's role in difficult physician-patient relationships and the factors underlying the attribution of difficult status to a patient helps identify avenues through which physicians can work to rectify such relationships. This study presents a descriptive model of a difficult physician-patient relationship, identifying physician and patient characteristics that may underlie its development. Future research might investigate the effect of these physician and patient characteristics on the physician-patient relationship in a prospective fashion so that further validity can be applied to these findings.

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