EXPERIENCED FAMILY PHYSICIANS' VIEWS OF DIFFICULT AND TYPICAL PATIENTS

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Abstract

Background/Objectives. Despite extensive evidence of physician frustration with "difficult" patients, we have no comparable information about physician empathy. This study investigated whether, in a population of experienced family physicians, there would be measurable differences between difficult and typical patients in terms of physician self-reported frustration and empathy. **Methods.** The study used a modified repeated measures survey design of 175 family physicians who were asked to describe emotional reactions to difficult and typical patients. **Results.** Frustration and empathy were negatively correlated. Physicians rated difficult patients as significantly more frustrating than typical patients, but there was no significant difference in physicians' self-perceived empathy. Predictors of difficult versus typical patients included presence of somatization, psychological disorder, and less time in physician's practice. **Conclusion.** While family physicians easily identify frustration toward difficult patients, overall their empathy toward difficult patients does not differ significantly from that experienced toward typical patients.

“Difficult” patients have long been recognized as a problem in health care (1,2). Patients perceived as difficult frustrate their physicians (3-6). They are often high utilizers of health care (7,8), and are frequently characterized by the presence of various psychological (9) and personality disorders (10), multiple medically unexplained somatic symptoms (11,12), and abrasive personalities (13). They also tend to have poorer functional status, more unmet expectations, less satisfaction with care, and perceived lack of control over their illness (14,15). It can be difficult to change the interactions of these patients and their physicians (16), although a variety of models and strategies have been developed from cognitive behavioral approaches to antidepressant drug therapy (17-19).

Despite ample evidence of physician frustration with such patients, we have little information about whether primary care providers are actually less empathic toward “difficult” as compared to “typical” patients. The presence of empathy could be important in these patient encounters, not only because it is a key component of professionalism generally (20), but because it might act as an “antidote” to physician frustration. In other words, interactions that recognize the patient’s perspective and are curious about the patient’s experience (21-23) may exert an ameliorating influence on physician feelings of frustration and discomfort. The purpose of this study was to determine whether experienced family physicians differentiated between difficult and typical patients in terms of their own emotional responses to these patients; and to determine predictors of empathy and frustration in this population of family physicians. Specifically, the study investigated whether, in a population of experienced primary care physicians, there were measurable differences between perceived “difficult” and

"typical" patients in terms of physician self-reported frustration and empathy. The study hypothesized that physician subjects would express more frustration and less empathy toward patients they perceived as difficult. Further, we hypothesized that frustration and empathy would be inversely correlated and differentially related to a number of diagnostic and demographic variables.

Method

The study used a modified repeated-measures design to compare physician self-assessment in response to "difficult" and "typical" patients on the dimensions of frustration and empathy. The study employed a survey methodology. Subjects were 175 family physicians identified through a mailing list of current clinical faculty in the Department of Family Medicine, as well as former residents practicing locally, who were mailed a survey packet. The packet included an introductory letter describing the study and inviting the recipient's participation; a questionnaire; and a consent form. All materials, as well as the study design, received IRB approval.

The questionnaire asked half of the subjects to think about a "typical" and half to think about a "difficult" patient in their practice, then answer questions describing patient characteristics and their reactions to this patient. In order not to bias the respondent, we did not provide definitions or examples of the terms "difficult" and "typical." The physician could decline to participate simply by not returning the questionnaire. Physicians who did not respond within a month period were sent a second follow-up mailing, again requesting their participation. Three months later, those physicians who did return a completed questionnaire were sent a second questionnaire identical to the first, but now asking them to describe their reactions to the "opposite" patient condition

(i.e., if they first described a “typical” patient, they would now describe a “difficult” patient, and vice-versa).

Measures. The survey elicited information about the imagined patient’s sex, age, marital status, employment status, primary diagnoses, and time in physician’s practice. Patient diagnoses were classified by the author as follows: Psychological disorders (e.g., depression, anxiety, substance, abuse, personality disorders); symptoms/diagnoses related to somatization (i.e., medically unexplained symptoms or symptoms associated with stress; psychophysiological conditions such as irritable bowel syndrome, tension headache, or pain syndromes); serious chronic illness (i.e., diabetes, hypertension, cardiac disease, cancer); or other. Respondents were limited to listing 3 diagnoses per patient. The survey also obtained information about the physician’s sex, age, ethnicity, years in practice, number of patients seen per half-day, and type of practice (managed care, fee for service).

In addition, two measures were used to assess physician frustration and physician empathy in relation to the imagined patient. The Difficult Doctor-Patient Relationship Questionnaire (DDPRQ) is a well-validated, reliable instrument measuring physician frustration. Typical items inquire about how frustrating a specific patient feels, the level of enthusiasm of the physician, how much the physician is looking forward to the next visit, and whether the clinician secretly hopes the patient will not return. In its original form, the DDPRQ reported an alpha reliability of .96. Scores were not related to number of medical diagnoses, but were associated with somatization, personality and psychiatric disorders. The 10-item version used in this study (10) had an R2 of .96 with the original

instrument and an internal consistency reliability (Cronbach's alpha) of .88. In this study, internal reliability was .86.

The 10-item empathy scale was based on the Empathy Construct Rating Scale (24). The ECRS has been demonstrated to have high internal consistency (alpha reliability = .92), content validity, and discriminant validity. Further, results of a study to determine the measure's construct validity (25) concluded that "empathy cannot be divided meaningfully into subscales," but must be measured as a whole. The original instrument of 84 items and an earlier modification of 36 items with an internal reliability coefficient of .89 (26) were both judged to be too long for inclusion in this type of survey study. Instead, a modified 10 item-scale was used. The internal reliability alpha for these items was .92. Typical items include self-assessments of ability to place oneself in the patient's shoes, ability to feel some of the emotions that the patient experiences, and checking to see if one's understanding of the patient is valid.

Data analysis. Depending on the nature of the variable and the statistical question asked, data were analyzed using paired t-tests (with the Bonferroni correction when necessary), analysis of variance, chi-square, and backward stepwise logistic regression. The dependent variables in the regression analyses were frustration and empathy; the independent variables entered were all physician and patient demographic and diagnostic variables. Variables that did not contribute significantly to the overall variance of the model were eliminated in stepwise fashion, until a best fit was achieved.

Results

Response rate. Of the initial 175 packets mailed, seven physicians stated they did not have continuity practices or were no longer in practice, and twenty forms were

received marked "return to sender," for a combined total of 148 viable forms. A total of 91 physicians returned completed questionnaires for both conditions, for a response rate of 61.5%. Mail surveys of physicians average a response rate of approximately 50% (27,28). Our somewhat higher rate may be attributable to the fact that all physicians surveyed currently or in the past had had some connection with the department sponsoring the survey.

Physician characteristics. The responding physicians were mostly male, middle-aged, and non-Hispanic white. The majority had been in practice over 10 years, and most currently practiced in a managed care environment with high patient volume (Table 1).

Patient characteristics. Physicians described both difficult and typical patients as primarily female, middle-aged, and non-Hispanic white. Difficult patients were described as unemployed or on disability significantly more often than were typical patients. They were also significantly more likely to be single or divorced. Difficult patients tended to have been in the physician's practice for a slightly shorter period of time (see Table 2).

Physicians reported over half of their difficult patients as having chronic illnesses; psychological disorders; and some symptoms/diagnoses associated with somatization. Physicians reported *more* typical patients having a chronic medical problem, but less than half having a psychological disorder, and a small number diagnosed with somatization. The mean number of chronic, psychological, and somatizing conditions diagnosed per both difficult and typical patients was similar. However, over half of the difficult patients had three or more diagnoses* in these three categories compared to only about a third of typical patients (see Table 2).

*Despite study instructions limiting number of diagnoses per patient to three, 8 respondents listed between 4-5 when rating difficult patients; no typical patients received more than three diagnoses.

Relationship between frustration and empathy measures. Frustration and empathy were moderately and negatively correlated (r= -.33; p=.001). Neither empathy nor frustration scores were related to order of receipt.

Differences in physician perceptions of difficult and typical patients. Physicians rated difficult patients as significantly more frustrating than typical patients (means = 3.27 (sd=.61) vs. 2.61 (sd=.74); t=5.51; p=.0001). Disconfirming the study's second hypothesis, there was no significant difference in physicians' self-perceived empathy toward difficult and typical patients (means = 3.96 (sd=.66) vs. 4.04 (sd=.43)). However, physicians rated their empathy toward difficult patients as significantly lower on 6 of the 10 items (see Table 3).

Differences between difficult and typical patients. Difficult patients were more likely to be on disability (p<.0001), to be unemployed (p<.0001), to be single (p=.02) or divorced (p=.03), and to have been under the physician's care for a shorter period of time (p=.0008). In terms of diagnosis, difficult patients were more likely to have psychological disorders (t=3.03; p=.003) or somatization (t=4.44; p <.0001); although typical patients were more likely to have chronic illnesses (t=-3.00; p=.003). Patient or physician ethnicity, age, and gender or concordance of these variables (i.e., matching patient and physician on these dimensions) were nonsignificant, indicating that there was no ethnicity, age, or gender effect. Type of medical coverage (i.e., managed care, fee-for-service, mixed) was also not related to perceived patient difficulty or typicality. Interestingly, while physicians in both fee-for-service and managed care practice reported similar levels of frustration and empathy toward difficult patients, managed care physicians reported significantly more frustration (although not less empathy) toward

typical patients (managed care frustration mean=4.45; fee-for-service frustration mean=3.53, $p<.0001$).

Predictors of difficult vs. typical patients. Using a stepwise backward logistic regression and a dependent variable anchored in a difference score between difficult and typical patients, three variables made significant contributions to the overall variance: somatization, psychological disorder, and length of time with patient (Table 4)

Predictors of physician frustration toward difficult and typical patients. Backward stepwise logistic regression identified 4 predictors of frustration toward difficult patients: marital status, presence of chronic illness, length of time in the physician's practice, and patient volume (see Table 5). Using the same procedure, frustration toward typical patients was predicted by employment status (retired), presence of psychological disorder or somatization, and volume of patients seen (see Table 6).

Predictors of physician empathy toward difficult and typical patients. The only variable that predicted empathy toward difficult patients was presence of chronic illness ($p = .03$; R2=17.4%; F=2.07). Empathy toward typical patients was predicted by gender of patient (approached significance), gender of physician, absence of somatization, and number of patients seen (see Table 7).

Discussion

As predicted, experienced family physicians were reliably able to distinguish between their negative emotional reactions to difficult and to typical patients. Although on over half of the items assessing empathy they rated themselves as significantly lower toward difficult than toward typical patients, overall they believed themselves able to express the same level of empathy toward both categories of patients. This suggests that,

while family physicians easily identify difficult patients as frustrating, in their own eyes they are able to experience empathy toward both groups fairly equally.

Replicating earlier research, although certain demographic variables such as employment and marital status differentiated between difficult and typical patients, the main predictors of perceived patient difficulty were presence of psychological disorders and somatization. Family physicians receive specialized training to prepare them to deal with these diagnoses, which are common in primary care medicine. Perhaps such training does little to mitigate feelings of frustration and discomfort, but does improve their ability to empathize with such patients. Encouragingly, as difficult patients remained in the physician's practice, they were perceived as less difficult, suggesting that continuity care is an important element in management.

Interestingly, the experiences of physician frustration and empathy may not be uniform across categories of patients, as somewhat different variables predicted these emotions within the groups of difficult and typical patients. Physician frustration toward difficult patients was heightened by the patient's marital status (single), and by increased patient volume, a finding replicated in British research with general practitioners (29). Continuity care diminished frustration as did the *presence* of chronic illness. It is possible that, if difficult patients were diagnosed with a chronic medical condition, this "legitimized" their difficulty in their physician's eyes.

Among typical patients, the positive association of increased patient volume and increased frustration remained a constant. (While not significant, physicians in managed care settings reported consistently higher levels of frustration with typical patients than physicians in other settings). On the other hand, employment status (retired), not marital

status, increased physician frustration. Significantly, while among difficult patients presence of psychological disorders and/or somatization was apparently definitional, and did not contribute to predicting physician frustration, among typical patients the presence of these disorders was predictive.

We learned little about what predicts physician empathy for either group of patients. For difficult patients, increased empathy was associated with the presence of chronic illness, supporting the above theory that organic medical disease made it easier for physicians to be not only less frustrated but actually more understanding toward these difficult patients. Among typical patients, there were small negative contributions made by gender of both patient and physician, suggesting that female physicians may have slightly better empathy skills with typical patients, although both genders are apparently equally frustrated by difficult patients. It was also easier for physicians to feel empathy toward typical patients in the absence of somatization. Finally, higher patient volume made a negative contribution to physician empathy toward typical patients.

Limitations of this study include the following: The sample was restricted to one geographic area, and did not contain significant ethnic or age diversity among either physicians or patients. Secondly, because definitions for the terms "difficult" and "typical" were not provided, we have no way of knowing if the meanings physicians attached to the concepts were similar. Finally, the limited scope of our study excluded examination of other factors that might contribute to physician frustration and empathy, such as professional and personal satisfaction.

In summary, these experienced family physicians were significantly more frustrated by difficult than by typical patients, but overall were able to express similar

levels of empathy toward both groups. Despite training to prepare them to deal with psychological and psychosomatic patient complaints, they found the presence of these problems to be strongly associated with perceptions of difficulty. Frustration and empathy did not appear to be cross-situational constructs, but rather were predicted by different factors for difficult and typical patients. Patient volume, however, was a consistent predictor of both increased frustration and decreased empathy. Future research needs to investigate more deeply the relationship between physician frustration and empathy as they are expressed in clinical practice.

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Table 1
Physician Characteristics

Variable	Percentage	Mean	(sd)
Sex	73.6%		
Age		45.2	(8.6)
Ethnicity			
Non-Hispanic white	72.4%		
Asian	16.5%		
Hispanic	5.6%		
African-American	3.3%		
Other	2.2%		
Type of practice			
Managed care	67.3%		
Mixed model	19.4%		
Fee-for-service	13.3%		
Years in practice		14.3	(7.7)
Pt. volume/half-day		13.6	(5.0)

Table 2

Patient Characteristics

Variable	Percentage-D*	Percentage-T*	Mean (sd) –D*	Mean (sd)-T*
Sex	74.4	69.1		
Age			47.9 (13.3)	50.8 (12.2)
Ethnicity				
Non-Hispanic white	81.1	74.6		
Hispanic	11.1	20.0		
Afr-American	2.2	3.6		
Asian	0	1.8		
Other	5.6	0		
Employment status				
Full	22.5	50.9		
Part-time	4.5	16.4		
Retired	6.8	5.5		
Unemployed	41.5	27.2		
Disability	24.7	0		
Marital status				
Married	47.2	66.7		
Single	23.6	9.3		
Divorced	24.7	13.0		
Widowed	4.5	11.0		
Length of time in practice			3.1 (sd=1.5)	3.9 (sd=1.2)
Diagnoses				
Chronic illness	62.6	85.5		
Mean # per patient			1.56	1.62
Psych disorder	57.1	41.8		
Mean # per patient			1.27	1.0
Somatization	52.7	14.5		
Mean # per patient			1.29	1.25
Patients w/3+ diagnoses of chronic illness, psychological or somatization disorder	53.8	34.5		

- **D=difficult patient; T=typical patient**

Table 3

Comparison of Physician Empathy Scores for Difficult and Typical Patients

Variable	mean diff	mean typ	t-value	Bonferoni p-value
Place myself in patient's shoes	3.22 (1.44)	4.22(1.28)	-4.21	.004
Accept patient's strengths and weaknesses	3.91(1.18)	4.65(.91)	-4.18	.004
Sometimes impatient and abrupt w/this patient	3.10(1.34)	2.35(1.28)	-3.30	.024
Generally communicate warmth and concern	4.25(.97)	4.89(.86)	-4.00	.004
Sometimes I seem hostile rather than sympathetic	2.94(1.23)	1.98(.1.02)	-4.84	.004
Generally show consideration for this patient's feelings	4.49(.76)	5.04(.73)	-4.23	.004

Table 4

Predictors of Patient Difficulty or Typicality

Variable	df	Estimate	Error	Chi-Square	p
Intercept	1	-0.99	0.63	2.47	n.s.
Somatization	1	-1.34	0.38	12.51	.0004
Psychological	1	-0.85	0.33	6.80	.009
Length of time	1	0.41	0.15	7.20	.007

Table 5
Predictors of Physician Frustration toward Difficult Patients

Variable	Parameter Estimate	Standard Error	Type II SS	F-value	p
Intercept	2.30	0.26	32.43	78.23	<.0001
Married	-0.42	0.14	3.53	8.50	.005
Chronic disease	-0.22	0.07	3.77	9.10	.003
Time in practice	-0.13	0.05	2.62	6.31	.01
Pt. volume	0.04	0.02	2.41	5.82	.02

R2=.29 F=7.34 p <.0001

Table 6
Predictors of Physician Frustration with Typical Patients

Variable	Parameter Estimate	Standard Error	Type II SS	F-value	p
Intercept	3.88	0.37	59.11	110.80	.0001
Retired	1.09	0.54	2.18	4.08	.05
Somatization	1.57	0.23	24.04	45.07	.0001
Psychological	0.46	0.21	2.50	4.69	.04
Pt. volume	0.07	0.03	3.38	6.33	.02

R2=58.4% F = 15.77 p <.0001

Table 7
Predictors of Physician Empathy toward Typical Patients

Variable	Parameter Estimate	Standard Error	Type II SS	F-value	p
Intercept	4.54	0.30	66.72	226.17	<.0001
Male pt	-0.32	0.17	1.09	3.68	.06
Somatization	-0.56	0.18	2.90	9.82	.003
Male physician	-0.47	0.20	1.64	5.55	.02
Pt. volume	-0.05	0.02	1.74	5.91	.02

R^2=.30 F=4.81 p = .003