FAMILY PHYSICIANS' ATTITUDES TOWARD DIFFICULT AND TYPICAL PATIENTS

Johanna Shapiro, Ph.D.
Department of Family Medicine,
University of California Irvine, College of Medicine

Contact Information:
Johanna Shapiro, Ph.D
Address: Dept. of Family Medicine, Rte 81 Bldg. 200, 101 City Dr. South, Orange, CA 92868-3298
Telephone: 949-824-3748
Fax: 714-456-7984
Email: jfshapir@uci.edu

Word Count: 2701
Date: December, 2002

This research was supported by HRSA Establishment of Departments of Family Medicine grant # PE10152 and by the UCI Department of Family Medicine

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. Although there was no overall significant difference in physicians' self-perceived empathy toward difficult and typical patients, significant differences were identified on six of ten individual scale items. Predictors of difficult versus typical patients included presence of somatization, psychological disorder, and less time in physician's practice. **Conclusion.** Family physicians identify frustration toward difficult patients, and report significantly less empathy for difficult as compared to typical patients on important dimensions such as acceptance, warmth, and consideration.

Word count: 165

"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 family physicians could differentiate between difficult and typical patients in terms of their own emotional responses to these patients; and to determine predictors of physician empathy and frustration. Specifically, the study investigated whether, in a sample of family 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 University of California, Irvine 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." Instead, we assumed that these terms had a certain face validity. 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 "alternative" 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 the 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 a third category of "other" diagnoses. 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 frustrated the physician feels by a particular patient, the level of enthusiasm of the physician toward the patient, how much the physician is looking forward to the next visit of the patient, and whether the physician 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 (see Table 3 for complete listing of items).

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[1] in these three categories compared to only about a third of typical patients (see Table 2).

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 of the study survey.

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). Partially 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

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

(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 influencing perceptions of difficulty or typicality. 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 5).

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 6).

Discussion

As predicted, family physicians were reliably able to distinguish between their negative emotional reactions to difficult and to typical patients. Although overall they believed themselves able to express the same level of empathy toward both categories of patients, on over half of the items assessing empathy they rated themselves as significantly lower toward difficult than toward typical patients. Even more troubling is the nature of the items on which family physicians indicated lower empathy. Specifically, in relation to difficult patients they reported themselves as significantly less able to understand the patient's perspective, be accepting of the patient, convey warmth and caring to the patient, and show consideration for the patient's feelings. They were also significantly more likely to view themselves as impatient, abrupt, hostile, and unsympathetic with difficult patients. This suggests that not only do family physicians easily identify difficult patients as frustrating, but they also have considerable difficulties in expressing empathy toward such patients.

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 was the 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. The findings of this study that, unfortunately, such training may do little to mitigate feelings of frustration and discomfort and lack of empathy toward difficult patients.

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 reduced physician 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 the physician's eyes.

Among typical patients, the positive association of increased patient volume and increased frustration remained a constant. (While not statistically 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), rather than marital status (as was the case with difficult patients), predicted increased physician frustration. Significantly, while among difficult patients presence of psychological disorders and/or somatization was apparently definitional, and therefore 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 physician empathy was associated with the presence of chronic illness, supporting the theory that organic 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 the 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. In addition, the limited scope of our study excluded examination of other factors that might contribute to physician frustration and empathy, such as the time pressures to see as many patients as possible, poor reimbursement in relation to time spent, systemic problems, and levels of professional and personal satisfaction. Finally, since neither self-reported frustration nor empathy necessarily translate into behavior, we are unable to determine to what extent physicians' self-perceptions were actually expressed in their patient interactions.

In summary, these family physicians were significantly more frustrated by difficult than by typical patients, and also had more problems expressing empathy toward their difficult patients along key dimensions such as acceptance, warmth, acceptance, and understanding and consideration of feelings. Despite training to enable family physicians to effectively address psychological and psychosomatic patient complaints, the presence of these problems continues to be strongly associated with physician perceptions of difficulty. Further, 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.

These findings suggest that more work remains to be done to better prepare family physicians to successfully manage patients with psychological and somatization disorders, especially under conditions of significant time constraint. Specifically, additional training is necessary to help physicians deal with their frustration, anger, and dislike of such patients, as well as to learn how to experience and express genuine empathy and caring for these individuals. Refinement of training needs to include the possibility that different factors contribute to physician frustration and lack of empathy depending on whether or not a patient is characterized as "difficult." Future research needs to investigate in more depth how physician frustration and empathy are actually expressed in clinical practice.

References

1. AAFP Commission on Health Care Services. AAFP White Paper on the provision of mental health care services by family physicians. *Am Fam Physician* 1995;51:1405-1412.
2. Hahn SR, Kroenke K, Spitzer RL, Brody D, Williams JB, Linzer M, de Gruy FV 3rd. The difficult patient: prevalence, psychopathology, and functional impairment. *J Gen Intern Med* 1996;11:1-8.
3. Noyes R, Holt CS, Kathol RG. Somatization: diagnosis and management. *Arch Fam Med* 1995;4:790-5.
4. Katon WJ, Walker EA. Medically unexplained symptoms in primary care. *J Clin Psychiatr* 1998;59 Suppl 20:15-21.
5. Garcia-Campayo J, Sanz-Carrillo C, Yoldi-Elcid A, Lopez-Aylon R, Monton C. Management of somatisers in primary care: are family doctors motivated? *Australian and New Zealand J Psychiatr* 1998;32:528-33.
6. Butler C.C, Evans M. The "heartsink" patient revisited. *Brit J Gen Pract* 1999;49:230-3.
7. Wagner PJ, Phillips W, Radford M, Hornsby JL. Frequent use of medical services: patient reports of intentions to seek care. *Arch Fam Med* 1995;4:594-9.
8. Smucker DR, Zink T, Susman JL, Crabtree BF. A framework for understanding visits by frequent attenders in family practice. *J Fam Pract* 2001;50:847-52.
9. Kroenke K, Jackson JL, Chamberlin J. Depressive and anxiety disorders in patients presenting with physical complaints: clinical predictors and outcome. *Am J Med* 1997;103:339-47.
10. Hahn SR, Thompson KS, Wills TA, Stern V, Bedner NS. The difficult doctor-patient relationship: somatization, personality, and psychopathology. *J Clin Epidemiol* 1994;47:647-57.
11. Kroenke K, Spitzer RL, deGruy FV 3rd, Hahn SR, Linzer M, Williams JB, Brody D Davies M. Multisomatoform disorder: an alternative to undifferentiated somatoform disorder for the somatizing patient in primary care. *Arch Gen Psychiatry* 1997;54:352-8.
12. Servan-Schreiber D, Kolb NR, Tabas G. Somatizing patients: Part I.Practical diagnosis. *Am Fam Physician* 2000;61:1281,1285.
13. Hahn SR. Physical symptoms and physician-experienced difficulty in the physician-patient relationship. *Ann Intern Med* 2001;134:897-904.
14. Walker EA, Katon WJ, Keegan D, Gardner G, Sullivan M. Predictors of physician frustration in the care of patients with rheumatological complaints. *Gen Hosp Psychiatry 1*997;19:315-23.
15. Katz RC. "Difficult patients" as family phyisicans perceive them. *Psych Reports* 1996;79:539-44.

16. Katon W, Von Korff M, Lin E, Bush T, Russo J, Lipscomb P et al. A randomized trial of psychiatric consultation with distressed high utilizers. *Gen Hosp Psychiatry* 1992;14:86-98.
17. Schulberg HC, Bock MR, Madonia MJ, Scott P, Rodriguez E, Imber SD, Perel J, Lave J, Houck PR, Coulehan JL. Treating major depression in primary care practice. *Arch Gen Psychiatry* 1996;53:913-19.
18. Lidbeck J. Group therapy for somatization disorders in general practice: effectiveness of a short cognitive-behavioural treatment model. *Acta Psychiatry Scand* 1997;96:14-24.
19. Walker EA, Uneutzer J, Katon WJ. Understanding and caring for the distressed patient with multiple medically unexplained symptoms. *J Am Board Fam Pract* 1998;11:347-56.
20. Markakis KM, Beckman HB, Suchman AL, Frankel RM. The path to professionalism: cultivating humanistic values and attitudes in residency training. *Acad Med* 2000;75:141-150.
21. Suchman AL, Markakis K, Meckman HB, Franke;l R. A model of empathic communication in the medical interview. *JAMA* 1997;277:678-82.
22. Gianakos D. Empathy revisited. *Arch Intern Med* 1996;156:135-6.
23. Burack JH, Irby DM, Carline JD, Root RK, Larsen EB. Teaching compassion and respect: attending physicians' responses to problematic behaviors. *J Gen Intern Med* 1999;14:49-55.
24. LaMonica EL. *Empathy Construct Rating Scale.* XICOM, 1996.
25. LaMonica EL. *Construct Validity of an Empathy Instrument.* Wiley & Sons, 1981.
26. Shapiro SL. Effects of mindfulness-based stress management on medical and premedical students. *J Behav Med.*
27. Williams ES, Konrad TR, Linzer M, McMurray J, Pathman DE, Gerritty M, Schwartz MD, Scheckler WE. Douglas J. Physician, practice, and patient characteristics related to primary care physician physical and mental health: results from the Physician Worklife Study. *Health Serv Res* 2002;37:121-43.
28. Solberg LI, Beth Plane M, Brown RL, Underbakke G, McBride PE. Nonresponse bias: does it affect measurement of clinician behavior? *Med Care* 2002;40:347-52.
29. Mathers N, Jones N, Hannay D. Heartsink patients: a study of their general practitioners. *Brit J Gen Pract 1995*;45:293-6.

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 disease	**62.6**	**85.5**		
Mean # per patient			**1.56**	**1.62**
Psychological disorder	**57.1**	**41.8**		
Mean # per patient			**1.27**	**1.00**
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
I can place myself in this patient's shoes	3.22 (1.44)	4.22(1.28)	-4.21	.004
I am able to feel some of the emotions this patient's experiences	3.53(1.28)	3.99(1.26)	-2.43	.324
I am able to accept this patient's strengths and weaknesses	3.91(1.18)	4.65(.91)	-4.18	.004
I am sometimes impatient and abrupt w/this patient	3.10(1.34)	2.35(1.28)	-3.30	.024
I generally communicate warmth and concern to this patient	4.25(.97)	4.89(.86)	-4.00	.004
Sometimes I seem hostile rather than sympathetic to this patient	2.94(1.23)	1.98(1.02)	-4.84	.004
I am generally sensitive to this patient's nonverbal cues	4.18(0.90)	4.65(0.76)	-3.00	.064
I generally show consideration for this patient's feelings	4.49(.76)	5.04(.73)	-4.23	.004
I rarely seem rushed when talking to this patient	3.73((1.18)	3.96(1.32)	-1.09	.999
I generally check to see if my understanding of this patient is valid	4.17(0.96)	4.35(1.17)	-1.00	.999

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 Symptoms	**1**	**-1.34**	**0.38**	**12.51**	**.0004**
Psychological Disorder	**1**	**-0.85**	**0.33**	**6.80**	**.009**
Length of time in physician practice	**1**	**0.41**	**0.15**	**7.20**	**.007**

Table 5

Predictors of Physician Frustration toward Difficult and Typical Patients

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

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 Symptoms	1.57	0.23	24.04	45.07	.0001
Psychological Disorder	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 6
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 Symptoms	**-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**

R2=.30 F=4.81 p = .003

PRELIMINARY DATA SUMMARY: TYPICAL VS. DIFFICULT PATIENTS

QUESTION: Did family physicians distinguish between typical and difficult patients in terms of frustration and empathy?
ANSWER: Family doctors rate difficult patients as significantly more frustrating than typical patients. However, they do not report having significantly less empathy for difficult than for typical patients.
NOTE: Although there were no significant differences between groups in terms of overall empathy, on specific items, on over half of the items physicians did report having less empathy for difficult than for typical patients.

QUESTION: Did typical and difficult patients differ in other ways in addition to effects on physician?
ANSWER: Variables examined included patient age, gender, marital status, ethnicity, employment status, diagnosis, insurance status, length of time with physician, and gender, ethnicity, and age concordance with physician. Difficult patients were more likely to be on disability, to have been under the physician's care for a longer (?) period of time, and to be single. In terms of diagnosis, difficult patients were more likely to have chronic illnesses, mental illness, psychosomatic illness, or substance-abuse problems. Ethnicity, age, and gender or concordance of these variables with the physician were not related to perceived difficulty or typicality. Neither was type of medical coverage (managed care, fee-for-service etc.). , altho fee for service had sig. less frustration w/ typical patients than managed care (empathy was n.s.)

QUESTION: What were predictors of perceived patient difficulty?
ANSWER: Presence of psychosomatic illness, mental illness, and length of time with physician were significant predictors of difficulty. These three variables were predictors of a difference score that anchored difficulty in relation to typicality.

QUESTION: What were predictors of empathy when anchored by comparing differences between difficult and typical patients?
ANSWER: No predictive models were successful, probably because there were not significant differences in empathy between difficult and typical patients.

QUESTION: What were predictors of frustration when anchored by comparing differences between difficult and typical patients?
ANSWER: The only predictor of frustration was the presence of mental illness.

QUESTION: Within the group of difficult patients, what predicted empathy?
ANSWER: In this group, empathy was predicted only by the presence of chronic illness. When the variable was treated categorically, this finding was upheld. male doc, hmo, yrs in practice all n.s.

QUESTION: Within the group of difficult patients, what predicted frustration?
ANSWER: In this group, frustration was predicted by marital status (single), the presence of chronic illness, the length of time in the physician's care (longer?), and the volume of

patients seen. When diagnostic variables were considered separately, only the presence of chronic illness was associated with frustration. When diagnostic variables were considered categorically, both chronic illness and mental illness were associated with increased physician frustration.

repeat

QUESTION: Within the group of typical patients, what predicted empathy?
ANSWER: In this group, empathy was predicted by sex of physician (male?), presence (?) of psychosomatic illness, and volume of patients seen. Sex of patient (male?) approached but did not achieve significance.

repeat

QUESTION: Within the group of typical patients, what predicted frustration?
ANSWER: In this group, frustration was predicted by employment status (retired), presence of psychosomatic illness, presence of mental illness, and volume of patients seen. When diagnostic variables were considered separately, both psychosomatic and mental illness were significantly associated with frustration, but not chronic illness.