

# Difficult Patients in Primary Care: a Quantitative and Qualitative Study

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**Aim.** To identify difficult («heartsink») patients (DP), describe their profile, and report the opinions and experiences they evoke in physicians who see them.

**Design.** Descriptive, cross-sectional study based on quantitative and qualitative methods.

**Setting.** Urban health care center.

**Participants.** Difficult patients were selected daily from among all patients seen in six primary care practices during the period from March to May 2001. Patients were identified according to the diagnostic criteria of Ellis (patients who cause a knot in the stomach when their name appears on the list of patients with an appointment that day) and O'Dowd (patients who cause distress or discomfort).

**Method.** Information was obtained on the number of DP seen, number of visits made by DP, age, sex, type of DP, level of education, occupation, family structure and comorbidity.

Type of DP was determined with a modification of the Groves classification (dependent clinger, entitled demander, manipulative help-rejecter, self-destructive denier, somatizer, emotive seducer). We analyzed the opinions DP generated by examining the discourse produced during a discussion group session with 9 physicians from the participating health center and a moderator.

**Results.** A total of 82 DP were identified (prevalence .7%, i.e., 2.3% of all visits). Most (67.1%) were women. Mean age was 57.8 years (standard deviation 15.2 years).

Dependent clinger patients predominated (41%). Most patients had primary-level education (62%), about one-third were retired (35%), and about one-third were married and had children (35%). Most had two or more medical diagnoses (74.4%), and many had at least one psychiatric diagnosis (40.2%).

The feelings these patients evoked most often in physicians were irritability and frustration.

Most physicians agreed that these patients are rare but have a severe emotional impact.

Physicians believe that the skills and strategies they have to help them manage these patients are limited, and consider specific training necessary to improve them.

**Conclusions.** Although DP are not a relevant problem in quantitative terms, they cause considerable emotional distress. Specific training in clinical interviewing is felt to be necessary given the difficulties in managing these patients.

**Key words:** Difficult patient. Primary care. Qualitative study

PACIENTES DE TRATO DIFÍCIL EN ATENCIÓN PRIMARIA: UNA APROXIMACIÓN CUANTITATIVA Y CUALITATIVA

**Objetivo.** Identificar a los pacientes «de trato difícil» (PD), describir su perfil y las opiniones y vivencias que generan en los médicos que los atienden.

**Diseño.** Estudio descriptivo transversal. Metodología cuantitativa-cualitativa.

**Emplazamiento.** Centro de salud urbano.

**Participantes.** Los PD seleccionados diariamente del total de pacientes atendidos en 6 consultas de atención primaria, entre marzo y mayo de 2001. Se identificaron mediante los criterios diagnósticos de Ellis (pacientes que provocan nudo en el estómago al leer su nombre en el listado) y O'Dowd (pacientes capaces de producir estrés, malestar).

**Método.** Se recogió información sobre los PD visitados, número de visitas realizadas por PD, edad, sexo, clasificación, estudios, ocupación, estructura familiar y comorbilidad. Se utilizó la clasificación de Groves modificada (pasivo-dependiente, exigente-agresivo, manipulador-masoquista, negador-autodestructivo, somatizador, emotivo-seductor). Analizamos las opiniones que generan a partir del discurso producido en un grupo de discusión (9 médicos del centro y un moderador).

**Diseño.** Se seleccionó a 82 pacientes (prevalencia del 0,7% [el 2,3% de las consultas realizadas]), de los que el 67,1% eran mujeres. La edad media era de 57,8 años (DE, 15,2). Predominó la paciente pasiva-dependiente (41%), con estudios primarios (62%), jubilada (35%), casada y con hijos (35%), con dos o más patologías médicas (74,4%) y al menos una psiquiátrica (40,2%).

Los sentimientos que predominantemente generan en los médicos son irritabilidad y frustración. La mayoría coincide en que estos pacientes son escasos pero ocasionan un impacto emocional intenso, cree que sus habilidades y estrategias para manejarlos son limitadas y considera necesaria formación específica para mejorarlas.

**Conclusiones.** Aunque cuantitativamente los PD no se consideran un problema relevante, provocan un gran desgaste emocional. Se consideran necesarios

formación/entrenamiento específicos en entrevista clínica dadas las dificultades que presenta su manejo.

**Palabras clave:** Paciente difícil. Atención primaria. Estudio cualitativo.

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A commentary follow  
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## Introduction

In connection with doctor-patient relationships, how to manage difficult (heartsink) patients (DP) is a frequent topic of conversation among primary care physicians. These patients evoke a variety of feelings that often include elements of emotional tension, and can contribute to the dreaded professional burnout. Conversations among practitioners suggest that distress is widespread, and in contrast to the situation for specific (especially organic) diseases, there seems to be no common set of skills or strategies for dealing with these patients and improving physician-patient relations. A number of studies have examined relations with DP. Most describe their characteristics,<sup>1-5</sup> the feelings they most often produce,<sup>2,6,7</sup> or strategies for managing such patients;<sup>2,5-9</sup> other studies have proposed ways to classify them.<sup>6</sup> However, few studies mention the prevalence of these patients or the numbers of visits they make.<sup>5,10-13</sup> In Spain, a notable study by Blay Pueyo<sup>14</sup> defined and characterized problem patients, and proposed strategies for improving their management. Another noteworthy study by Sanz-Carrillo et al.<sup>15</sup> reported practitioners' reactions to somatizer patients. Other texts, such as that by Borrell,<sup>16</sup> are of a more general nature. We are aware of no studies that report the opinions of medical team members regarding DP in qualitative terms, or that describe the prevalence and profile of these patients. The aims of the present study were to identify DP seen by members of a primary care team, to describe the profile of these patients, and to analyze the opinions they generate in the physicians who see them in their daily practice.

## Participants and methods

### Setting

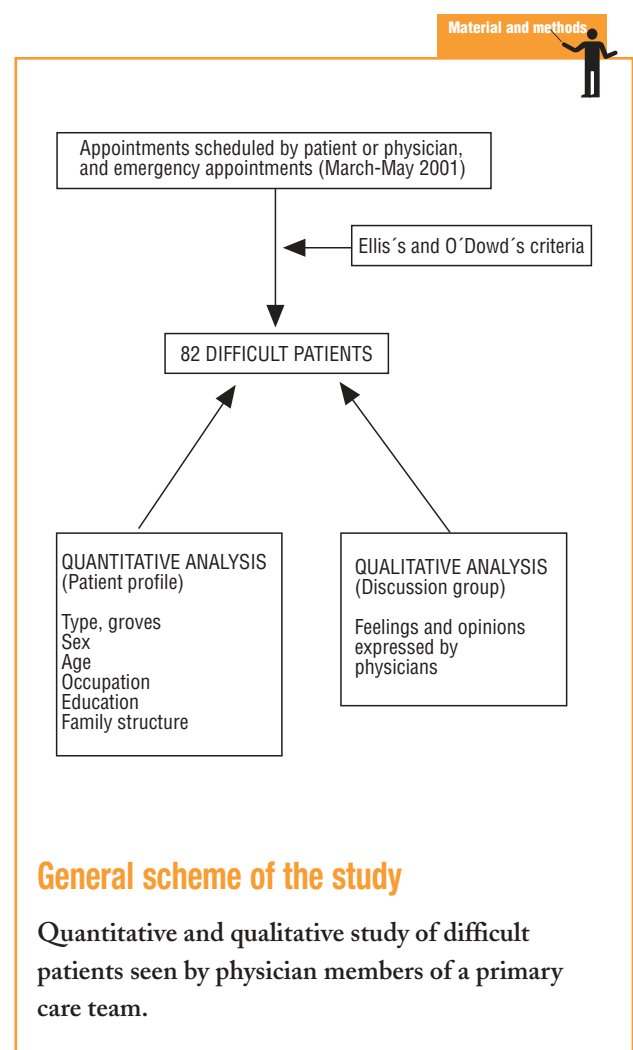
The study was carried out in the Santa Eulalia Sud urban Basic Health Area (L'Hospital de Llobregat, Barcelona, Spain). The staff consists of 9 family physicians and 3 pediatricians who serve a population of 23 000 inhabitants.

### Sample and participants

Six family doctors took part in the study. Two temporary staff doctors were excluded, as was one new staff member whom it was felt did not yet know his patients well enough to provide information on their profiles.

Heartsink patients were selected and classified during the period from March to May 2001. The inclusion criteria were chosen by consensus among the participating physicians as being straightforward and readily applicable: the criteria of Ellis (patients who cause a knot in the stomach when their name appears on the list of patients with an appointment that day),<sup>7</sup> and the criteria of O'Dowd (patients who produce distress or discomfort in those who see them).<sup>17</sup>

From the list of the patients with a scheduled appointment (requested by the patient or scheduled by the physician) or an emer-



gency appointment, the physicians identified patients who satisfied the inclusion criteria noted above. The study variables were number of DP seen, number of visits made by DP, age, sex, type of DP, family structure, level of education, occupation and comorbidity (associated medical or psychiatric problem). Groves' classification<sup>6</sup> was used to identify difficult patients as dependent clingers, entitled demanders, manipulative help-rejecters or self-destructive deniers, and the categories emotive seducer and somatizer were added as recommended by Blay Pueyo<sup>14</sup> (Table 1).

### Discussion group

A qualitative study was done to record the opinions and experiences these patients generated in the physicians who saw them. Because of its ease of application and suitability for the aims of the present study, we used a focus group approach (discussion group), a qualitative analytical and research technique that consists of a semistructured conversation guided by a moderator with the help of a flexible script based on a series of open questions.<sup>18-22</sup> All 9 staff physicians at the center participated in the discussion group. The three physicians who did not participate in the patient selection phase were included. Although being a staff member for only a short time before the study was done may ha-

ve influenced how they identified DP, we felt that this would not influence their opinions about these patients. The staff health technician at the center acted as the discussion group moderator. A script that served as the basis for the discussion included the following issues: quantitative and qualitative magnitude of the problem (emotional impact), feelings evoked, management strategies, perception of management skills and need for training. The discussion group met during 1 hour during working hours, and the meeting was tape-recorded for later data analysis. The recording was analyzed by the moderator and one of the participants to identify the opinions expressed most frequently or most strongly, although all opinions considered of interest were noted.

## Results and discussion

### *Characteristics of difficult patients*

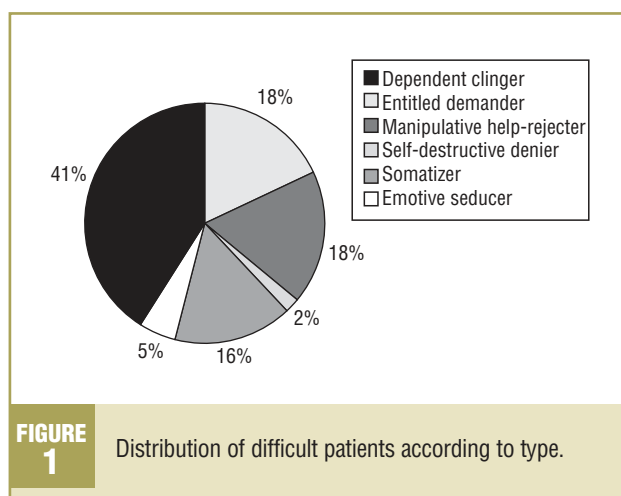
The 82 patients identified (average of 13.6 patients per physician) represented a prevalence of 0.7%, and generated 2.3% of all visits during the study period. Two-thirds (67.1%) were women and 32.9% were men, and mean age was 57.8 years (standard deviation 15.2 years). The general profile was that of a woman classified as a passive clinger type of patient (41%), with primary level education (62%), retired (35%), married with children (35%), and with two or more medical problems (74.4%) and at least one psychiatric problem (40.2%).

Figures 1 to 4 show the how difficult patients were distributed according to Groves' classification, educational level, occupation and family structure.

Few studies have evaluated the prevalence of DP and the number of times they visit their doctors. Mathers et al.<sup>23</sup> reported a mean of 6 DP per participating physician, with considerable variability ranging from 1 patient to 50 (i.e., from <1% to >3% of the physician's list of patients). The mean number of DP per physician in the present study was higher, and similar to that reported by Schwenk and colleagues.<sup>12</sup> We found less variability between physicians (12 to 19 patients identified as DP), and like Mathers et

**TABLE 1**  
**Groups and characteristics of difficult patients**

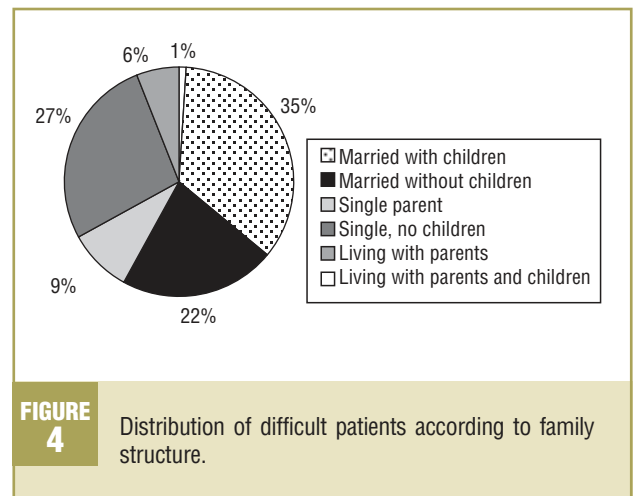
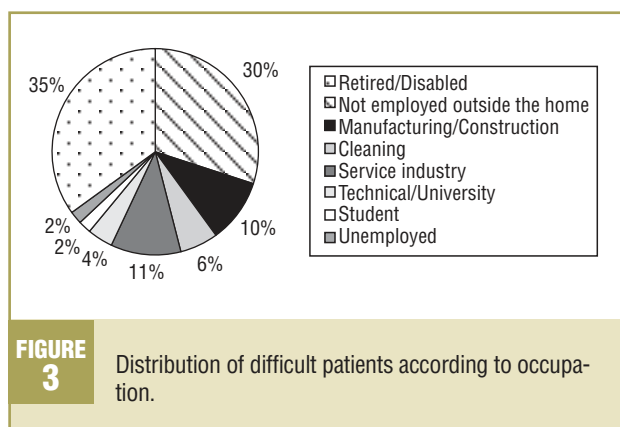
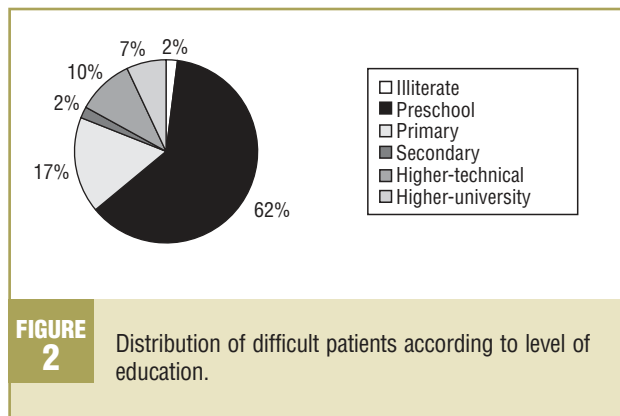
Dependent clinger	Frequent visits (unlimited needs). Low self-esteem and decision-making capacity
	Sees doctor as a mother with endless resources
	Appreciative and manipulative
	Causes feelings of defeat and aversion
Entitled demander	Highly demanding patient who uses intimidation and denigration, and creates guilt feelings
	Hostile, complaining, superior attitude hides a high degree of dependence and fear of being abandoned
Manipulative help-rejecter	Pessimistic, long-suffering, depressive
	These patients often seek care for the same reasons as entitled demanders, but reject help because «nothing can be done.» If one symptom improves, another symptom appears immediately
	Noncompliance blamed on side effects of medication, which always appear
Causes guilt feelings	
Self-destructive denier	Noncompliance because of negligence despite information provided by the physician, or because of denial (personal decision not to comply with treatment, with or without a self-destructive component)
	These patients cause feelings of aversion, fear, guilt and possibly a secret with that the patient would die
Emotive seducer	Tries to manipulate the practitioner's feelings by flattery
Somatizer	Multiple symptoms with problems hard to trace to any biomedical explanation
	Generates many team consultations, referrals and complementary tests



al., we found that all participants had at least one DP among their regular patients.

The prevalence of almost 15% reported by Hahn et al.<sup>11</sup> was notably high. In their study, DP were identified with the help of a questionnaire that participating physicians responded to, which may have avoided recall bias. We believe the facts that the physicians who participated in the present study had held their primary care post for 5 years or longer, and were responsible for similar numbers of patients, helped to stabilize the number of DP, either through mechanisms of mutual adaptation or because patients were allowed to change physicians.

We note that earlier studies have reported the proportion of DP visits as 15%,<sup>10</sup> 20%<sup>5</sup> or even 30%.<sup>13</sup> Jackson and Kroenke<sup>10</sup> studied only first visits, a factor that introduced



can therefore be considered to be qualitative rather than quantitative. All physicians had at least one DP, but they were surprised at how few such patients they actually saw, as they had assumed when they were invited to participate in the study that they would identify many more. We agree with O'Dowd<sup>17</sup> that the scarcity of published quantitative data might lead to the perception that the problem is greater than it actually is. This might be explained by the phenomenon of gradual mutual adaptation with time, as reflected by the statements «*With time I get to like them*» and «*I think the two come to an understanding.*»

significant bias because of the difficulties associated with the first physician-patient encounter. The study by Hahn et al.<sup>5</sup> was done in a hospital setting. The rate of DP visits of 2.32% in the present study represents a mean of 30 visits per day per physician, one visit by a DP every 2 days, or 14 difficult encounters per month. We consider that although the prevalence of DP in the present study is lower than that found by others, these patients are more frequent attenders, an important consideration given the impact of these visits.

With regard to the characteristics associated with DP, we found, as did many earlier studies, that more such patients were women,<sup>1,4,7,17</sup> and that DP often had complex medical problems (both physical and psychological).<sup>3-5,10,11,17,24-27</sup> Although John et al.<sup>4</sup> found no differences in family composition, we noted, as did O'Dowd,<sup>17</sup> that married persons clearly predominated. O'Dowd also reported a higher employment rate (67%) than we found (25%).

#### *Magnitude of the problem*

In consonance with these results, all members of the discussion group felt that the number of DP they saw was not large. However, dealing with these patients involved considerable psychological or emotional distress. The problem

#### *Feelings evoked by difficult patients*

Most of the feelings described by Groves<sup>6</sup> were expressed by the participants in the present study, although with subtle differences. The most frequently reported feelings were irritability («*I get nervous*», «*I get uptight*», «*I realize that without meaning to, I raise my voice when I speak to them*») and frustration, which were noted in relation with all groups of DP. Most participants felt that frequent attenders, a group represented mainly by «dependent clinger» patients, were readily perceived to be difficult patients («*They're like glue*», «*They stick to everything*»), and that their degree of dependency can generate feelings of defeat («*On the day you see them, you end up feeling drained*») as well as insecurity («*In spite of your years of experience, they manage to make you feel insecure since you can't solve their problem*»). This was an important point for many participants, as it led some to resort to referral to other practitioners to «*cut down on your own responsibility.*» Although the aversion described by Groves as arising in the relationship with dependent clinger patients was not mentioned per se during the discussion session, the tendency to refer the patient to another physician might be understood as a consequence of this feeling. With regard to manipulative help-rejecter patients, the guilt feelings mentioned by Groves were not



Discussion  
Key points**What is known about the subject**

- Heartsink patients are common in primary care practice.
- They generate many feelings, generally of distress, in practitioners who see them.
- Strategies and skills exist to improve the management of these patients.

**What this study contributes**

- This study provides data on the prevalence and number of visits heartsink patients make in primary care practices.
- It describes the general profile of heartsink patients seen by the primary care team.
- It offers a qualitative approach to the problem by exploring physicians' opinions on these patients.

alluded to, but participants reported feelings of impotence because they could not do anything about the patient's problem.

We note that although experience accumulated through years of practice might be thought to provide physicians with more skills to manage these situations and patients, physicians continue to experience unease: *«I still have problems», «I thought I had it under control but some patients still throw me off balance.»* The information published to date regarding the influence of experience is contradictory. In their study of predictors in physicians who saw difficult patients, Jackson and Kroenke<sup>10</sup> found no differences in the number of DP identified in connection with years in practice. However, Crutcher and Bass<sup>13</sup> reported that more experienced physicians had fewer problematic encounters. *Strategies used with difficult patients*

Each practitioner described his or her personal strategy, acquired over the years. Referral was used often, but was perceived as a strategy that yielded poor results and was aimed at keeping the patient from complaining or reducing the physician's distress rather than at solving the patient's underlying problem. To understand the reasons that led patients to create difficulties, physicians reported occasionally making determined efforts to comprehend the causes or keys to a patient's particular attitude by asking themselves *«Why hasn't the patient ever smiled at me in all these years?»* or *«Why isn't the patient ever satisfied with anything I do?»* Some physicians turn to someone in the patient's immediate circle who might help him or her to understand the patient: *«I try to talk to a relative and ask him or her what the patient is normally like.»* This

approach, which has been proposed and evaluated by others<sup>3-5,17</sup> as an intervention that can improve the situation, is difficult within the setting of practices with large patient loads.

Negotiating and making pacts are considered necessary and useful strategies for managing heartsink patients, and often make it possible for the patient and the physician to reach agreement: *«Look, this is the last time I'm going to write out prescriptions for you; next time I'm not going to do this.» «I'll write out this prescription, but first let me explain why I think I shouldn't be doing this.»* Another strategy is to try to place limits on the reasons for visiting the doctor: *«With some patients, especially the passive clingers, you could spend all day talking and they'd still never get tired of listening, since they need you to solve their problems. In this group it is very important to be able to stop them from coming, to limit their reasons for coming in, and if necessary to give them an appointment for an interview outside regular hours to be able to spend more time talking with them (but even then they'd use up the time allotted for their scheduled appointment and would never leave.)»* It is also important to make patients understand that *«as a doctor you have two thousand patients to look after, not just one.»* This is a way to try to reduce the patient's dependency, as Groves<sup>6</sup> noted.

Consultation with other members of the health care team is rarely used during regular team meetings. Instead, personal experiences are commented on informally, usually in the hallways; this *«gives us a chance to get it off our chest.»* However, participants in the present study agreed that being able to talk about patients could be a valid tool, especially when for some reason the patient changes physicians: *«If the relationship with the previous physician was bad, it might well turn out to be bad with me too.»* In such cases knowing about a difficult patient in advance would allow the physician to prepare a strategy to prevent problems.

*Need for training to cope with difficult patients*

Most participants felt that specific training in physician-patient relations was inadequate. Almost all had completed a basic course in clinical interviewing, but had not subsequently studied the course contents in depth. Thus practitioners adopted strategies or maneuvers that they had learned on their own: *«You learn from your mistakes.»* It is worth recalling here that in the study by Mathers et al,<sup>23</sup> less training in communication skills and inadequate postgraduate training were associated with the perception of larger numbers of patients as difficult. Other authors<sup>2,10</sup> have noted the usefulness of specific training as a tool for improving the management of heartsink patients. Continuous training in aspects of the physician-patient relationship is therefore considered necessary to equip the practitioners with skills that will allow them to make headway in difficult situations.

## Conclusions

The profile of heartsink patients in our setting was similar to that described in earlier studies, but the prevalence and rate of visits were lower than expected. Nonetheless, members of the team of physicians who see these patients reported difficulties in dealing with them, emotional distress, and inadequate skills to cope with them. Specific training in strategies to improve the physician-patient relationship is essential. As Ellis proposed,<sup>7</sup> we should be able to assist our patients and, while not curing them, help them to resolve their conflicts, and at the same time –as noted by Powers<sup>8</sup>– decrease our level of frustration and the danger of burnout.

We believe our study should be broadened to examine another aspect of the problem: as Jewell<sup>2</sup> asked, on the basis of Balint's view, how much of the problem can be attributed to physicians? Undoubtedly, knowledge of physician-associated factors which, according to some authors,<sup>10,23</sup> can be considered predictors of «difficult encounters,» should help to improve the physician-patient relationship under adverse conditions.

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## COMMENTARY

# Difficult patients and an examination of practitioners' distress

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This issue of ATENCIÓN PRIMARIA contains an article that reports an elegantly designed study aimed at identifying difficult patients, describing their profile and characterizing the opinions and feelings these patients evoke in the physicians who see them regularly.<sup>1</sup> The study centers on difficult patients; however, the literature contains few items on this topic. The first problem that arises is the label «difficult» or «heartsink» patient. Several authors have tried to identify which group of patients these terms designate. Although many types of patient fit this label, the two most widely accepted definitions refer explicitly to subjective feelings of distress in practitioners who see these patients.<sup>2-4</sup>

Analyses of the origin of this discomfort have identified multiple factors, which can be classified into three main groups. The first group comprises patient-dependent factors, the second consists of practitioner-dependent factors, and the third reflects factors that are setting-dependent. Let us start with patient-related factors. The health problem that leads the patient to seek medical care may itself generate unease because we lack the appropriate training to deal with it, or because its connotations create an unpleasant situation for us. The patient's personality (or that of members of the patient's family) (including physical appearance, systems of belief, or differing interpretations) and the patient's circumstances in relation with his or her sociocultural environment, may also cause unease. These elements can lead to problems of incomprehension between the patient and physician, manifested as a lack of information or situations that, because of our own life experiences, evoke certain feelings that are unpleasant for us. The authors of the study cited above<sup>1</sup> found difficult patients to have the following characteristics: about 67% were women, and most had more than two health problems often including a psychiatric disorder. Mean age was about 58 years and the patients had retired from their job, or, if they did not work outside the home, had ceased to perform some parenting and housekeeping tasks because of their age and the stage the household had reached in the family lifecycle. Patients were classified on the basis of specific characteristics into the

## Key points

- Difficult patients are identified on the basis of the distress they produce in practitioners who see them; because these patients make up a disparate group, figures on the frequency of these patients vary widely.
- Factors that make physicians feel uneasy when they see certain patients can be patient-dependent, setting-dependent, or practitioner-dependent.
- Dealing effectively with these situations in clinical practice will require investigation into the factors that evoke discomfort in order to identify them as accurately as possible.

following groups: *a)* dependent clingers, who often behaved as frequent attenders because of their view of the physician as a professional with unlimited resources; *b)* emotive seducers, who differ from the former in their use of flattery and false compliments, which they often employ to manipulate the physician's emotions; *c)* help-rejecters, who also make frequent visits to their doctor but are characterized by their permanent refusal to accept any type of help on the assumption that it will not do them any good; *d)* somatizers, whose characteristics are well known; *e)* entitled demanders, who make great demands on primary care resources with a combination of devices such as guilt and aggressiveness; and *f)* non-complying deniers, who systematically fail to follow our advice because of lack of information, negligence or self-destructiveness.<sup>2-4</sup> The authors of the study published in this issue of ATENCIÓN PRIMARIA show that dependent clingers make up the largest group. The findings are in agreement with earlier studies except with regard to the prevalence of difficult patients, which varies widely depending on the detection method used and on differen-

ces between studies in the characteristics of participating practitioners.

Practitioner-dependent factors include the physician's life experiences and personality, as already noted. Also forming part of this group are elements related with the profession, such as training, factors that affect how quickly the physician must work, and the circumstances surrounding the patient-physician encounter, in which lack of training in the management of psychosocial factors is of great importance.<sup>3</sup> These variables were not analyzed in the study described here; however, what this study did examine was the opinions and feelings these patients evoke in the physicians who see them. There were slight differences between the findings of the present study and those of others. The main limitation of the present study was that difficult patients were identified on the basis of a definition that takes physicians' feelings into consideration; such studies should be interpreted with caution. When qualitative analyses are sought, as in the present case, it is advisable to select patients on the basis of characteristics other than the feelings they evoke in practitioners.

It is setting-dependent factors which are most closely related with the characteristics of the health center, and particularly with how it is run – which in turn is related with how the administrative department is organized, how long waiting times are and how many interruptions occur. The study of difficult patients included in this issue does not mention these factors, although they should be taken into account given their importance in managing patients, and the fact that they are difficult to modify.

The article ends with some conclusions regarding the problems physicians encounter when they see these patients in their practice.<sup>2-4</sup> The most important problem is inadequate training, according to the results of the qualitative analysis. This limitation is related with the psychosocial

aspects of practice. Shortcomings in biomedical training are usually not confessed, as in this area everything is more tangible: we know where to train, and how to train. The psychosocial element of our professional profile is more intangible, and has to do with health-determining factors that are less easily modifiable; moreover, there is initial resistance on the part of professionals toward such training. However, the study in this issue of ATENCIÓN PRIMARIA draws attention to the prevalence of difficult patients, and to the considerable differences in prevalence between studies. It would be interesting to see whether the way physicians «select» difficult patients –or other types of patient– is affected by our training profile, capacity for self-control, or other characteristics.

Unquestionably, effective and efficient management strategies for these patients are not homogeneous, just as difficult patients do not form a homogeneous group. Research on this problem is just beginning, and each patient will require a different approach depending on his or her characteristics and determinants. This is why thus far, most authors note that there is broader agreement on how to evaluate difficult patients than on how to cope with them.

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