Turkish Journal of Medical Sciences

Volume 47 | Number 1 Article 32

1-1-2017

Attitudes and behaviors of physicians in dealing with difficult patientsand relatives: a cross-sectional study in two training and research hospitals

KAMURAN BAHAR SANDIKCI

YUSUF ÜSTÜ

MERT MUHİTTİN SANDIKCI

BURCU KAYHAN TETİK

DERYA IŞIK

See next page for additional authors

Attitudes and behaviors of physicians in dealing with difficult patientsand relatives: a cross-sectional study in two training and research hospitals

Authors
KAMURAN BAHAR SANDIKCI, YUSUF ÜSTÜ, MERT MUHİTTİN SANDIKCI, BURCU KAYHAN TETİK, DERYA IŞIK, and MEHMET UĞURLU

TÜBİTAK

Turkish Journal of Medical Sciences

http://journals.tubitak.gov.tr/medical/

Research Article

Turk J Med Sci
(2017) 47: 222-233

doi:10.3906/sag-1509-34

Attitudes and behaviors of physicians in dealing with difficult patients and relatives: a cross-sectional study in two training and research hospitals

Kamuran Bahar SANDIKCI[1,*], Yusuf ÜSTÜ[2], Mert Muhittin SANDIKCI[3], Burcu KAYHAN TETİK[4], Derya IŞIK[5], Mehmet UĞURLU[2]

[1]Karşıyaka Kamil Nalbant Family Health Center, Kocaeli, Turkey
[2]Department of Family Medicine, Faculty of Medicine, Yıldırım Beyazıt University, Ankara, Turkey
[3]Department of Plastic, Reconstructive and Esthetic Surgery, Dışkapı Yıldırım Beyazıt Research and Training Hospital, Ankara, Turkey
[4]Department of Family Medicine, Faculty of Medicine, İnönü University, Malatya, Turkey
[5]Çubuk Akkuzulu Family Health Center, Ankara, Turkey

Received: 07.09.2015 • **Accepted/Published Online:** 12.06.2016 • **Final Version:** 27.02.2017

Background/aim: The aim of this study was to examine the reasons constituting the definition of 'difficult patient' and to evaluate attitudes and behaviors of physicians in coping with these patients and their relatives.

Materials and methods: This cross-sectional study was conducted in May and June 2013 with 400 randomly selected physicians from different specialties working in two training and research hospitals in Ankara. A questionnaire was created by reviewing the relevant literature, by family medicine clinic, and delivered to the physicians following a pilot study.

Results: In our study 92.8% of the physicians participating had experienced a negative contact with patients and/or their relatives, previously; 46.8% of the participants stated that they used their own experiences in coping with those situations. The frequency of negative communications was higher in surgical departments, increasing with average daily working hours and number of patients and decreasing with the experience of the physicians. The ways of coping with a difficult patient were nonjudgmental listening, patience, tolerance, and empathy, in declining order of importance.

Conclusion: Physicians frequently experience negative communications with patients and/or relatives. Awareness of physicians about the concept of difficult patients and the causes and solutions should be enhanced.

Key words: Patient–physician communication, difficult patient, communication skills

1. Introduction

Communication skills and problem-solving skills as well as the educational background, knowledge, and experience of doctors are important for establishing effective communication (1–4). Doctors with good communication skills can conceive the problems of patients more accurately, can provide more compliance and satisfaction of patients with treatment, and can reduce stress while improving their professional work satisfaction (4–7). When communication between physicians and patients is considered from this angle, the features and effectiveness of the communication become more important for maintaining a healthy interaction.

Difficult situations in which communication is disrupted or broken during physician–patient interviews may occur. During their daily practice, doctors encounter patients described as "difficult" who leave them in difficult situations, frustrate them, and make them feel helpless and inadequate (8,9). For example, it is estimated that difficult patients constitute 15%–30% of examinations performed by family physicians (8,10). The difficulties in patient–physician communication seem to be affected by many factors stemming from the interactions between physicians, patients, situational factors, and the health care system (11). In the literature, the definition of difficult patient includes patient groups such as female patients, patients of low socioeconomic status, and patients who need excessive medical care such as those with psychosocial problems and substance abuse, with multiple medical complaints, and those feeling constantly ill, exhibiting drug-seeking behavior, and with chronic pain (10,12–15). Physicians have to allocate a lot more time and energy for these patients to recognize and solve their problems (15). Sometimes, physicians may perceive a

* Correspondence: bahar_deu@hotmail.com

patient who normally demands to be informed as difficult because of excess work load, lack of job satisfaction, fatigue syndrome, and long working hours; as a consequence the relationship between the physician and the patient is disrupted (14,16–18). The lack of administrative policies and strategies for coping with difficult patients may also cause patients to be perceived as difficult. Identifying and managing difficult patients should involve teamwork. This teamwork should include all physician-, patient-, and system-related problems, and should be appropriate for different situations in clinical practice (19).

It has been observed that physicians experience more problems and cannot establish patient–physician relationship in an expected way during clinical practice with patients who were qualified as behaviorally or emotionally difficult. Failure to establish an effective physician–patient relationship may disrupt the execution of health-care services effectively in daily practice, delay the treatment of patients, cause physicians to feel exhausted psychologically, cause discontentment of both physicians and patients, and lead to legal issues (20–22). All these conditions cause health-care facilities to be used more than necessary, much more laboratory testing to be performed, unnecessary medications to be prescribed, and as a result increased healthcare costs (22–24).

In the present study, we focused on patient-, physician-, and healthcare-system-related reasons for the difficulties experienced in patient–physician communication. With this study, it is aimed to examine the reasons why a patient is evaluated as difficult, and to shed light for subsequent studies by evaluating attitudes and behaviors of physicians in coping with difficult patients and/or relatives.

2. Materials and methods

2.1. Study protocol

This cross-sectional survey study was conducted between 15 May 2013 and 15 June 2013 in order to determine the reasons why patients are considered difficult and to evaluate attitudes and behaviors among physicians in coping with difficult patients and/or relatives. The study population included 245 specialists and 256 residents from Ankara Atatürk Training and Research Hospital, and 216 specialists and 244 residents from Dışkapı Yıldırım Beyazıt Training and Research Hospital. A total of 223 physicians from Ankara Atatürk Training and Research Hospital and 247 from Dışkapı Yıldırım Beyazıt Training and Research Hospital were contacted for the survey and the questionnaires were delivered them to be filled out, but only 400 questionnaires were received back. Four hundred and ninety-one physicians could not be reached due to reasons such as their heavy workload, serving in the operating room, and being on annual leave.

This survey was conducted in order to evaluate the attitudes and behaviors of physicians in coping with difficult patients and their relatives. The content of the questionnaire was prepared by making use of the contemporary national and international literature. The terms "patient–physician communication", "difficult patient", "coping with a difficult patient", "negative communication", and "communication skills" were searched using Google, PubMed, and the ULAKBİM database, in Turkish and English. First, a draft was prepared by our family medicine clinic and implemented as a pilot and after the necessary corrections were made the content of the questionnaire was finalized.

The final questionnaire included 23 questions about the socio-demographic characteristics of the physicians, the factors that affect evaluating the patients as difficult including the reasons and frequency of negative communications with patients and relatives, the difficult patient groups that physicians face, and the methods they use in dealing with difficult patients. Twenty questions were in multiple-choice form, and three questions were prepared as a 5-point Likert scale. Each questionnaire was delivered to the physicians personally at their workplaces. The questionnaires were filled out by the physicians themselves. Participation was entirely on a voluntary basis. In this regard, participation consent forms were included at the beginning of the questionnaires. One of the limitations of our study is that the study was conducted in two training and research hospitals randomly selected in Ankara district.

2.2. Statistical analysis

The data collected by survey were transferred to computer media using a statistical analysis program. The chi-square test used in the statistical analyses. All of the returned surveys, including uncompleted ones, were included in the study. A level of $P < 0.05$ was considered statistically significant.

The study was approved by Yıldırım Beyazıt University Faculty of Medicine Coordinatorship of Non-Pharmaceutical Clinical Research Ethics Committee on 5 November 2012 with ethics committee decision no 72.

3. Results

The mean age of the 400 respondent physicians was 32.24 ± 6.77 years (range 23–62); 191 (47.8%) of them were male and 209 (52.3%) were female. While 38.3% of the physicians were serving in internal branches, 32.5% of them were serving in surgical branches and 26% in family medicine. Moreover 66.1% of the participants were residents and 33.9% of them were specialists. Regarding the units in which the physicians worked, 53.5% of them were working in outpatient clinics, 38% in clinics, 2.5% in family medicine centers, and 6% were academic staff. The rate of physicians examining less than 50 patients a day

was 50.8% and the rate of those examining more than 50 patients was 49.2%; in addition, the rate of physicians who work more than 10 hours a day was 41.8%. We found that 345 (86.3%) physicians were on duty after hours at their institutions, while 55 (13.8%) physicians were not. The number of physicians being on duty between 4 and 8 times a month on average was 167 (48.4%). The rate of physicians being on duty 4–8 times a month on average was 39.6% in internal branches and 42.5% in surgical branches, while 41.7% of the physicians in surgical branches were on duty more than 8 times a month. The majority of the family medicine specialists/residents (70.1%) were on duty an average of 4–8 times monthly. Three hundred physicians (75%) stated that they had been working less than 10 years and 100 physicians (25%) stated that they had been working more than 10 years. In addition, 371 (92.8%) physicians stated that they had experienced negative communication with patients previously, 24 (6%) physicians stated that they had not, and 5 (1.3%) physicians stated that they could not remember.

The physicians working an average of 7–9 hours daily stated that they usually experience negative interactions with patients and/or relatives 1–5 times per year, whereas the physicians working an average of 10–12 hours and more than 12 hours stated that they experience negative interactions with patients and/or relatives 1–3 times per month. It was found that 51% of the patients with whom the physicians experienced negative interactions were university graduates and 43.25% were illiterate. Furthermore, 164 (85%) female physicians and 148 (83.1%) male physicians stated that the sex of the patients does not affect their negative interaction with patients ($P > 0.05$). In addition, 381 (95.5%) physicians answered the question on whether patients and/or relatives were negatively biased in communicating with healthcare professionals as "absolutely yes" or "yes", and they also stated that these negative biases of the patients mostly (81%) resulted from TV programs that they had been watching.

Regarding the physicians' methods of coping with difficult patients, 46.81% of the physicians stated that they cope with difficult patients depending on their own experiences, 22.50% of them stated that they cope with difficult patients by depending on impressions they get from colleagues, and 15.28% of them stated that they depend on the impressions they acquired from teachers during their education.

Regarding their ability to cope with difficult patients 47.8% (n = 191) of the physicians participating in the study evaluated themselves as medium and 41.0% (n = 164) evaluated themselves as good. Regarding experiencing negative communications with patients and/or relatives, 92.7% of the physicians working more than 10 years in the profession and 93% of those working less than 10 years stated that they had experienced negative communications with patients and/or relatives. The majority of the physicians (33.9%) working less than 10 years in the profession stated that they experience negative communications with patients and/or relatives 1–3 times a month, whereas the majority of the physicians (51.6%) working more than 10 years stated that they experience negative communications with patients and/or relatives between 1 and 5 times a year. In our study, a statistically significant negative correlation between the physicians' working experience and the frequency of negative communications was found ($P = 0.000$). There is a significant relationship between the working branch and frequency of negative communications experienced with patients and/or relatives ($P < 0.05$) (Table 1).

Table 1. Comparison of sex, marital status, after time duty conditions, sex of the patient with whom a negative communication was experienced, and frequency of negative communications according to the branches the physicians work in.

		Working branch						P
		Internal		Surgical		Family medicine		
		n	%	n	%	n	%	
Sex	Female	97	48.0	33	16.3	72	35.6	0.000*
	Male	56	30.3	97	52.4	32	17.3	
Frequency of negative communications with patients and/or relatives	Almost every day	15	10.3	18	14.4	5	5.4	0.005*
	1–3 a week	40	27.4	22	17.7	16	17.4	
	1–3 a month	43	29.5	47	3 37.9	21	22.8	
	1–5 a year	44	30.1	34	27.4	46	50	
	5–11 a year	4	2.7	3	2.4	4	4.3	

*$P < 0.05$

The majority of the physicians (30.4%) who examine more than 50 patients a day stated that they experience negative communications with patients and/or relatives 1–3 times a month, whereas the majority of the physicians (43.4%) who examine less than 50 patients a day stated that they experience negative communications with patients and/or relatives 1–5 times a year. There is a significant relationship between the number of patients daily examined and the frequency of negative communications experienced with patients and/or relatives ($P < 0.05$).

The comparison of physicians' agreeing with the physician- and healthcare-system-related precipitators of difficult patient encounters according to branches of the physicians are given in Tables 2 and 3.

Table 2. Comparison of physicians' agreeing with the physician-related precipitators of difficult patient encounters according to branches of the physicians.

	Working branch								P
	Medical		Surgical		Family medicine		Total		
	n	%	n	%	N	%	n	%	
Physician-related causes									
A patient that I labeled difficult may not be regarded in the same way by another physician	83	54.6	75	58.1	81	77.9	239	62.1	0.002*
Physician-related problems may also cause a patient to be labeled difficult	90	59.6	85	65.9	85	81.7	260	67.7	0.007*
I understand the negative reactions of patients/relatives towards healthcare workers resulting from their psychological conditions	57	37.5	29	22.7	42	40.8	128	33.4	0.000*
I believe I allocate sufficient time to difficult patients	119	78.8	88	69.3	74	71.8	281	73.8	0.040*
A negative communication I experienced with a patient affects the next patient	117	77	97	75.2	66	63.5	280	72.7	0.177
The frequency of negative communications with patients has been decreasing as I have been gaining experience in the profession	75	50	64	49.6	70	67.3	209	54.6	0.014*
Problems I experienced with patients affect my private life	110	72.8	77	60.2	66	64.1	253	66.2	0.109

*$P < 0.05$

Table 3. Comparison of physicians' agreeing with the healthcare-system-related precipitators of difficult patient encounters according to branches of the physicians.

	Working branch								P
	Medical		Surgical		Family medicine		Total		
	n	%	n	%	n	%	n	%	
Healthcare-system-related problems									
Problems that patients experienced with hospital personnel affect their communication with me negatively	137	90.1	106	82.8	87	83.7	330	85.9	0.432
Deficiencies in providing healthcare services as a team affect my communication with patients negatively	137	90.1	95	73.6	86	82.7	318	82.6	0.005*
Problems related to the healthcare system (repayments, health insurance, examination fee, referrals, etc.) affect my communication with patients negatively	129	84.9	101	78.3	81	77.9	311	80.8	0.589
Hospital administration can find effective solutions	16	10.5	11	8.5	15	14.4	42	10.9	0.284
I believe that organizing seminars and conferences about communication in the hospital would be helpful	59	38.8	54	41.9	75	72.1	188	48.8	0.000*
I believe healthcare communication applied at the hospital is adequate	18	11.8	17	13.2	18	17.3	53	13.8	0.340

*$P < 0.05$

There is a statistically significant relationship between being experienced more than 10 years and agreeing with the statement "The frequency of negative communications with patients has been decreasing as I have been gaining experience in the profession" (P = 0.035).

When comparing the physicians' agreeing with the physician- and healthcare-system-related precipitators of difficult patient encounters according to the number of patients they examined daily, it is found that there are statistically significant relationships between examining less than 50 patients a day and encountering (P < 0.05):

- Physicians' personality traits play an important role in communication with patients (P = 0.007).
- A patient that I labeled difficult may not be regarded in the same way by another physician (P = 0.007).
- Physician-related problems may also cause a patient to be labeled difficult (P = 0.000).
- I believe I spend enough time for difficult patients (P = 0.028).
- Hospital management is able to find effective solutions to the problems (P = 0.001).
- I believe that organizing seminars and conferences about communication in the hospital would be helpful (P = 0.000).

There are statistically significant relationships between examining more than 50 patients a day and the levels of agreement with the expressions below (P < 0.05):

- The frequency of negative communications with patients and/or relatives has been decreasing as I have been gaining experience in the profession (P = 0.013).
- I believe healthcare communication applied at the hospital is adequate (P = 0.026).

The comparative data for the frequency of encountering a difficult patient and the branches of the physicians are given in Table 4.

There are statistically significant relationships between physicians with experience less than 10 years and frequency of encountering:

- Verbally abusing, offending patients or those prone to violence (P = 0.010).
- Patients with unresolved, recurrent complaints (P = 0.001).
- Patients with multiple complaints and chronic diseases (P = 0.042).
- Manipulative, lying patients (P = 0.011).
- Patients with high levels of anxiety (P = 0.035).
- Patients with inappropriate demands (report, audit etc.) (P = 0.000).
- Patients angry towards physicians (P = 0.001).
- Patients difficult to manage due to lack of knowledge and experience (P = 0.000).

When comparing the frequency of encountering a difficult patient according to the number of patients examined daily, it is found that there are statistically significant relationships between examining more than 50 patients a day and encountering:

- Verbally abusing, offending patients or those prone to violence (P = 0.030).
- Patients angry towards physicians (P = 0.033).

There is a statistically significant relationship between examining less than 50 patients a day and the frequency of encountering patients with unresolved, recurrent complaints (P = 0.038).

There is no statistically significant relationship between the frequency of using specified methods in coping with difficult patients and the branches of the physicians. The frequencies of using the aforementioned methods are similar between specialists working in internal, surgical, and family medicine branches (Table 5).

There is a statistically significant relationship between being more experienced in the profession and the frequency of predefining time and content limits, it is found that the physicians serving less than ten years predefine time and content limits more frequently (P = 0.041).

There is a statistically significant relationship between physicians examining more than 50 patients a day and those examining less than 50 patients in terms of frequency of using a direct approach (to maintain minimum communication) or suggesting the patient consult another physician to cope with difficult patients (P = 0.032, P = 0.45).

4. Discussion

In our study, we aimed to define the traits of patients that cause them to be labeled difficult and to present the methods of coping with these patients from the physicians' perspective by evaluating the results of questionnaires filled out by 400 physicians. Physicians tend to label patients as difficult under conditions including excess workload, lack of job satisfaction, fatigue syndrome, and long working hours; as a consequence the relationship between the physician and the patient is disrupted (14,16–17). In the study by the American Medical Association conducted with 1391 participants from family medicine, internal medicine, and subspecialty areas, it has been reported that working more than 55 hours a week and under high stress conditions leads to high frustration in relationships with patients (14). Similarly, in our study the physicians working 7–9 hours a day stated that they usually experience negative communication with patients and/or relatives 1 to 5 times a year, whereas the physicians working 10–12 hours and more than 12 hours a day (41.8%) stated that they usually experience negative communication with patients and/or relatives 1 to 3 times a month.

Table 4. Comparison of frequency of encountering a difficult patient and the branches of the physicians.

Traits of difficult patients		Working branch								P
		Internal		Surgical		Family medicine		Total		
		n	%	n	%	n	%	n	%	
Verbal abuse, offensiveness, tendency to violence	Always	20	13.2	10	7.9	6	5.8	36	9.4	0.169
	Frequently	35	23.0	27	21.4	17	16.3	79	20.7	
	Occasionally	59	38.8	51	40.5	40	38.5	150	39.3	
	Rarely	35	23.0	33	26.2	39	37.5	107	28.0	
	Never	3	2.0	5	4.0	2	1.9	10	2.6	
Unresolved recurring problems	Always	23	15.1	11	8.7	13	12.5	47	12.3	0.000*
	Frequently	84	55.3	43	34.1	52	50.0	179	46.9	
	Occasionally	29	19.1	51	40.5	31	29.8	111	29.1	
	Rarely	14	9.2	21	16.7	8	7.7	43	11.3	
	Never	2	1.3	0	0.0	0	0.0	2	0.5	
Multiple complaints and chronic diseases	Always	43	28.3	15	11.9	20	19.2	78	20.4	0.002*
	Frequently	76	50.0	61	48.4	60	57.7	197	51.6	
	Occasionally	25	16.4	37	29.4	20	19.2	82	21.5	
	Rarely	6	3.9	13	10.3	3	2.9	22	5.8	
	Never	2	1.3	0	0.0	1	1.0	3	0.8	
Psychosomatic diseases	Always	24	15.7	12	9.5	10	9.6	46	12.0	0.001*
	Frequently	71	46.4	37	29.4	43	41.3	151	39.4	
	Occasionally	39	25.5	45	35.7	41	39.4	125	32.6	
	Rarely	18	11.8	28	22.2	10	9.6	56	14.6	
	Never	1	0.7	4	3.2	0	0.0	5	1.3	
Manipulative, lying	Always	16	10.5	11	8.9	7	6.7	34	8.9	0.320
	Frequently	25	16.3	32	25.8	21	20.2	78	20.5	
	Occasionally	71	46.4	50	40.3	43	41.3	164	43.0	
	Rarely	41	26.8	28	22.6	31	29.8	100	26.2	
	Never	0	0.0	3	2.4	2	1.9	5	1.3	
High anxiety	Always	26	17.0	7	5.6	10	9.6	43	11.3	0.004*
	Frequently	79	51.6	51	40.8	52	50.0	182	47.6	
	Occasionally	37	24.2	51	40.8	33	31.7	121	31.7	
	Rarely	10	6.5	12	9.6	9	8.7	31	8.1	
	Never	1	0.7	4	3.2	0	0.0	5	1.3	
Anger towards physicians	Always	30	19.6	22	17.5	11	10.6	63	16.4	0.228
	Frequently	61	39.9	51	40.5	35	33.7	147	38.4	
	Occasionally	51	33.3	41	32.5	45	43.3	137	35.8	
	Rarely	11	7.2	12	9.5	13	12.5	36	9.4	
	Never	0	0.0	0	0.0	0	0.0	0	0.0	
Drug addiction	Always	4	2.6	54.0		2	1.9	11	2.9	0.451
	Frequently	6	3.9	7	5.6	12	11.5	25	6.5	
	Occasionally	27	17.6	24	19.2	19	18.3	70	18.3	
	Rarely	90	58.8	66	52.8	52	50.0	208	54.5	
	Never	26	17.0	23	18.4	19	18.3	68	17.8	

*$P < 0.05$

Table 5. Comparison of the physicians' frequency of using specified methods in coping with difficult patients according to the branches they work in.

Methods of coping with difficult patients		Working branch								P
		Medical		Surgical		Family medicine		Total		
		n	%	n	%	n	%	n	%	
Empathizing	Always	37	24.3	25	19.8	34	32.7	96	25.1	Cannot be tested
	Frequently	80	52.6	68	54.0	47	45.2	195	51.0	
	Occasionally	27	17.8	26	20.6	22	21.2	75	19.6	
	Rarely	5	3.3	6	4.8	1	1.0	12	3.1	
	Never	3	2.0	1	0.8	0	0.0	4	1.0	
Direct approach (to maintain minimum communication)	Always	16	10.5	19	15.3	6	5.8	41	10.8	0.283
	Frequently	46	30.3	37	29.8	29	28.2	112	29.6	
	Occasionally	63	41.4	46	37.1	42	40.8	151	39.8	
	Rarely	22	14.5	21	16.9	21	20.4	64	16.9	
	Never	5	3.3	1	0.8	5	4.9	11	2.9	
Predefine time and content in advance	Always	14	9.5	8	6.5	5	5.0	27	7.3	0.217
	Frequently	43	29.3	35	28.2	20	19.8	98	26.3	
	Occasionally	53	36.1	51	41.1	38	37.6	142	38.2	
	Rarely	26	17.7	24	19.4	25	24.8	75	20.2	
	Never	11	7.5	6	4.8	13	12.9	30	8.1	
Suggesting the patient consult another physician	Always	4	2.6	6	4.8	6	5.8	16	4.2	0.256
	Frequently	23	15.1	21	16.8	18	17.3	62	16.3	
	Occasionally	77	50.7	49	39.2	54	51.9	180	47.2	
	Rarely	37	24.3	43	34.4	22	21.2	102	26.8	
	Never	11	7.2	6	4.8	4	3.8	21	5.5	

*$P < 0.05$

In a study investigating effects of doctor–patient relationship on healthcare utilization, it was concluded that patients with lower level formal education use healthcare services more frequently, and have been labeled more difficult patients by physicians (25). Magnus and Mick noted that many research studies concluded that highly educated patients with high socio-economic status received more information from physicians, whereas patients with low socio-economic level could not get more information from physicians, although they would like to (13). In a survey conducted in Selçuk University Meram Medical Faculty (SUMTF) with 178 healthcare professionals, the question about whether the socio-economic and educational status of the patients affected the interaction between healthcare workers and patients was answered as "I strongly agree" by 38.8% of the participants and as "I agree" by 39.3% (26). In a study conducted via face-to-face interviews with 10 physicians in the province of Isparta, 5 participants stated that high level of education and 3 participants stated that very low levels of education affect communication positively. It has been suggested that patients with high levels of education may affect the communication positively by understanding the instructions of physicians better but negatively by insisting on unnecessary tests, whereas patients with low levels of education may affect the communication positively by being more obedient and cooperative during treatment (27). In our study 51% of the patients experiencing negative communication with physicians were university graduates and 43.25% were illiterate.

In a study investigating the demographic data and healthcare characteristics of difficult patients among 166 patients, it was found that the definition of difficult patient usually includes elderly patients, those divorced

or widowed, and women with high percentages (10). In another two studies including primary healthcare services and ambulatory care clinics, it was found that younger and female physicians encounter difficult patients more commonly (14,17). In a study conducted with 400 patients at two state hospitals and a university hospital in Elazığ, it was found that belonging to the same sex is necessary for a healthy physician–patient relationship (49.9%), where the researchers related this result to the mentality connected with the traditional way of life (28). In the study conducted at SUMTF, the question regarding whether the sex of the patient affects communication was answered as "I strongly agree" by 46.1% of the participants and "I agree" by 28.1% of the participants (26). In our study, contrary to the literature, we found no significant correlation between the sex of the patient and physician–patient communication ($P > 0.05$). This may be due to higher socio-economic level of Ankara, where we conducted our study, and a general transition from the traditional lifestyle to modern lifestyle.

It is known that the media has mental and behavioral effects on people (29). The impact of the media on the increasing violence in society is one of the matters debated in recent years. In the study conducted at SUMTF, the reasons for the negative biases of patients and/or relatives towards healthcare workers were related 35% with previous negative experiences of patients and 20.8% with the impact of the media (26). In our study, 95.5% of the physicians stated that they believe that patients and/or relatives have negative biases in communication with healthcare workers, and 81% of them thought that negative thoughts of patients are related to media publications. In addition, the other reasons for the biases stated by the physicians were the negative attitudes in society by 63.75%, the things heard from other people by 45.25%, and negative experiences of patients by 44.75%.

Physicians use their abilities of clinical communication in both planning the treatment and informing patients and/or relatives (2). The physicians who have taken communication courses before graduation experience negative communication less and have better empathy with patients and/or relatives than others (30–32). In a surgical broad participation study conducted with surgery residents it was shown that communication skills are learnable behaviors (30). In this country, communication skills training in faculties of medicine has been provided by few universities (33,34). In our study, we observed that only 9.44% of the physicians had received courses on coping with difficult patients. In our study, 46.81% of the physicians could cope with difficult patients based on their own experiences. In Akdeniz University Faculty of Medicine, after the communication skills courses, the students stated that they were mostly impressed by the experiences and practices of their clinical trainers and the patients' stories (35). Although practice in medical education has been considered to be based on a master–apprentice relationship, in our study, 15.28% of the physicians stated that they received experience from their trainers, whereas 22.50% stated that they received experience from their co-workers. Medical students' higher dependence on the courses may be due to their lack of professional experience. In our study 49.7% of the physicians thought that seminars and conferences about communication with difficult patients in the hospitals may be useful.

Devoting patients adequate time for providing information about disease process and treatment helps establishing better communication and a secure environment between physicians and patients (15,36). Frequent and longer examinations help physicians to know their patients better and facilitate solving problems, because difficult patients often require more time and energy (15). In survey conducted in a training and research hospital in İstanbul with 80 residents including 40 from internal branches and 40 from surgical branches, the question "Extending examination time boosts my performance" was agreed with more by residents working in internal branches than those working in surgery branches. In the same study it was found that presence of allied health personnel increased the performance of residents (37). In our study, we found that the physicians working in internal branches allowed sufficient time for difficult patients and they were significantly more knowledgeable about the effects of teamwork on communication in comparison to those in surgical branches.

In a cohort study including physicians and patients in primary care outpatient clinics, the physicians with 10 years of professional experience defined 23% of their patients as difficult, whereas those with 20 years of professional experience defined 2% as difficult (38). In a study conducted with family medicine physicians the frequency of encountering difficult patients was calculated on a monthly basis for family medicine physicians with 10 years of experience and on a weekly basis in family medicine physicians with less than 10 years of experience (39). In our study, the majority of physicians with less than 10 years of experience stated that they experience negative interactions with patients and/or relatives 1–3 times per month, whereas the majority of physicians with more than 10 years of experience stated that they experience negative interactions 1–5 times a year ($P = 0.000$). This may be due to physicians' recognizing difficult patients easily and learning how to cope with them depending on their professional experience. In our study, we found a statistically significant relationship between having more than 10 years of experience and approving of the statement "The frequency of negative communications with patients has been decreasing as I have been gaining experience in

the profession" ($P < 0.05$). We also found a statistically significant relationship between branches of the physicians and experiencing negative interactions with patients and/or relatives; the physicians working in surgical branches were found to experience negative interaction with patients and / or relatives more frequently than those in other branches ($P < 0.05$). The reason for this may be that surgery patients may be stressful and have greater expectations from their physicians or the surgeon's malpractice concerns, intense working conditions, and the pressure of the master–apprentice relationship dominant in surgery clinics may also increase the frequency of negative interactions. In a study conducted in the Hospital of Dokuz Eylül University Medical Faculty a work satisfaction survey was applied to residents and it was reported that work satisfaction was higher among internal medicine and internal medicine branches than the surgical branches (40).

Absence of administrative policies and strategies for coping with difficult patients may also cause patients to be perceived as difficult. Identifying and managing difficult patients should be teamwork. This teamwork should include all physician-, patient-, and system-related problems and should be appropriate for different situations in clinical practice (11,19). In a survey conducted in Celal Bayar University Faculty of Medicine Research and Application Hospital 40% of the medical staff stated that the hospital administration can find effective solutions to problems experienced, whereas 87.2% stated that they experience communication problems because of the hospital administration (41). Similarly, in our study, only 55 of the 400 physicians (13.8%) approved of the expression "I believe healthcare communication applied at the hospital is adequate". The rate of physicians who believe that the hospital administration can find effective solutions for the problems experienced with difficult patients was 10.9%. In a study in which 95 hospital managers from private and public hospitals in Mersin Province evaluated their perception of problem solving, it was found that the managers adopted an avoidant and estimating approach (19). The health care system implemented by hospital management should help doctors and patients by facilitating devoting more time to difficult patients, preventing frequent admissions, and raising awareness (42). Hospital ethical boards, which include several evaluators, should help to establish a communication bridge by implementing binding rules in cases of conflicts between doctors, patients, and hospital management (43).

The most common traits of difficult patients were listed as psychological problems and drug addiction in the study of Krebs et al. and as multiple medical complaints, constantly feeling ill, drug-seeking behavior, and chronic pain, by Elder et al. (14,15). In our study the most common trait of difficult patients was "multiple complaints and chronic diseases", whereas the least common trait was "drug addiction". The reasons may include the increasingly aging population of Turkey, psychiatric diseases cannot be diagnosed by physicians or are denied by the patient, or legal issues about drug addiction may prevent patients from presenting to hospitals.

In a study that evaluated family medicine and internal medicine specialists together, the traits of difficult patients were listed as insisting on nonindicated drugs, dissatisfaction with the treatment given, and expectations that cannot be fulfilled with the treatment given (10). In another study including 627 patients, 15% of the patients were classified as difficult by the physicians. The common traits of difficult patients were found to be somatoform disorders, panic disorders, arrhythmia, generalized anxiety, major depression, and alcohol abuse or drug addiction (44). In recent studies, difficult patients are defined as patients with multiple and repetitive complaints who are not satisfied with the treatment; this is followed by problems related to socio-cultural behavior and literacy and language problems (12). In a study conducted in 92 patients who had been classified as difficult, significant differences were found between the difficult patients and the control group in terms of being divorced or separated, demanding more testing, and presenting to physicians more frequently (24). In another study examining difficult patient–nurse communications, 84% of the nurses defined difficult patients as those who are grumbling, furious, or shouting, 81.6% those who reject the treatment, 87.2% those with much pain and constantly shouting, and 84% those who demand, ask something, or call the nurse to the bedside (45). In our study, we evaluated the responses of the physicians by classifying them according to branches, professional experience, and number of patients examined daily. We found that physicians in internal branches significantly more frequently encounter patients with unresolved, recurrent complaints, multiple complaints and chronic diseases, psychosomatic diseases, and high anxiety, compared to other branches ($P < 0.05$).

In a study comparing family physicians, internal medicine physicians, and subspecialty physicians in terms of encountering difficult patients, it was found that the rate of dissatisfaction in relationships with patients is significantly lower in family medicine physicians compared to other branches. This result was suggested to be due to the holistic approach of family medicine and family medicine physicians' higher awareness of the importance of psychosocial care (14). We found that family medicine physicians/specialists are significantly more sensitive than other medical specialties regarding physician-related problems in communication with difficult patients, empathy to patients, and achieving improvement in communication skills by training and experience ($P <$

0.05). This difference may be due to the fact that 95.45% of the participants in our study were family physicians and patient–physician communication courses in family medicine training includes detailed discussions of subjects such as communication, interviewing techniques, difficult patients, training patients and counseling, telling bad news, and management of patients with behavioral problems.

Serour at al. reported that physicians with professional experience of less than 10 years more commonly encounter with patients with chronic illness and multiple physical diseases (39). Steinmetz et al. reported that family physicians with more than 5 years of experience defined the most common traits of difficult patients as verbal abuse, offensiveness, tendency to violence, unresolved recurring complaints, and multiple complaints like a shopping list, in that order (46). Perry, in his study, disparately from the others, evaluated experience as frequency of encountering difficult patients and suggested that these doctors provide better care to the difficult patients (17). In our study the physicians with less than 10 years of experience encounter difficult patients significantly more frequently than those with more than 10 years of experience. This may be due to the acquisition of the ability to communicate with difficult patients by professional experience and learning how to manage the patients who had been labeled difficult easily.

In our study, we found a significant relationship between examining more than 50 patients a day and frequency of encounters with verbal abuse, offensive patients, tendency to violence, or those who were angry with physicians. Excess number of patients results in increased waiting time and reduction of the time allocated per patient and the resulting stress is one of the precipitators of patients with a tendency to violence. In addition, communication skills of the physicians may deteriorate due to excess workload and a patient they labeled difficult may not be regarded as difficult by another physician (46,47). Mathers et al. reported that physicians examining excessive numbers of patients experience difficult patient encounters 3 times more than those examining normal or less than normal numbers (16).

In our study, 371 (92.8%) physicians stated that they had experienced negative interactions with patients and/or relatives previously. Despite this high rate, 47.8% of the physicians evaluated their ability to cope with difficult patients as medium and 41.0% as good. We found that the physicians' methods of coping with difficult patients included nonjudgmental listening, patience, tolerance, and empathy, in that order, similarly in three groups. Another study conducted by interviews with 15 family medicine physicians with more than 5 years of professional experience reported the same methods, with empathy at the top (46). In our study, we found that physicians with less than 10 years of professional experience had been predefining time and content limits more frequently. In the current approach, defining time and content limits is one of the recommended methods for focusing on the most important complaints of patients (46). On the other hand, more experienced physicians may prefer leaving time limits according to the needs of patients in order to achieve details that may explain the reasons that make a patient difficult (8).

We found that physicians examining more than 50 patients daily had been using a direct approach (to maintain minimum communication) and suggesting another physician less frequently than those examining less than 50 patients; the difference was statistically significant. The reason for this may be that the physicians examining excessive numbers of patients may have to focus directly on the actual complaint and its main reason, without empathy, due to the time limitation. Kutlu et al. in their study evaluated physicians' thoughts about their patients, whether they emphasize with their patients, and whether they reflect this empathy in their practice and relationship with the patients; they found that 71.1% of the physicians thought that understanding the emotional states of both the patients and their relatives is an important part of their relationship with patients. On the other hand, 57.8% of the physicians stated that they do not allow strong relationships between them and the patients and/or relatives to affect them (48). Suggesting patients visit another physician can be preferred in order to avoid overlooking some symptoms due to anxiety resulting from difficulties experienced in communication. A patient labeled difficult by one physician may not be so for another physician (46,47). However, it should be noted that this method may cause anxiety due to elongated waiting time or time loss.

The limitations of our study include being carried out in two hospitals and with 400 physicians and the reasons for defining a patient as difficult were investigated only from the physicians' point of view. Larger studies investigating the reasons explaining difficult patients and solutions including the points of view of patients and the hospital administration are needed.

In conclusion, we found that patients with multiple complaints and chronic diseases are the most commonly encountered group of difficult patients with whom the doctors experienced negative communication. Additionally we found that the frequency of experiencing negative communication increased with average daily working hours, the number of examinations, and working in surgical branches, whereas it decreased with the experience of the physicians. The most common ways of coping with difficult patients are nonjudgmental listening, being patient and tolerant, and empathizing, in that order. The doctors were found to prefer using a direct approach (to maintain a minimum communication) or suggesting

the patient consult another physician more commonly as the number of patients examined increases.

We found that the rate of doctors who had taken communication courses during their education in order to communicate and cope effectively with difficult patients they describe was low and the doctors used their own experience rather than training as a way of coping with difficult patients and/or relatives. Interestingly, the doctors' evaluation of their own state of coping with difficult patients was found to be medium/good. Family physicians and specialists were found to be significantly more sensitive compared to other medical specialties in terms of doctor-related problems in communication with difficult patients, empathizing, communication skills achieved by training, and experience.

The doctors' statement that hospital management cannot find sufficient solutions for problems they encounter with difficult patients, in other words the lack of strategies for difficult patients, may also cause patients to be perceived as difficult. Identifying and managing difficult patients should be teamwork. This teamwork should include all physician-, patient-, and system-related problems and should be appropriate for different situations in clinical practice (19).

References

1. Aspegren K. Teaching and learning communication skills in medicine - a review with quality grading of articles. Medical Teacher 1999; 21: 563-570.
2. Brown J. How clinical communication has become a core part of medical education in the UK. Med Educ 2008; 42: 271-278.
3. Rosenberg W, Donald A. Evidence based medicine: an approach to clinical problem-solving. BMJ 1995; 310: 1122-1126.
4. Đorđević V, Braš M, Brajković L. Person-centered medical interview. Croat Med J 2012; 53: 310-313.
5. Ong LM, De Haes JC, Hoos AM, Lammes FB. Doctor-patient communication: a review of the literature. Social Science & Medicine 1995; 40: 903-918.
6. Zolnierek KB, DiMatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. Med Care 2009; 47: 826-834.
7. Maguire P, Pitceathly C. Key communication skills and how to acquire them. BMJ 2002; 325: 697.
8. Haas LJ, Leiser JP, Magill MK, Sanyer ON. Management of the difficult patient. Am Fam Physician 2005; 72: 2063-2068.
9. Kroenke K. Unburdening the difficult clinical encounter. Arch Intern Med 2009; 169: 333-334.
10. An PG, Rabatin JS, Manwell LB, Linzer M, Brown RL, Schwartz MD. Burden of difficult encounters in primary care: data from the minimizing error, maximizing outcomes study. Arch Intern Med 2009; 169: 410-414.
11. Lorenzetti RC, Jacques CM, Donovan C, Cottrell S, Buck J.. Managing difficult encounters: understanding physician, patient, and situational factors. Am Fam Physician 2013; 87: 419-425.
12. Dhar H, Dhar D. Difficult patient encounters in the developing world. Middle East Journal of Family Medicine 2013; 11: 41-47.
13. Magnus SA, Mick SS. Medical schools, affirmative action and the neglected role of social class. Am J Public Health 2000; 90: 1197-1201.
14. Krebs EE, Garrett JM, Konrad TR. The difficult doctor? Characteristics of physicians who report frustration with patients: an analysis of survey data. BMC Health Serv Res 2006; 6: 128-135.
15. Elder N, Ricer R, Tobias B. How respected family physicians manage difficult patient encounters. J Am Board Fam Med 2006; 19: 533-541.
16. Mathers N, Jones N, Hannay D. Heartsink patients: a study of their general practitioners. Br J Gen Prac 1995; 45: 293-296.
17. An PG, Manwell LB, Williams ES, Laiteerapong N, Brown RL, Rabatin JS, Schwartz MD, Lally PJ, Linzer M. Does a higher frequency of difficult patient encounters lead to lower quality care? J Fam Pract 2013; 62: 24-29.
18. Ratanawongsa N, Roter D, Beach MC, Laird SL, Larson SM, Carson KA, Cooper LA. Physician burnout and patient-physician communication during primary care encounters. J Gen Intern Med 2008; 23: 1581-1588.
19. Çelik C, Yurdakul M. Problem solving skills of hospital managers: a field research. Journal of the Cukurova University Institute of Social Sciences 2009; 18: 95-108 (article in Turkish with an abstract in English).
20. Kravitz RL. Measuring patients' expectations and requests. Ann Intern Med 2001; 134: 881-888.
21. Virshup BB, Oppenberg AA, Coleman MM. Strategic risk management: reducing malpractice claims through more effective patient-doctor communication. Am J Med Qual 1999; 14: 153-159.
22. Huntington B, Kuhn N. Communication gaffes: a root cause of malpractice claims. Bayl Univ Med Cent Proc 2003; 16: 157-161.
23. Mayou R, Sharpe M. Patients whom doctors find difficult to help: an important and neglected problem. Psychosomatics 1995; 36: 323-325.
24. John C, Schwenk TL, Roi LD, Cohen M. Medical care and demographic characteristics of 'difficult' patients. J FamPrac 1987; 24: 607-610.

25. Lynch DJ, Mc Grady AV, Nagel RW, Wahl EF. The patient-physician relationship and medical utilization. Prim Care Companion J Clin Psychiatry 2007; 9: 266.

26. Celik F. Communication in health institutions; a research on patient and medical staff. PhD, Selçuk University Institute of Social Sciences, Konya, Turkey, 2008 (in Turkish).

27. Atilla G, Oksay A, Erdem RA. Qualitative pre-study on the physician-patient communication. İstanbul University Faculty of Communication Journal 2012; 43: 23-37 (article in Turkish with an abstract in English).

28. Yağbasan M, Çakar FA. A field study to reveal language - and attitude based communicational problems in doctor - patient relationship. Selçuk University The Journal of the Institute of Social Sciences 2006; 15: 609-629 (article in Turkish with an abstract in English).

29. Erjem Y, Çağlayandereli M. Television and youth: the effects of national television serials on the role modelling behaviour of youngsters. Cumhuriyet Üniversitesi Edebiyat Fakültesi Sosyal Bilimler Dergisi 2006; 30: 15-30 (article in Turkish with an abstract in English).

30. Wehbe-Janek K, Song J, Shabahang M. An evaluation of the usefulness of the standardized patient methodology in the assessment of surgery residents' communication skills. J. Surg Educ 2011; 68: 172-177.

31. Rahman A. Initial assessment of communication skills of intern doctors in history-taking. Medical Teacher 2000; 22: 184-188.

32. Bredart A, Bouleuc C, Dolbeault S. Doctor-patient communication and satisfaction with care in oncology. Curr Opin Oncol 2005; 17: 351-354.

33. Kılıç B, Sayek İ. Undergraduate medical education report 2000. Community and Physician 2001; 16: 230-240 (in Turkish).

34. Elçin M, Orhan Odabaşı O, Turan S, Sincan M, Başusta NB. Developing communication skills using standardized patients and structured assessments in medical education. Hacettepe Tıp Dergisi 2010; 41: 219-230 (article in Turkish with an abstract in English).

35. Şenol Y, Özdoğan M, Oktay C, Yılmaz TT, Bozcuk H. Doctor - Patient Relationship, - Communication skills training and role modelling of faculty member. Tıp Eğitimi Dünyası 2011; 31: 38-44 (article in Turkish with an abstract in English).

36. Harvey KJ, Vitry AI,Roughead E, Aroni R, Balenden N, Faggotter R. Pharmaceutical advertisement in prescribing software: an analysis. Med J Aust 2005; 183: 75-79.

37. Tanrıverdi H, Teker ÇA. Comparison of performance measures in education hospitals in point of clinical work loads in assistant doctors. Sağlıkta Performans ve Kalite Dergisi 2010; 1: 114 (article in Turkish with an abstract in English).

38. Hinchey SA, Jackson JL. A cohort study assessing difficult patient encounters in a walk-in primary care clinic, predictors and outcomes. J Gen Intern Med 2011; 26: 588-594.

39. Serour M, Othman HA, Khalifah GA. Difficult patients or difficult doctors: an analysis of problematic consultations. European Journal of General Medicine 2009; 6: 87-93.

40. Tan MN, Özçakar N, Kartal M. Resident doctors' professional satisfaction and its effect on their lives. Marmara Medical Journal 2012; 25: 20-25 (article in Turkish with an abstract in English).

41. Adıgüzel Z. The characteristics of the communication between the health personnel- patients and elements influencing communications (Celal Bayar University Health Practice and Study Center). PhD, Celal Bayar University Institute of Social Sciences, Manisa, 2005 (in Turkish).

42. Breuner CC, Moreno MA. Approaches to the difficult patient/ parent encounter. Pediatrics 2011; 27: 163-169.

43. Çobanoğlu N. Kuramsal ve Uygulamalı Tıp Etiği. 1st ed. Ankara, Turkey: Eflatun Printing House; 2009 (in Turkish).

44. Hahn SR, Kroenke K, Spitzer RL, Brody D, Williams JB, Linzer M. The difficult patient. J Gen Intern Med 1996; 11: 1-8.

45. Akgün Çitak E, Avci S, Basmaci Ö, Durukan İ. Investigating the communication behaviours of nurses towards patients defined as difficult by nurses in a university hospital. Turkish Journal of Research & Development in Nursing 2011; 13: 35-46 (article in Turkish with an abstract in English).

46. Steinmetz D, Tabenkin H. The 'difficult patient' as perceived by family physicians. Family Practice 2001; 18: 495-500.

47. Romano SE, Schwenk TL. The challenging patient encounter. In: Sloane PD, Slatt LM, Ebell MH, Jacques LB, Smith MA, editors. Essentials of Family Medicine. 5th ed. Philadelphia, PA, USA: Lippincott Williams & Williams; 2008. pp. 31-38.

48. Kutlu M, Çolakoğlu N, Özgüvenç ZP. A study on the importance of empathy in patient-doctor relationship. Sağlıkta Performans ve Kalite Dergisi 2010; 1: 127-143 (article in Turkish with an abstract in English).