RESEARCH ARTICLE

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Difficult Encounters Experienced by Family Physicians and the Coping Methods They Employ: A Cross-sectional Study

ABSTRACT

Objective: The purpose of this study was to determine difficult encounters and the practice of medicine among family physicians (FPs).

Method: The research was conducted as a cross-sectional study using a questionnaire between 15 June and 15 July, 2019. The questionnaire included sociodemographic characteristics, difficult situations that may be encountered, and methods of coping with such situations. Three hundred twenty-five FPs took part in the study.

Results: The FPs reported being most frequently troubled by "requests for unnecessary reports" and "patients requesting unindicated tests". FPs described male gender, age 31-40, possession of a moderate income level, being married, and being a civil servant as the patient characteristics most frequently causing difficulties. The mean length of time spent with an ordinary patient was 7.4±0.1 minutes, but this rose to 12.6±0.3 in case of difficult patients. The coping method most frequently employed by FPs in the face of difficult encounters was empathy. Ninety-two percent of the FPs reported experiencing a communication problem with patients at least once a year. Only 22.5% of FPs reported having taken part in training regarding managing difficult situations.

Conclusion: FPs frequently experience difficult encounters. The most frequent of these involve demanding, frequently presenting patients with numerous complaints. The principal reason for FPs experiencing difficult encounters was found to be problems in the health service. Although empathy was the most frequently employed coping method, a lack of training on the subject was also identified.

Keywords: Delivery of Health Care; Difficult Encounter; Family Practice; Physician-Patient Relations; Primary Health Care

Aile Hekimlerinin Karşılaştığı Zor Durumlar ve Başa Çıkma Yöntemleri: Kesitsel Bir Çalışma

ÖZET

Amaç: Bu çalışma ile aile hekimlerinin zor durumlarla karşılaşma durumlarının ve hekimlik pratiklerin saptanması amaçlanmıştır.

Gereç ve Yöntem: Kesitsel tipteki bu çalışma 15 Haziran-15 Temmuz 2019 tarihleri arasında bir anket formu ile yürütülmüştür. Anket formunda sosyodemografik özellikler, karşılaşılabilecek zor durumlar ve zor durumlarla başa çıkabilme yöntemleri yer almaktadır. Çalışmaya toplam 325 aile hekimi katılmıştır.

Bulgular: Aile hekimleri en sık "gereksiz yere rapor talepleri" ve "endikasyon olmadan tektik isteyen hastaların" kendilerini zorladığını belirtmektedir. Aile hekimlerini zorlayan hasta özellikleri erkek olma, 31-40 yaş arası olma, orta gelir düzeyinde olma, evliler ve devlet memurları olarak bildirilmiştir. Sıradan bir hasta görüşmesi ortalama 7,4±0,1 dakika iken, zor hastalarda 12,6±0,3 dakikaya çıktığı bildirilmiştir. Aile hekimleri zor durumlarla karşılaştıklarında en sık başa çıkma yöntemi olarak empati kurmaya çalıştığını belirtti. Aile hekimlerinin %92'si son 1 yılda en az bir kez hastalarla bir iletişim problemi yaşadıklarını belirtmiştir. Zor durum yönetimi ile ilgili sadece %22,5'i bir eğitime katıldığını belirtti.

Sonuç: Aile hekimleri zor durumlar ile çok sık karşılaşmaktadır. Talepkar, sık başvuran, çok sayıda şikâyeti olanlar hastalar en sık karşılaşılan zor durumlardır. Aile hekimleri tarafından zor karşılaşmaların en önde gelen nedeni olarak sağlık sistemi sorunları gösterilmektedir. Empati kurma en sık kullanılan başa çıkma yöntemi olsa da bu konuda eğitim eksikliği olduğu saptanmıştır.

Anahtar Kelimeler: Sağlık Hizmeti Sunumu; Zor Karşılaşma; Aile Hekimliği; Hekim-Hasta İlişkileri; Birinci Basamak Sağlık Hizmeti

INTRODUCTION

Health services are by their nature highly complex and are provided in an environment of uncertainty. Health service users vary considerably in terms of character, needs, and demands. Problems may from time to time be experienced between patients and health personnel during the provision of services. Indeed, these problems may sometimes develop into violence, aggression, and physical assaults against health personnel (1). Turkey is a country where the patient-physician relationship is difficult. Health workers in the country may be subjected to violence or even killed while doing their jobs (2).

Communication between the patient and physician is of great importance in terms of health. This is because appropriate communication is the simplest and most effective means of preventing potential problems between the patient and physician. However, difficult encounters capable of lowering the quality of communication between patient and physician are inevitable in the provision of health services. Almost all physicians experience varying dimensions and levels of difficulty with patients throughout their working lives. However, patients are generally implicated as the source of difficulty between the patient and physician in the literature (3). Health workers employ terms such as "difficult patient", "hateful patient", or "heart sink patient", to refer to such individuals (4, 5).

The term "difficult patient" is used to refer to patients who cause problems in the normal flow of health service provision. The majority of health workers describe difficult patients as "demanding", "aggressive", "obstinate", "self-damaging", or "seeking to manage the health worker" compared to a "normal patient". Patients who do not cooperate with the health worker, "who constantly find fault with the service provided", "who list symptoms that have nothing whatsoever to do with one another", "who demand unnecessary medications", "who distrust the health worker", or who "possess bulging medical files" are also included in the difficult patient category (3). The characteristics of difficult patients may differ. These depend on several factors, such as the patient's age, sex, social class, sociocultural characteristics, psychological state, and disease (4, 6, 7).

Studies have increasingly come to recognize the idea of the" "difficult patient". However, that label entails both practical and emotional implications, and some authors have therefore elected to concentrate instead on encounters and relationships, referring either to "difficult encounters" or "difficult relations" (8).

Researchers investigating interviews with patients described as difficult report that difficulties occurring during these may not only derive from the patient, but also from factors associated with the physician or the health service. Other reported causes of difficult patient-physician interviews include physician-related factors such as long working hours, weak communication skills, and insufficient professional experience, and factors related to the health service such as performance pressure and changes in health financing (9).

It is estimated at 15-30% of family physician (FP) examinations fall into the "difficult" category (10-12). Physicians who encounter large numbers of difficult patients are reported to have higher probabilities of burnout and associated stress or other adverse outcomes than colleagues with fewer such encounters (9, 13). In addition, while some studies report that physicians provide more inadequate health care for difficult patients, others report that difficult encounters are not associated with worse patient care or higher error rates (9, 13).

Treatment is a process based on the patient-physician relationship. Disruption of this process is one of the greatest obstacles to a high quality health service. It is therefore of great importance that that patient-physician relationship be elucidated from all aspects.

The purpose of this study was to determine difficult encounters and the practice of medicine among FPs. There have been a small number of such studies among FPs in Turkey. With this study, we will have the chance to compare the difficult patient encounters of physicians in Turkey with physicians in other countries. The experiences of physicians in different countries will guide us about the causes and solutions of the problem.

MATERIAL AND METHODS

The population of this descriptive research consisted of 413 FPs working in 143 family health centers in 17 districts in the Turkish province of Samsun. With a population of 1.37 million, Samsun is the largest province on the Black Sea coast in the north of Turkey. No sample was selected in the study, and all FPs actively working in Samsun at the time of the study were contacted. The questionnaires were completed at face-to-face interviews with physicians. The study was conducted between 15 June and 15 July, 2019. The aim of the study was forwarded to the FPs prior to the commencement of the study, at which time it was explained that participation was on a voluntary basis, and verbal consent was obtained. Three hundred twenty-five (78.9%) FPs eventually took part. Approval from the Ondokuz Mayıs University clinical research ethical committee and all administrative permissions were obtained before commencement. (IRB No. OMUKAEK 2017/137).

A questionnaire consisting of 20 questions was employed. This was prepared on the basis of a search of the relevant literature (3, 9, 14, 15). Prior to application, the questionnaire was tested on 10 physicians. This self-report form can be completed in approximately 10 minutes. The first part contains questions about FPs' sociodemographic characteristics and working conditions. The second

part lists difficulties that may be encountered in health service provision, and respondents are asked to indicate how frequently they encounter each one. The third part investigates the frequency with which respondents employ coping methods with difficult encounters. Experience of difficult encounters is evaluated from 1, "very rarely" to 5, "very often". It is presented by combining the "Very Rarely/ Rarely" and "Often/Very Often" options. The extent of agreement with propositions is evaluated from 1, "I strongly disagree" to 5, "I strongly agree". The frequency of employment of coping methods was assessed from 1, "I rarely use this" to 5, "I often use this".

The questionnaire data were transferred onto SPSS 22.0 software and analyzed as number and percentage. Paired t-test was used to compare the examination times of physicians for difficult patients and non-difficult patients.

RESULTS

Men represented 64.9% of the FPs in the study, 88.6% of the participants were married, their mean age was 44.6±0.4 years, and their mean time in the profession was 19.7±0.54 years (Table 1). The frequencies of difficult encounters during FPs' professional experience are shown in Table 2. FPs most frequently reported difficulties resulting from "unnecessary requests for reports" and "patients requesting unindicated tests" (Table 2). When asked about the features of patients causing difficulties for them, FPs predominantly responded men (52.6%); individuals aged 31-40 (43.1%), those with a moderate income level, married individuals (59.4%), and civil servants (37.2%). (Table 3)

Table 1. Family physicians' demographic and professional characteristics

	Number	**Percentage**
Sex		
Male	211	64.9
Female	114	35.1
Marital status		
Married	288	88.6
Single/Widowed/Divorced	37	11.4
Place of employment		
Urban center	144	44.3
Outlying district	146	44.9
Rural	35	10.8
	Mean ±SD	**Median (Min-Max)**
Age	44.6±0.4	45(26-64)
Years in the profession	19.7±0.4	20(1-37)

Table 2. The frequencies at which family physicians' experienced difficult encounters

	Percentage		
	Very rarely/ Rarely	Sometimes	Often/Very often
Patients seeking various health reports (for driving licenses, swimming, running, military service, etc.)	5.5	10.8	83.7
Seeking unindicated tests (inappropriate)	11.3	18.2	70.5
Patient relatives making requests on behalf of a patient in the absence of that individuals	13.2	19.7	67.1
Patients making frequent presentations	19.1	25.8	55.1
Patient seeking medications in the absence of any indication (inappropriate)	22.1	27.4	50.5
Patient seeking sick notes for work in the absence of any indication (inappropriate)	27.4	27.4	45.2
Patients with numerous complaints	36.3	27.7	36.0
Patients with insoluble recurrent complaints	31.3	31.4	37.3
Patients seeking to take advantage of the doctor's good nature	48.5	26.2	25.3
Patients with poor treatment compliance	40.4	36.6	23.0
Poorly behaved (over familiar or impolite) patients	57.6	20.6	21.8
Irritable, angry, aggressive patients	55.7	24.9	19.4
Patients expecting a secondary gain	55.0	26.2	18.8
Psychiatric patients	44.4	37.8	17.8
Patients who are never satisfied (dissatisfied)	57.5	25.6	16.9
Manipulative, deceptive patients	72.9	17.2	9.9
Crying patients	85.8	8.3	5.9
Patients with mental problems	83.4	11.4	5.2
Parents unwilling to have their children vaccinated	84.6	10.8	4.6
Cancer patients	76.6	16.9	6.5
Patients exhibiting sexually inappropriate behavior	95.7	2.2	2.1
Terminal patients (in the final stage of life)	85.5	11.1	3.4
Addicts	92.6	5.3	2.1

Table 3. Distributions of the sociodemographic characteristics of difficult patients in the according to family physicians

Difficult Patients Encountered	Number	Percentage
Sex		
Male	171	52.6
Female	154	47.4
Age group *		
0-10	2	0.6
11-20	20	6.1
21-30	44	13.5
31-40	140	43.1
41-50	103	31.7
51-60	52	16.0
61-70	31	9.5
Socioeconomic level *		
Low	128	39.4
Average	186	57.2
High	38	11.7
Marital status		
Married	193	59.4
Single	132	40.9
Occupation *		
Civil servants	121	37.2
Salaried staff-manual workers	57	17.5
Housewives	56	17.2
Commercial, self-employed	41	12.6
Unemployed	27	8.3
Agricultural workers	26	8.0
Retired	23	7.1
Students	16	4.9
No difference between occupations	53	16.3

* More than one answer was given.

FPs were asked an open-ended question about difficult patients' occupational groups. The most frequent reply to that question (29.5%, n=96) was "teachers". Fifty-two percent of FPs stated that patients' negative attitudes toward health workers may derive from their psychological states. The median number of FPs' patients was 60 (min=8; max=110). The mean time spent per patient was 7.4±0.1 min [median (min-max) = 5(2-20)], rising to 12.6±0.3 in [median (min-max) = 10(2-30)] in case of difficult patients. Duration of examination was significantly longer in difficult patients than in non-difficult patients (Paired t=17.95; p<0.001). Only 33.9% of FPs thought that they were able to devote sufficient time to difficult patients.

The extent of agreement among FPs with propositions concerning health workers and the health system as potential causes of interviews with difficult patients is shown in Table 4. FPs described 'creating empathy' as the method they most frequently used for coping with difficult encounters (Table 5). Forty-seven percent of FPs reported experiencing a communication problem with patients at least once a week (Table 6). Only 9.1% of FPs thought that their communication with patients was inadequate. In addition, 66.2% of FPs had received training on the subject of communication, and 22.5% on the subject of difficult patients/encounters (Table 6). Moreover, 26.3% of FPs considered that receipt of training on the subject of education would not contribute to solving their problems, and 23.2% reported that problems experienced with patients affected their private lives.

Table 4. Extents of agreement among family physicians with propositions regarding causes of difficult encounters

Propositions	1	2	3	4	5
My frequency of negative communication with patients decreased as my professional experience increased.	15.6	16.3	22.1	**22.2**	**23.8**
The problems that patients have with other healthcare professionals adversely affect communication between me and the patient.	13.8	21.3	25.9	**20.9**	**18.1**
I began to describe fewer patients as difficult as my professional experience increased.	23.2	15.0	25.0	**20.9**	**15.9**
A negative experience with one patient affects my behavior toward the next patient.	24.0	19.7	21.6	**15.9**	**18.8**
A patient I describe as difficult might not be difficult for another physician.	28.4	20.9	21.9	**11.3**	**17.5**
Problems with physicians cause patients to be labeled as difficult.	27.5	30.3	21.6	**10.6**	**10.0**
The management of the institution I work for do not produce effective solutions to communication problems I have with patients.	11.0	11.9	19.1	**16.3**	**41.7**
Deficiencies among health providers adversely affect my communication with patients.	10.0	13.1	20.0	**19.4**	**37.5**
Problems associated with the health system (payments, health insurance, examination fees, etc.) adversely affect my communication with patients.	21.2	13.8	20.3	**16.6**	**28.1**
High weekly/monthly working hours cause me to describe more patients as difficult.	22.2	21.6	23.1	**17.5**	**15.6**
I describe patients as difficult because my work is not satisfying.	61.9	15.3	15.0	**4.7**	**3.1**

1. Strongly agree, 2. Agree 3. Neither agree nor disagree 4. Agree 5. Strongly agree

Table 5. Methods employed by family physicians to cope with difficult encounters

	1	2	3	4	5
Establishing empathy	4.6	11.1	27.4	20.0	36.9
Learning the patient's method of coping with his clinical problem	12.6	22.8	35.1	19.7	9.8
The direct approach (reducing communication to a minimum)	18.5	26.5	28.6	16.9	9.5
Recommending that the patient consult another physician	23.4	22.2	29.5	16.6	8.3
Specifying a time and subject matter beforehand	31.4	22.8	31.7	9.8	4.3

1. Rarely used 5. Often used

Table 6. Frequencies of communication problems with patients and receipt of training among family physicians

	No.	Percentage
Frequency of communication problems with patients		
Several times a week	82	25.2
Once a week	71	21.8
Once a month	68	20.9
Once in a few months	78	24.0
None in the past year	26	8.0
Receipt of training on the subject of communication	215	66.2
Receipt of training regarding difficult patients/encounters	73	22.5

DISCUSSION

FPs everywhere in the world from time to time find themselves in difficult encounters (9). A study from the USA reported that almost all the FPs interviewed had patients whom they regarded as unpleasant, difficult, and problematic. Having difficult patients appears to be an almost universal experience among doctors (16). These encounters are generally frustrating for the physician. Patients may also be dissatisfied by these encounters due to their needs and expectations not being met and to unresolved medical problems.

In the present study, FPs reported that the difficult encounters they experienced during their professional practice often consisted of "demanding" patients and their relatives requesting inappropriate (non-indicated) reports, examinations, and drugs. Difficult encounters may be attributable to factors associated with the physician, patient, or medical condition, or a combination thereof (9, 17). Numerous factors may be listed under the headings of patient-related factors that may be evaluated as difficult, including "behavioral issues, conditions, and psychiatric diagnoses". "Angry/argumentative/rude" or "demanding/entitled" patients occupy an important place among the behavioral problems (9). A qualitative study from Israel reported that 'patients with a broad range of "behavioral problems" are the most difficult individuals for the majority of FPs interviewed (8). Physicians in another study performed in the USA most frequently described patients with "multiple problems", "demanding behaviors", and "stay sick behaviors" as difficult (16). In other research, 41% of patients identified as difficult were described as "dependent clinger patients", 18% as continually complaining or demanding, and 18% as seeking to direct the course of or refusing treatment (18). In contrast to studies from other countries, "demanding" patients appear to be more prominent in Turkey. We think that labeling a patient as "demanding" cannot simply be reduced to individual patient characteristics or behaviors or to "poor" doctoring. Demanding patients have attracted considerable interest in clinical terms and also in the sociological literature. While healthcare providers seek to characterize demanding patients and minimize detrimental effects on the clinical encounter; sociologists have rather focused on the social contexts resulting in the label "compulsive" (19). Patients making excessive demands on physicians in Turkey can be explained in terms of several factors, including "sociocultural structure", "the social security system" and "red tape". This is because the process that renders a patient demanding is a dynamic one and is associated with several causes. Numerous factors may play a role in this, such as the costs of drugs purchased without a doctor's prescription being met by the Social Security System after a prescription has been obtained, primary health services being free of charge, and reports recommending rest being regarded as "the most valid way of avoiding going to work or school".

FPs most frequently described patients causing difficulties for them as male, aged 31-40, with an average level of income, married, and civil servants. One study reported that 67.1% of patients described as difficult were women, that their mean age was 57.8±15.2 years, that 62% were elementary school graduates, 27% were single and without children, and 35% were retired (18). Another study of practitioner physicians reported that the majority of patients described as difficult were single, aged over 40, and divorced or widowed women (20). According to Stevens (21), academics, the retired, teachers, the unemployed, the self-employed, housewives, and manual workers are all regarded as difficult patients. A study from Turkey performed under hospital conditions reported that 37% of the

patients described as difficult by health personnel were young adults, 38.7% had an average socioeconomic level, 57.1% were married, 56.3% were men, 35.3% were high school graduates, and 36.2% were public sector workers (22). Two different studies reported that that poor and minority group patients feel powerless due to clinical encounters and more compelled to present themselves to physicians in a positive light compared to white, high socioeconomic-level patients (23, 24). Although existing research suggests that there is no association between the patient's sex, age, sociocultural level, or marital status and health providers' perceptions of difficult encounters (12), we think that further research is needed to explore the possible link between the patient's social position and difficult encounters.

FPs in this study were asked an open-ended question concerning the occupational groups with which they experienced difficult encounters. The most frequent response was "teachers". According to Cline and Hayes, 63% of the 90-120 million Americans who regularly use the internet do so to gather information (25). It has been suggested that the internet and other electronic sources of medical information shape patients' understanding of disease. Difficult encounters are embedded within innumerable sociocultural conditions but, as described here, these conditions account for only part of the turmoil between physicians and patients. Difficult encounters are reported to be most common when patients directly or indirectly challenge the physician's judgment or expertise (16). The reason why teachers emerge as the occupational group most frequently reported among difficult encounters in Turkey may derive from teachers making greater use of the internet to obtain health-related information.

FPs reported spending approximately twice as much time on difficult patients than on "normal patients". However, a significant proportion of FPs also thought they were unable to devote sufficient time to difficult patients. One study reported that physicians who described encountering more difficult patients thought that they provided a lower level of care for patients compared to colleagues who reported fewer difficult patients (10). However, the perception of frequent difficult encounters is also reported not to be associated with poorer quality of patient care or higher error rates (13). However, although FPs spend more time during difficult encounters compared to "normal patients", the fact that they regard the time they spend as insufficient should be interpreted as reflecting physicians' desire for quality in health service delivery.

The propositions with which FPs most frequently expressed agreement were "The frequency of negative communication with patients decreases as one's time in the profession increases" and "The management of the employer institution does not produce effective solutions to communication problems with patients". FPs reported that the frequency of difficult encounters as the length of time spent in the profession increased. Similarly to the present research, another study reported that younger health providers provided experienced difficult encounters more frequently (15). Difficult encounters are associated with various factors deriving from the physician, the patient, the condition, or a combination thereof. Every physician brings his own past, personality, and experience to every patient encounter (26). The authors of one study reported that different character traits can either help or hinder physicians in their encounters with difficult patients. Only a small minority of physicians believe that there is nothing in their character that might contribute to difficult encounters or to their assessing a patient as difficult. Physicians cited personal concerns, being a dominant individual, having an overly critical and judgmental personality, the need to be constantly liked by patients, a defensive personality, and being overly polite as characteristics that can make encounters difficult (8). Weak communication skills on the part of the physician, situational stress factors, and prejudices concerning specific health conditions have also been described as causes of difficult encounters (9). Additionally, encounters are much more difficult when physicians bring their own family lives, social lives, economic problems, and anxieties over problems in the health service to the interview. In the light of the negativities in the health system in Turkey, the economic problems experienced by health workers and the violence inflicted on them, it may be concluded that difficult encounters experienced by physicians are not solely due to difficult patients.

FPs most frequently reported 'establishing empathy' as their main coping method in the context of difficult encounters. A study of FPs from Israel also reported also reported establishing empathy as the most widespread and apparently effective means of coping (8). It is encouraging to see that physicians in Turkey do not reject difficult patients, but that, on the contrary, they seek ways of improving difficult medical encounters. The majority of solutions lie in the field of proper communication and improving patient-doctor relationships. FPs recognize the importance of empathy listening without judging, patience, and tolerance. Such methods are frequently recommended in medical interviews in general, and particularly in coping with difficult patients (9, 27, 28). However, the responses of family physicians may be conditioned by the bias of social desirability. This response about using empathy in difficult encounters may reflect the "desire" to do so rather than the fact that they actually do. It is unlikely that a FP, faced with emotional distress caused by a difficult encounter with a patient, will be able to connect and understand the patient's

feelings and also communicate it appropriately. Feelings of helplessness, anger, or being overwhelmed by FPs would make it difficult for them to face the situation with empathy. In fact, when difficult encounters are studied through audio or video recordings, empathy is conspicuous by its absence, as in the case of patients with medically unexplained symptoms (29).

FPs reported experiencing communication problems with patients at least once a week, although the great majority regarded themselves as proficient on the subject of communicating with patients. More than half of FPs had received training on the subject of communication, but the proportion who had received training regarding difficult patients or encounters was low. Communicating with the patient is highly important in achieving the desired therapeutic results. Studies report that the patient's satisfaction with the service provided is largely dependent on the behavior of the healthcare worker. In addition, a patient leaving happy with the interview that has taken place also ensure the satisfaction of the health workers are reduces occupational stresses (30-32). Some authors believe that the patient is usually the source of physician-patient conflict (33). However, physicians themselves can also be responsible for difficult encounters (14). Even if patients do cause communication problems, physicians need to possess the professional communication skills to allow them to cope with difficult encounters (34). Studies involving physicians report that education is effective in the management of encounters with difficult patients (35, 36). However, the majority of medical education programs do not involve structured or specific approaches to developing communication skills (37). We therefore think that FPs in particular should receive regular training on the subject of communication and coping with difficult encounters.

CONCLUSION

FPs frequently experience difficult encounters. These encounters most commonly involve patients who are demanding, who make frequent presentations, and those with numerous complaints. FPs regard problems in the health service as the leading reason for difficult encounters. Establishing empathy is the most frequently employed coping method. FPs should receive regular training on communication and coping with difficult encounters.

Limitations: There have been no previous such studies among FPs in Turkey. FPs participation in the study is high. However, the study was conducted in a single province and only with physicians. Patients' opinions on this issue were not taken. What is really needed to advance this field of research is the performance of more cohort studies, the use of objective measures of the difficult encounter (audio or video-recordings) and the simultaneous study of the opinion of the patient and FP in the same difficult encounter.

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