What makes a challenging consult: A cross-sectional study of 1053 dermatology patients in Singapore

To the Editor: A good physician-patient relationship leads to improved health outcomes.[1] This relationship has been studied primarily through patients' perspectives, and physicians' sentiments toward patients are frequently overlooked.

Forty-four physicians and 1053 unique adult patients were recruited through convenience sampling from 3 dermatologic centers in Singapore between October 2021 and September 2022. For each patient, physicians completed the Difficult Doctor-Patient Relationship Questionnaire (DDPRQ-10),[2] which was used to assess their frustration, enthusiasm, and ease of interaction with the patient. Each patient also independently completed a separate questionnaire.

The DDPRQ-10 scores ranged from 0 to 44 (median, 13) out of a maximum of 60. Difficult patients, as perceived by physicians, were older and had greater disease severity, greater quality of life impairment, increased disease cyclicity, poorer illness coherence (understanding of disease), lower personal and treatment control, higher anxiety, and increased need to emphasize symptoms. For difficult patients, the physicians were more likely to switch treatment, reframe mindsets, set expectations, explore nonmedical factors, teach coping strategies, spend a longer than usual time listening to the patient, and write a memo for the purpose of excuses. Difficult patients reported lower trust in their physicians, and physicians were more likely to feel pressure to wrap up the consult quickly (multilevel univariable analysis, Table I).

The factors that remained significant in a multivariable analysis include the following: older patients, lower personal control and trust, perceived overreporting of symptoms, physician's need to reframe mindset, spending longer time listening, writing a memo for the purpose of excuses, and feeling pressure to wrap up the consult (Table II).

The reasons for the association between age and being difficult are unclear. It may be that older patients have more complex medical and social issues or experience more communication barriers. These speculations deserve further study. The strength of this study is the comprehensive measurement of psychologic constructs, with minimal of (<0.5%) missing data. The limitations include the use of convenience sampling, absence of longitudinal measurements, and lack of prior validation of the DDPRQ-10 score in dermatologic cohorts. Generalizability may also be limited outside of the sample population.

In summary, a difficult patient is not one with just a complex medical condition but also with greater functional and emotional needs. They tend to report more symptoms and consume more time and energy of physicians. Yet, they may express more dissatisfaction toward the provider. Physician frustration may develop if secondary intentions are perceived or the physician is ill equipped to deal with the psychosocial aspects of the disease.[4] This is compounded in a setting in which the physician lacks resources or the ability to adequately manage. These lead to worsening trust and rapport as well as a downward spiral of physician and patient discontent.[5]

To better the well-being of patients and physicians, we need to first recognize our feelings and prejudices for the patient in front of us. Understanding why patients behave or react in a certain way may help physicians develop a level of "tolerance" and is also the foundation for cultivating strategies to address and resolve any underlying issues.

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Table I. Multilevel univariable analysis of factors associated with being a "difficult patient," accounting for clustering at the physician level

Variable		Coefficient (SE)	*P* value
Patient demographics			
Age		0.04 (0.01)	<.001*
Sex (reference group: males)	Female	0.18 (0.34)	.600
Race (reference: Chinese)	Malay	−0.34 (0.55)	.527
	Indian	−0.37 (0.60)	.537
	Caucasian	−2.09 (2.25)	.355
	Others	−1.51 (0.76)	.047*
Marital status (reference: single)	Married	−1.26 (0.43)	.003*
	Dating	0.41 (0.65)	.523
	Divorced/separated	0.45 (0.85)	.595
	Widowed	−0.88 (1.51)	.557
Education level		−0.14 (0.19)	.447
Visit type (reference group: follow-up visit)	First visit	0.30 (0.46)	.517
Paying rate (reference group: subsidized)	Self-paying	0.42 (0.63)	.506
All the following variables were adjusted for patient age, sex, and race			
Disease characteristics			
Disease type (reference: eczema)	Psoriasis	−0.88 (0.42)	.035*
Disease duration (y)		0.01 (0.02)	.416
Objective disease severity		0.01 (0.005)	.004
Patient cognitive and emotional constructs			
Quality of life impairment		0.57 (0.11)	<.001*
Disease cyclicity		0.75 (0.23)	.001*
Illness coherence		−0.73 (.24)	.002*
Personal control		−0.90 (0.26)	.001*
Treatment control		−0.88 (0.29)	.003*
Resilience		−0.069 (0.05)	.126
Anxiety		0.13 (0.03)	<.001*
Consultation factors			
Patient's self-consciousness		0.07 (0.15)	.636
Patient's need to emphasize symptoms		0.43 (0.16)	.007*
Patient's reporting of physician trust		−0.09 (0.03)	.003*
Patient's reporting of physician empathy		−0.07 (0.06)	.248
Physician's perception of patient's degree of symptom reporting		3.62 (0.34)	<.001*
Physician's management plan	Escalated or switched treatment	2.15 (0.36)	<.001*
	Reframe mindset by comparing with other patients	3.25 (0.43)	<.001*
	Set expectations re. chronicity	2.46 (0.37)	<.001*
	Explored nonmedical factors contributing to symptoms	1.75 (0.39)	<.001*
	Taught coping strategies for symptoms	1.90 (0.46)	<.001*
	Spent longer time than usual listening to the patient	5.37 (0.39)	<.001*
	Wrote a memo for the purpose of excuses	7.42 (1.00)	<.001*
	Felt pressure to wrap up the consult	9.04 (0.95)	<.001*
	None of the above used	−4.24 (0.45)	<.001*

*$P < .05$. Disease cyclicity, illness coherence, as well as personal and treatment control were assessed using the revised illness perception questionnaire; resilience was assessed using the Brief Resilience Scale; and anxiety was assessed using the Generalised Anxiety Disorder-7 scale. Self-consciousness and the need to emphasize symptoms were single questions scored on the Likert scale. The objective disease severity was taken as a product of body surface area and investigator/physician global assessment score. Perceived patient exaggeration of symptoms was reported by physicians as underplaying, overplaying, or reported symptoms accurately. The components of the physician management plan were scored as done or not done. Additional variables tested and found to be not significant include the following: patient's personality using the 10-Item Personality Index, physician demographics (age, sex, race, rank, years of experience) and physician burnout.[3]

Table II. Multilevel multivariable modeling of factors associated with a difficult patient*

Variable	Unstandardized coefficient (SE)	*P* value
Age	0.05 (0.01)	<.001†
Race (reference: Chinese)		
Malay	−0.63 (047)	.186
Indian	0.23 (0.51)	.660
Caucasian	−0.34 (1.91)	.859
Others	0.14 (0.67)	.834
Marital status (reference: single)		
Married	−0.91 (0.37)	.013†
Dating	0.06 (0.54)	.919
Divorced/separated	−0.45 (0.71)	.530
Widowed	−1.38 (1.25)	.271
Disease type (reference: eczema)		
Psoriasis	0.38 (0.36)	.298
Objective disease severity	0.003 (0.004)	.466
Quality of life impairment	0.19 (0.11)	.083
Disease cyclicity	0.29 (0.21)	.164
Illness coherence	0.26 (0.23)	.272
Personal control	−0.57 (0.27)	.037†
Treatment control	0.23 (0.32)	.466
Anxiety	0.02 (0.03)	.573
Patient's need to emphasize symptoms	0.10 (0.14)	.477
Patient's reporting of physician trust	−0.07 (0.03)	.013†
Physician's perception of whether patients overplayed symptoms	2.19 (0.33)	<.001†
Physician's management plan		
Escalated or switched treatment	0.43 (0.36)	.229
Reframe mindset by comparing with other patients	1.20 (0.39)	.002†
Set expectations re. chronicity	0.33 (0.36)	.357
Explored nonmedical factors contributing to symptoms	0.17 (0.35)	.618
Taught coping strategies for symptoms	0.63 (0.40)	.111
Spent longer time than usual listening to patient	33.47 (0.38)	<.001†
Wrote a memo for the purpose of excuse	4.20 (0.89)	<.001†
Felt pressure to wrap up the consult	4.37 (0.88)	<.001†
None of the above used	−1.21 (0.52)	.019†

*Variables significant at $P < .05$ in the univariable model were included in this multivariable regression. The model was additionally controlled for patient sex, education level, and self-paying/subsidized status and accounted for clustering of observations at the physician level.
†$P < .05$.

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Conflicts of interest

None disclosed.

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