# Physicians' Emotional Reactions to Patients

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*The purpose of this study was to determine which circumstances and behaviors of patients elicit the greatest emotional reactions in experienced internists. A questionnaire, generated from interviews with physicians, was mailed to every other board-certified internist in St. Louis. They rated their "degree of emotion" in response to each of 33 statements about different patient behaviors or circumstances. Questionnaires were returned by 59 (22%) of 265 physicians. The mean respondent age was 50 years and the mean year of medical school graduation was 1960. The 11 statements rated as having the highest degree of emotional reaction focused upon threats to physician integrity or self-esteem. The intermediately rated group of 11 statements focused upon clinical circumstances where patients were demanding or upset, creating undue demands on the physician. The 11 statements with the lowest rated emotional responses focused upon patient circumstances that were more objectively unalterable or were independent of the physician. With physicians divided in four groups by year of graduation, there were no differences among mean ratings for any of the 33 statements. The authors conclude that the greatest emotional reaction resulted from threats to physician integrity or self-esteem and that these responses did not abate with experience. These results pinpoint specific areas for those interested in teaching and studying the physician–patient relationship.*

The physician–patient relationship is central to the scientific[1] and humanistic[2] practice of medicine. The physician's contribution to the interaction is logically the area to focus upon if medical educators wish to improve the relationship.[3–6] There is a wide range of physicians' responses to patients;[3,6,7] to know which are most troublesome and most persistent would lead to improvement in those areas potentially most disruptive to the physician–patient relationship.

Two physician variables considered to influence the physician–patient interaction are attitudes toward patients and emotional reactions to patients. Existing studies have primarily evaluated the attitudes of medical students[8–10] and residents,[5,11–13] but some have also emphasized physicians' feelings or emotional reactions. In describing their humanistic medicine program for students and residents, Gorlin and Zucker[7] stressed the importance of physicians' negative feelings (e.g., guilt or impatience) in the physician–patient relationship and the adverse influence these feelings can exert on diagnostic accuracy and treatment decisions. Smith[3,6] also reported that both medical students and primary care trainees exhibited many potentially deleterious feelings, such as anger or fear, toward their patients. Underscoring the need to teach

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awareness of these feelings was his finding that most of the feelings were not recognized by the students and physicians. Both concluded that the feelings of physicians are powerful determinants of the physician–patient relationship and that they should be addressed in teaching.[3,6,7]

These studies, however, do not provide information about the emotional reactions of experienced physicians. The primary purpose of this study was to investigate the emotional reactions of a random sample of internists certified by the American Board of Internal Medicine.[14] The study evaluated the degree of the physicians' emotional reactions to each of a series of circumstances and behaviors of patients. A secondary purpose was to evaluate the idea that the greater the amount of clinical experience internists have, the less is their degree of emotional reaction to difficult patient circumstances and behaviors. This idea was based on the recent findings of Harris et al.[5] that suggest negative attitudes toward patients may become more positive as physicians obtain more clinical experience, and also on the earlier findings of Reinhardt and Gray[15] that a noticeable downward shift occurred in the number of physicians with highly cynical attitudes after they entered practice.

## METHODS

A cover letter, questionnaire, and stamped addressed return envelope were mailed in the spring of 1985 to the initial pool of 330 subjects, consisting of every other board-certified internist listed in the *1981–1982 Directory of Medical Specialists*[14] for the St. Louis metropolitan area. The directory was the most recent one available at the time of the mailing; 65 of the envelopes were returned undelivered. The final pool of subjects thus consisted of the 265 internists who presumably received the mailing.

The cover letter asked that no name be put on the questionnaire to guarantee anonymity and noted that without names no follow-up request to nonrespondents could be made. The questionnaire did request the age, sex, and year of graduation from medical school. It contained 33 randomly ordered statements (see Table 1) that were described as representing circumstances or behaviors of patients that may arouse emotions in physicians. This questionnaire was derived from many observations made by one of the authors (RCS) of countertransference issues in interviews conducted by students and physicians, some of whom were board certified. The directions were as follows: "Rate the degree of emotion that you ordinarily experience when you are faced with the situation in each statement. Use the following scale to make your ratings. The seven points on the scale designate low (1,2), moderate (3,4,5), and high (6,7) degrees of emotion. Circle one of the scale points listed before each statement."

## RESULTS

Completed questionnaires were returned by 59 (22%) of the 265 subjects. Of the 59 respondents, 57 were men and 2 were women, and all analyses were based on the total group of 59 subjects. The mean age was 49.6 years (range, 34 to 71 years). The mean year of graduation from medical school was 1960, ranging from 1937 to 1977. Age and year of graduation were highly correlated ($r = 0.98, p < 0.001$), and year of graduation was selected for analysis.

Table 1 contains the means, standard deviations, and ranges of the scale ratings by the 59 subjects for each of the 33 items, rank-ordered from highest to lowest mean rating. The physicians varied widely in their ratings of the 33 individual statements. The maximum range, 1 to 7 points, was used by subjects for 17 (52%) statements, and the 1-to-6 (or 2-to-7) range was used for 13 (39%) statements. As shown in the table, the mean ratings of degree of emotion among the 33 statements ranged from 1.5, midway in the low degree of emotion on the scale, to 5.5, midway between the moderate and high degrees. The quite different circumstances or behaviors of patients thus produced quite different degrees of emotion in the physicians.

The general theme of the 11 statements having the highest mean ratings was different from that of the second 11 statements, which, in turn, differed from the 11 statements with the

**TABLE 1. Mean ratings of degree of emotion for 33 statements of patient circumstances or behaviors as reported by 59 board-certified internists in St. Louis, 1985**

| Statement* | Rating† | | |
|---|---|---|---|
| | $\bar{X}$ | $s$ | Range |
| Is disrespectful, critical, or demeaning of me. | 5.53 | 1.26 | 1–7 |
| Expresses anger toward me. | 4.93 | 1.20 | 2–7 |
| Keeps trying to control our interaction by interrupting, not listening, or changing the subject. | 4.92 | 1.30 | 2–7 |
| Wants me to certify him/her as disabled but I don't think that he/she is. | 4.86 | 1.53 | 1–7 |
| Wants lab tests or medications such as narcotics but I think they are unnecessary. | 4.61 | 1.46 | 1–7 |
| Is getting worse even though I know I've done everything possible. | 4.34 | 1.65 | 1–7 |
| Presents what appears to be a serious problem that I do not understand. | 4.22 | 1.54 | 1–7 |
| Wants me to fill out many legal or insurance papers. | 4.17 | 1.74 | 1–7 |
| Is seductive, making suggestive remarks or behaving in a sexual way toward me. | 4.12 | 1.61 | 1–7 |
| Has poor general hygiene, is malodorous, or has an unkempt appearance. | 4.08 | 1.56 | 1–7 |
| Has multiple needs that require more than the usual amount of time and attention from me. | 3.88 | 1.51 | 1–7 |
| Tells me he/she is going to change to another physician. | 3.76 | 1.58 | 1–7 |
| Appears troubled but is necessary that I give him/her some unpleasant information. | 3.75 | 1.36 | 1–7 |
| Does not accept my explanation that there is no serious organic disease. | 3.68 | 1.34 | 1–7 |
| Is complaining about not getting better although things are going as well as could be expected. | 3.68 | 1.33 | 1–6 |
| Is noncompliant for medications, recommended testing, or follow-up visits. | 3.66 | 1.35 | 2–7 |
| Is psychologically unstable. | 3.59 | 1.40 | 1–7 |
| Expresses sadness, depression, inability to cope, or suicidal ideation. | 3.58 | 1.51 | 1–6 |
| Requests to be seen in his/her home. | 3.47 | 1.83 | 1–7 |
| Behaves in a passive way, expecting others including me to be more active and responsible for his/her care. | 3.41 | 1.53 | 1–7 |

lowest mean ratings. The highest rated statements were concerned primarily with negative, actively expressed, interpersonal behaviors by the patient that tended to attack or challenge, and thereby threaten, the physician's integrity or self-esteem. The middle group of statements primarily reflected circumstances where patients were themselves demanding or upset, but without the personal threat seen in the first group. The lowest rated group of statements consisted primarily of circumstances that posed neither threat nor undue demand and were objectively unalterable or independent of the physician.

The subjects ranged widely in year of graduation from medical school, 1937 to 1977, so it was possible to evaluate whether earlier, more experienced graduates would indicate lesser degrees of emotion for some statements than less experienced graduates. To evaluate this, each of the 59 subjects was placed, based on year of graduation, into one of four time periods. The four periods and the number of subjects in each period were 1937 to 1949, 14 subjects; 1950 to 1959, 14 subjects; 1960 to 1969, 14 subjects; and 1970 to 1977, 17 subjects. A one-way analysis of variance was carried out to test the significance of the differences among the mean ratings of the four groups for each of the 33 statements. None of the 33 $F$-values was significant at the 0.05 probability level. It was concluded that the time

**TABLE 1. Continued**

| Statement* | Rating† | | |
|---|---|---|---|
| | $\bar{X}$ | $s$ | Range |
| Becomes familiar with me by asking personal questions or otherwise showing undue interest in me. | 3.37 | 1.47 | 1–6 |
| Relatives want a meeting to discuss the patient's problem, although I've fully discussed it already with the patient. | 3.36 | 1.31 | 1–6 |
| Presents multiple somatic complaints without an apparent organic basis for them. | 3.29 | 1.45 | 1–6 |
| Is an unreliable historian. | 3.17 | 1.49 | 1–6 |
| Is dying and keeps bringing up concerns about death and seems to want to discuss it. | 2.98 | 1.56 | 1–7 |
| Speaks only a foreign language so that another person must be present to translate his/her statements. | 2.90 | 1.62 | 1–7 |
| Has an unknown type of disease that could be proven in the future to be communicable. | 2.90 | 1.48 | 1–6 |
| Raises troublesome personal issues in their life such as divorce, job problems, or difficulties with children. | 2.63 | 1.30 | 1–6 |
| Appears to be of higher status than I am, such as being more intellectual, more influential, or having more money. | 2.41 | 1.33 | 1–6 |
| Has a communicable disease such as tuberculosis, to which I might be susceptible. | 2.27 | 1.11 | 1–5 |
| Asks for my advice about nonmedical matters. | 2.25 | 1.31 | 1–6 |
| Indicates that he/she had very limited financial resources for paying me. | 2.15 | 0.93 | 1–4 |
| Skin color or ethnic origin is different from mine. | 1.53 | 0.75 | 1–5 |

*Each statement began with "The patient" or "The patient's."
†Scale of low (1,2), moderate (3,4,5), high (6,7) degree of emotion.
$n = 59$

period of graduation from medical school had no differential effect upon the mean ratings of degree of emotion for any of the 33 statements.

## DISCUSSION

This study showed that board-certified internists reported the greatest degree of emotional reaction when patient behaviors or circumstances actively threatened their integrity or self-esteem; the second greatest reaction occurred when undue demands were made upon them by patients. In addition, these responses did not decrease as the internists gained more experience.

It is useful to compare these findings to the work of Harris et al.[5] and Johnson and Hoffman.[8] These investigators identified four groups of patients who were viewed negatively by students, residents, and their staff physicians. Among them were patients exhibiting threatening characteristics similar to those who provoked the greatest degree of emotional response in the board-certified internists of this study. However, patients exhibiting many other characteristics were also negatively perceived,[5] and these included patient circumstances that the physicians in this study rated as causing the least degree of emotional reaction (poor historian, use of foreign language, and raising troublesome personal problems). Their results indicate that a broader range of

patient characteristics were negatively perceived by that group of students, residents, and staff physicians. Although that pair of studies and this study differed in a number of ways, one plausible explanation of the differences in the findings is that we included only board-certified internists, with a mean age of approximately 50 years. Our subjects differed markedly from the medical students in Johnson and Hoffman's[8] study and the residents in the Harris et al.[5] study, and they may well have differed from the hospital staff physicians in the latter study. Our study suggested that many of the patient characteristics perceived as negative by less experienced physicians were not as troublesome to experienced internists. This was also suggested by Harris et al.,[5] who cautioned that their findings may not be generalizable to more experienced internists. Our findings were also consistent with observations by Reinhardt and Gray[15] that, as physicians enter high-interaction specialties, emotional reactions to certain patient characteristics often disappear.

Our study included a further investigation of the relationship between physicians' experience levels and their reactions to patients. It evaluated the proposal that the greater the amount of clinical experience that board-certified internists have, the less is their degree of emotional reaction. The board-certified physicians were widely divergent in experience, having graduated from medical school between 1937 and 1977; however, using the findings for the four groups of physicians based on year of graduation, this proposal was not confirmed for any of the 33 statements. Thus, the four groups of physicians differed widely in years of experience, but not in degree of emotional reaction to patient circumstances and behavior. This finding suggested that with a minimum of experience, the themes of threat to integrity and self-esteem, undue demands, and nonthreatening–nondemanding patient characteristics develop in decreasing order and remain stable over a long period of time. The minimum experience suggested by the present study is five years postresidency, as the study was conducted in 1985, the latest year of graduation was 1977, and three years of residency are ordinarily required in internal medicine.

The low response rate was disappointing and restricts the generalizability of the study. Response rates in this range are usual, however, for physicians and probably reflect the shortcomings of mail surveys.[16] In addition, it had been our experience that sensitive, emotion-laden information is difficult to obtain by the alternative survey route, the telephone. Thus, this represented an expected response from this highly surveyed population of busy physicians. The study represented the first effort to learn about the emotional responses of experienced internists, and has identified some specific problems that provide a target area for future research in the physician–patient relationship. In addition to stimulating the need for confirmatory study, the results should also be valuable to those teaching about the physician–patient relationship. In using this information, however, it is important to reemphasize that nonresponders may differ from responders.

There are additional caveats about the findings of this study. Responses to a questionnaire do not necessarily reflect physicians' unconscious motivations with patients, a primary determinant of behavior with patients.[3,4,6] However, until a study of unconsciously based responses in this group is performed, the information generated by this study can be used as an index to the emotional reactions of these physicians. It is important, in addition, that this study did not evaluate physicians' behaviors toward patients, nor the quality of their physician–patient relationships. Whether the more highly charged emotional circumstances in the 33-question hierarchy were more likely to have a negative effect upon the physician's behavior and the physician–patient relationship is another research question highlighted by this study.

This study is significant because it indicates that seasoned, highly trained physicians harbor strong emotional reactions that may affect their physician–patient interactions. It thus establishes that emotional responses are important considerations in this group, as well as in the students and residents where previous work has been done. If educators believe that the physician–patient relationship is important, these emotion-

al responses of physicians must be addressed during training. Our results suggest three specific messages for medical educators: First, traditional education and experience do not eradicate physicians' emotional reactions to patients. Second, the two themes that consistently produce the greatest emotional reactions are personal to the physician—threat to integrity and self-esteem and undue demands. Third, education in the physician–patient relationship should include helping trainees to cope effectively with their emotional reactions to these two themes.

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