The difficult patient in private practice physiotherapy: A qualitative study

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This qualitative study utilised the nominal group technique to identify a typology of the difficult patient in private practice physiotherapy and to determine strategies physiotherapists use, and would like to improve, when dealing with such patients. The two areas physiotherapists found most difficult to manage were behavioural problems of patients and patient expectations. Few differences were evident regarding ranking of difficult patient attributes between the experienced (n = 19) and less experienced (n = 18) physiotherapists except for the categories of pain and diagnosed psychological problems. While less experienced physiotherapists ranked the pain category highly, experienced physiotherapists did not identify this category. Further, more experienced physiotherapists specifically distinguished between patients with diagnosed psychological problems and patients with psychosocial concerns, while less experienced physiotherapists did not, and placed both these issues into one category. To assist in their interaction with difficult patients, physiotherapists (n = 37) identified that communication skills and behaviour modification techniques were strategies that they would like to learn more about. The results of this qualitative study contribute to the evolving literature relating to physiotherapist-patient interactions and form a useful basis for educational programs directed at improving the therapeutic relationship in private practice physiotherapy.


Key words: Behavior; Communication; Patients; Private Practice
The importance of effective communication skills within physiotherapy rehabilitation has also been emphasised (Gordon et al 1998, Klaber-Moffett and Richardson 1997). The literature is replete with reference to the ‘therapeutic relationship’ which was described by Gartland (1984, p. 26) “as a means of communication wherein both therapist and patient interact to achieve a therapeutic goal” (Gard and Gyllensten 2000, Gartland 1984, Hamilton-Duckett and Kidd 1985, Williams and Harrison 1999).

Gallois et al (1979) explored non-verbal behaviour in same-gender and mixed-gender physiotherapist-patient interactions and reported that it was likely physiotherapists would show less affiliative behaviour with difficult patients, which may negatively affect treatment outcomes. Gallois et al recommended that physiotherapists should not only increase their awareness of the non-verbal messages they receive from patients but, perhaps more importantly, also heighten their awareness of the non-verbal cues they send to their patients and how these cues may be interpreted. Thornquist (1992), who explored the first encounter between patients and physiotherapists, further supports this recommendation. She noted that usually the therapist and patient unconsciously establish self-presentation, role ascription and role formation, when it would be of greater benefit if communication were part of a conscious agenda.

Despite an acknowledgment by the physiotherapy profession of the existence of the difficult patient (Harding and Williams 1995, Lincoln 1978), very little research has examined the physiotherapist-patient interaction. Gyllensten et al (1999) have explored expert physiotherapists’ perception of important factors influencing the quality of the physiotherapeutic interaction, and Gard et al (2000) have investigated the verbally expressed emotions between physiotherapists and patients. Overall, these researchers suggest that in order to improve patient management skills, physiotherapists should express their emotions more emphatically to their patients and become more reflective of the physiotherapist-patient interaction. While these two studies have begun to address the lack of knowledge concerning the physiotherapist-patient interaction, no research has explicitly set out to determine the attributes of the difficult patient in private practice physiotherapy.

To enhance performance in managing difficult patients it is necessary to gain specific information about the construct of a “difficult” patient and to determine the skills necessary to assist physiotherapists in these situations. Further, given that fee-paying patients have the freedom to choose what services they will access, research to assist in understanding the physiotherapist-patient interaction that may impact on utilisation and satisfaction with private sector services is important. Consequently, the purposes of this study were to gain an understanding of physiotherapists’ perceptions of the difficult patient in private practice physiotherapy and to determine what strategies physiotherapists use, and those that they would like to improve, when dealing with difficult patients.

Method

The nominal group technique, a qualitative research procedure, was employed in this study for three reasons:

i. It would provide a richness and depth of information.

ii. A discovery-oriented methodology would ensure physiotherapists were active agents in clearly defining the problem and identifying potential solutions.

iii. With physiotherapists’ ownership of the ideas and solutions, there would be greater potential to effect change.

This qualitative methodology has been advocated as an effective method for exploring a broad range of ideas among a target population (Delbecq et al 1975).

Subject recruitment The sample for this study was physiotherapists working in private practice in the metropolitan area of Perth, Western Australia. The process of recruitment followed nominal group technique principles and is outlined in Figure 1, demonstrating the two phases of the study.

Phase 1: Initially, the 1998/99 Register of Members of the Australian Physiotherapy Association Private Practitioners Group (Western Australian Branch) was used to recruit a random stratified sample of 50 physiotherapists who were then invited to participate in the study. Of the 23 people who initially agreed to participate, three dropped out because they were unable to attend one of the three scheduled nominal group meetings, resulting in a sample of 20 physiotherapists. A high degree of data saturation was accomplished in the first three nominal group meetings (ie by the third meeting there was little or no new information being volunteered). However, since the respondents were generally very experienced (ie > 10 years experience) and were principals of the private practices, a second round of nominal group meetings was conducted (Phase 2) involving less experienced practitioners (ie < 5 years experience). This two-phase approach to sampling enabled a broader range of responses to be gained (Glaser and Strauss 1967).

Phase 2: In this phase, a further 50 physiotherapists with up to five years experience were identified from two sources:

i. contact with private practice principals from the first round of nominal group meetings who had employees who met the criteria; and

ii. the Australian Physiotherapy Association (WA Branch) database.
Of the 25 physiotherapists who expressed an interest in being involved in Phase 2, eight were unable to attend one of the three scheduled meetings, leaving an overall sample of 17.

**Procedure**

The nominal group technique was used for data collection. It is a highly structured meeting process that lasts up to two hours and involves five stages: introduction and explanation, silent generation of ideas, sharing ideas, group discussion, voting, and ranking of ideas (Delbecq et al 1975).

The nominal group technique procedures for this study were piloted with a group of six physiotherapist volunteers. Feedback from the pilot study enabled minor modifications to be made to the protocol prior to the first nominal group technique meeting. In particular, due to the generation of such a large number of ideas in the pilot study, it was decided that these ideas were best amalgamated into a smaller number of categories before ideas were finally voted on and ranked by the group members. No ideas were eliminated in this process and all group members contributed to the discussion and formulation of each category. This modification to the original nominal group technique protocol has been used successfully in research with community nurses (Carney et al 1996) and was applied to subsequent nominal group technique meetings.

Three nominal group meetings were held for each sub-sample (ie a total of six meetings were conducted), with the process continuing until no new ideas were generated (ie data saturation was achieved; Krueger 1994). The principal researcher, a physiotherapist, acted as facilitator of each meeting and an independent observer, familiar with the nominal group technique protocol, attended each meeting. The observer provided feedback to the facilitator at a debriefing session at the conclusion of each meeting. Each meeting was audiotaped and transcribed verbatim so that researchers could verify data and utilise the information for ongoing analysis once all meetings were completed.

The Human Research Ethics Committee of The University of Western Australia granted ethical approval for this research study. Informed consent was obtained from each participant, along with demographic information including age group, gender, qualifications, number of years of experience, and so on.

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**Figure 1.** An overview of the process of recruitment for Phases 1 and 2 of the nominal group meetings, including demographic detail of the sample recruited.
physiotherapy experience, and average number of patient treatments per week. During the course of each meeting, three issues were discussed:

i. Attributes of the difficult patient.

ii. Strategies to deal with difficult patients.

iii. Physiotherapist and patient expectations.

Due to the large volume of qualitative data collected, this paper will limit discussion to physiotherapists’ responses to the first two issues.

Data analysis All physiotherapists in the nominal group technique meetings were directly involved in analysis of the information they provided by rank ordering the categories they had generated. Further inductive content analysis (Patton 1990) was carried out on group meeting transcripts to identify explanatory quotes that represented key points made by group members.

Credibility As recommended by Lincoln and Guba (1985), a number of steps were taken to address the issue of credibility of this research including:

i. data were collected in two phases to ensure a broad range of views were sourced from the target population;

ii. data collection continued until data saturation was achieved;

iii. all meetings were tape recorded and transcribed verbatim with quotes from participants included to explain findings;

iv. the choice of the nominal group technique methodology enabled participants to be directly involved in both data collection and analysis, ensuring findings and interpretations accurately reflected their thoughts; and

v. an independent trained observer was involved with the nominal group technique to verify data, monitor consistency of the process and to provide feedback to the facilitator at a debriefing session at the conclusion of each group meeting.

Results

Demographics Of the total sample (n = 37), 46% (17/37) were male and 54% (20/37) female, which reflects the gender distribution of private practitioners in Western Australia as listed in the telephone directory at the time of this study (ie males 47%, females 53%). Fourteen physiotherapists had postgraduate qualifications in either sports physiotherapy (n = 6), manipulative physiotherapy (n = 6), or both disciplines (n = 2). The remaining 23 physiotherapists had no postgraduate qualifications. Years of experience as a physiotherapist ranged from 0.25-29 years (mean = 8.6) with 49% (18/37) having less than five years experience. Sixty-two per cent (23/37) of physiotherapists reported seeing 41-80 patients per week, 27% (10/37) reported seeing 81-100+ patients per week, while 11% (4/37) could not be determined, due to missing data.

Attributes of the difficult patient A total of 53 separate ideas were generated from the six nominal group meetings and sorted into seven separate categories (see Table 1). Following the organisation of ideas into categories, voting and ranking was completed indicating which issues physiotherapists felt were most difficult for them to deal with. The category of behavioural problems was the issue all physiotherapists found most difficult to manage, followed by patient expectations for four of the six groups. Pain was an important issue that created problems for two groups of less experienced physiotherapists (Groups D and F). Conversely, diagnosed psychological problems were ranked highly by two groups of more experienced physiotherapists (Groups A and B).

Behavioural problems A broad range of patient behaviours were identified by three or more groups as being problematic. However, as illustrated in Table 2, patients who are passive, dependent, angry/aggressive, or think they “know it all” were identified by all groups of physiotherapists as being hardest to deal with.

Patient expectations There were two problems raised by physiotherapists relating to patient expectations. The first involved patients with unrealistic expectations of the physiotherapist and/or physiotherapy treatment, for example:

• “Patients who want a quick fix in one session when that is not possible.” [Participant Group D]

• “Patients who expect you to treat all their injuries today (eg multiple physical problems) so they have unrealistic expectations.” [Participant Group F]
Table 2. Behavioural attributes of the difficult patient that physiotherapists found hardest to deal with. The number in brackets indicates the number of groups which identified this behaviour.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Examples</th>
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<tr>
<td>Passive (ie do not take responsibility for themselves) (6)</td>
<td>• ‘The passive patient is someone who is not willing to participate in their own rehabilitation.’ [Participant Group C]</td>
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<td>Angry/aggressive toward physiotherapist regarding their injury, rehabilitation and/or other health care professionals involved in their management (6)</td>
<td>• ‘They [patients] think that someone else is to blame for their pain, whether it is their work because they’ve had an injury at work, or whether they’ve had a car accident and they were the innocent party. They are motivated to keep their pain going, it is an outlet for their anger. They’re angry and they want someone to blame.’ [Participant Group F]</td>
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<td>Patients who think they ‘know it all’ and who are ill-informed (6)</td>
<td>• ‘People that have a little bit of knowledge about the anatomy, they don’t actually understand it in the sense of the pathology of the problem, but they basically think they know more than you do.’ [Participant Group F]</td>
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<td>Dependency on a particular treatment and/or physiotherapist (6)</td>
<td>• ‘Dependent patients expect us to do everything for them.’ [Participant Group B]</td>
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<td>Non-compliant with rehabilitation advice and/or exercises prescribed (5)</td>
<td>• ‘Patients who are non-compliant with instructions or exercise programs, or something you ask them to do.’ [Participant Group F]</td>
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<td>Demanding of a physiotherapist’s knowledge, time and/or attention (5)</td>
<td>• ‘The demanding person, they could demand our knowledge, our time or attention. For example, they demand you see them now; they can’t wait until tomorrow. They want your attention. It might be for 10 seconds but they want it now. Sometimes you give that extra time and attention and that is not long enough.’ [Participant Group D]</td>
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<td>Manipulative of health care professionals and/or the health care system (5)</td>
<td>• ‘A patient may have a hidden agenda. For example, there may be medico-legal issues with a workers’ compensation claim and so they don’t improve. They just won’t get better because if they do it will affect their claim. Sometimes they will try to manipulate the situation to serve their own ends.’ [Group A]</td>
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<td>Lacks trust in physiotherapist and/or is sceptical of physiotherapy treatment (4)</td>
<td>• ‘Someone that’s had a bad experience with another physiotherapist, maybe that treatment made them worse so they are less trusting of you.’ [Participant Group F]</td>
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<td>Unreliable (ie arrive late for treatment or fail to attend) (3)</td>
<td>• ‘People who are frequently arriving late for treatment and you need to chase them up.’ [Participant Group F]</td>
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<td>Seeks multiple opinions from various health care professionals (3)</td>
<td>• ‘Somebody who has gone to many different people to have assessment and perhaps treatment for their problem which has not improved a great deal.’ [Participant Group C]</td>
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<td>In denial of their problem or severity of their problem (3)</td>
<td>• ‘You can get patients who won’t accept the severity of their injury or that they have a problem that requires treatment which makes them difficult to deal with.’ [Participant Group E]</td>
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<td>Lacks motivation in physiotherapy (3)</td>
<td>• ‘The doctor may have referred them but they are unmotivated and don’t want to be there. They could be unmotivated because they are not willing to do anything about their problem. I find this more with those on workers’ compensation when someone else is paying for the treatment.’ [Participant Group E]</td>
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<td>High performance drive (3)</td>
<td>• ‘These people have an inability to rest, or to not do things. They are different from those who just don’t comply at all. They’ll do all the exercises that you give them, but they won’t take a rest and instead tend to overdo it.’ [Participant Group F]</td>
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<td>Catastrophisers/negative thinkers (3)</td>
<td>• ‘It doesn’t matter what you say or how much objective improvement they show, they always think the worst. So sometimes you have to really push them to do their exercises or try to work out how to show them they are getting better because they are so negative and can easily get worse for no good reason.’ [Participant Group A]</td>
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<td>Other (1-2)</td>
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The second issue reflected patients with preconceived ideas about physiotherapy, including the nature of their problems, appropriate treatment and the number of treatments required. For instance, the following statements reflected this sub-category:

- “Patients who have preconceived ideas about the number of treatments they require and the treatment methods that should be used are always hard to manage.” [Participant Group C]
- “Somebody who has a preconceived idea of the problem and treatment, these people might have many things they want to get treated and have a preconceived idea of what they want the physiotherapist to do” [Participant Group D]

**Physical problems** Regardless of experience, physiotherapists identified the issue of patients with multiple physical problems being difficult due to potentially high levels of pain and the extra time required to manage these patients. However, only Groups C and E ranked this category highly. Other issues raised in this category by any single group were: undiagnosed injury or pathology, frail patients, patients with allergic reactions to tape, patients who are obese, patients with pacemakers, or patients with physical problems that are slow to respond to treatment.

**Pain** Pain was raised as a specific category by less experienced physiotherapists (ie Groups D to F). It was ranked at two and three by groups D and F respectively, indicating that it was something they felt was relatively difficult to deal with. The issues raised by these groups were patients with a low pain threshold, patients with chronic pain, pain-focused individuals and patients with neuropathic or neurological pain because it was considered by physiotherapists as not only being difficult to treat, but also difficult to explain to the patient.

**Patient communication issues** All groups identified English as a second language and patients with cultural differences in this category, but only one group of experienced physiotherapists (Group A) ranked communication issues highly. Other issues raised by groups were general comprehension and communication ability of non-English-speaking patients, and patients with vision and hearing impairments.

**Psychological problems** There were some variations between more and less experienced physiotherapists regarding the categorisation of psychological problems. More experienced physiotherapists (Groups A to C) created a category called “Diagnosed Psychological Problems” for people with diagnosed psychological, or psychiatric conditions who sought physiotherapy treatment for a physical injury problem. Less experienced physiotherapists (Groups D to F) did not distinguish between diagnosed psychological problems and psychosocial issues and created a single category called “Psychological Problems”.

**Other issues** Aside from Groups A and C who included patients with psychosocial concerns in this category, a number of additional issues were raised. These included: bad debtors (Groups A and C) and “financially challenged” patients (Groups E and F); “failed patients” who no-one else had been able to help (Groups A and D); younger age groups, specifically 8 to 12 year old children with poor parental support, and disinterested teenagers (Groups E and F); patients with poor body awareness (Groups E and F); and, gender conflict, ie male therapist treating female patient and vice versa (Group D).

**Strategies to deal with difficult patients** As illustrated in Table 3, physiotherapists identified 27 strategies they utilise in the management of difficult patients. Of these, “physiotherapist communication skills” was identified as the primary area in which practitioners would like to develop more skills, followed by the category labelled “behaviour modification”. Apart from the recommendation in the “Other” category that physiotherapists should be committed to ongoing education in both physical and non-physical areas, the remaining two categories were primarily focused on establishing procedures rather than developing skills.

**Discussion**

The purposes of this study were to gain an understanding of physiotherapists’ perceptions of the difficult patient in private practice physiotherapy and to determine strategies physiotherapists currently utilise, and would like to improve, when in these situations.

**Attributes of the difficult patient** This study identified patient behaviours as the main issue that physiotherapists had problems dealing with. This finding is supported by research in other health professions. Lorber (1981), in a hospital-based study with doctors and nurses, found patients with behavioural problems overlying their medical condition to be problematic, and labelled them “deliberately deviant”. Similarly, Steinmetz and Tabenkin (2001), who interviewed family physicians, reported that patients with behavioural problems were more difficult than those with complex medical problems.

Only one group of experienced and one group of inexperienced physiotherapists ranked the issue of physical problems highly. The reasons provided by therapists as to why these patients were difficult related to the extra time required to treat patients with multiple physical problems and the pain associated with multiple injuries. The time issue in private practice could relate to a number of factors. For instance, an unscheduled long consultation means the physiotherapist will be running late for the next patient, who may then become a difficult patient because they had to wait. Alternatively, the receptionist or practice principal may disapprove of the physiotherapist running late for appointments. This is likely to result in increased pressure to perform duties more quickly, consequently making patients who are in pain and have multiple physical problems difficult to manage.
Jensen et al (1992 and 2000) reported that less experienced practitioners are more likely to be problem-focused rather than patient-focused, be more uncomfortable with diagnostic uncertainty, and have less confidence in predicting patient outcomes than their more experienced counterparts. This might explain why the category of pain was ranked highly by two groups of less experienced physiotherapists (ie Groups D and F), but not identified at all among the attributes of difficult patients by the more experienced physiotherapists in this study.

Patient communication issues were not a major concern for most physiotherapists in this study. It may be that the majority of physiotherapists in this study have not had much exposure to, or problems with, such patients. However, by generating this category physiotherapists acknowledged such patients as potentially being “difficult”.

Although this study identified patients with diagnosed psychological or psychosocial problems among the attributes of difficult patients, this was emphasised less than in studies with doctors (Goodwin et al 1979, Hahn et al 1994). This is understandable given that doctors, not
physiotherapists, are likely to be the primary providers of care for these patients. As such, a physiotherapist recognising a patient with possible psychological or psychosocial concerns is likely to refer the patient back to the doctor, or to another allied health professional for assistance.

In this study, more experienced physiotherapists were explicit in their categorisation of patients with diagnosed psychological problems, while less experienced therapists were not. It is not clear whether more experienced physiotherapists were making this distinction based on their own judgment, from patient self-disclosure, or via referral information received at the time the patient was assessed. If the categorisation was judgment-based it is not supported by findings gathered from expert clinicians who demonstrated less judgmental behaviour when compared with novice therapists (Jensen et al 2000).

Less experienced physiotherapists were responsible for more classifications categorised as “Other issues”. This could relate to their relative inexperience, such that there were more issues that were problematic for them. The concerns raised in this category were not specifically injury-related, but involved psychosocial, financial, physical and behavioural attributes of patients. This highlights the importance of practitioners developing effective communication skills for management of the broad spectrum of patients who seek their services, as well as greater self-awareness of their own attitudes, values, needs, beliefs and emotional responses to patients they find difficult.

While most ideas regarding attributes of difficult patients were readily categorised by physiotherapy groups, all groups made the point that a number of the patient attributes were interrelated and that consideration should be given to the interaction of the physiotherapist and patient in a particular context. This is supported by researchers in both medicine and physiotherapy who have identified various factors such as patient and practitioner knowledge, expectations, attitudes, emotions, perceptions, behaviours, and communication skills as impacting on the quality of the practitioner-patient interaction (Corney et al 1988, Gard et al 2000, Gerrard and Riddell 1988, Gordon et al 1998, Klaber-Moffett and Richardson 1997).

### Strategies to deal with difficult patients

A number of the approaches to manage difficult patients that were highlighted by physiotherapists in this study have also been identified by family physicians (Steinmetz and Tabenkin 2001). These include the communication skills of gaining rapport, active listening, providing an adequate explanation of the treatment process, along with referral or involvement of others in patient management.

Existing research suggests that teaching physiotherapists basic psychological skills that could be usefully applied to patient management, would seem to be both appropriate and necessary (Potter and Grove 1999). Certainly, physiotherapists in this study expressed an interest in improving their communication skills, and learning behaviour modification techniques for dealing with difficult patients. Thus, the application of psychological skills training in the curriculum of physiotherapists appears warranted.

### Limitations

The limitations of this study include the small sample size, which prohibits generalisation of results, and the role of the principal researcher (ie a practising physiotherapist) as a facilitator in nominal group meetings. While steps were taken to address the latter issue by having an independent observer present at each meeting, there was the potential for participant-observer bias to occur. However, the very nature of the highly structured nominal group technique process minimises researcher bias (Gallagher et al 1993).

### Summary

This study set out to determine the attributes of the difficult patient along with the strategies private practitioners currently use, and wish to develop, to assist in difficult physiotherapist-patient interactions. Seven categories of difficult patient attributes were identified with non-physical attributes being most problematic. Physiotherapists highlighted communication and behaviour modification strategies as the two areas they would like to improve, to assist their work with difficult patients.

### Conclusion

The findings of this research present a typology of the difficult patient in private practice physiotherapy and identify strategies physiotherapists would like to know more about in their work with patients. As such, results from this study contribute important information to the evolving literature relating to physiotherapist-patient interactions, and should promote self-reflection and self-awareness among physiotherapists who work in the private sector. Also, the results highlight the need for further training of physiotherapists in skills that are part of the affective domain.

Further research is necessary to verify or refute these findings among larger numbers of private practitioners, with physiotherapists from within the public sector and other specialist areas. In addition, it is important to explore the patient’s perspective, since every patient, like every physiotherapist, will have their own perceptions of the physiotherapist-patient interaction that will affect their experience, satisfaction and clinical outcomes.

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