Journal of Physical Education & Health, 2022, vol. 11 (20), 13-22

https://doi.org/10.5281/zenodo.8079773

NIGERIAN PHYSIOTHERAPISTS' PERCEPTIONS OF DIFFICULT PATIENTS AND THEIR RELEVANT MANAGEMENT STRATEGIES

Chidozie E. Mbada[1], Adebowale Adesola[2], Akinsulore Adesanmi[3], Ayodiipo O. Idowu[4], Omole O. John[2], Makinde M. Oluwatosin[2], Saturday N. Oghumu[5], Adegbemigun O. David[6], Francis Fatoye[6]

[1] Department of Health Professions, Faculty of Health and Education, Manchester Metropolitan University, Birley Fields Campus, Bonsall Street, Manchester, United Kingdom
[2] Department of Medical Rehabilitation, Obafemi Awolowo University, Ile-Ife, Nigeria
[3] Department of Mental Health, College of Health Sciences, Obafemi Awolowo University, Ile-Ife, Nigeria.
[4] Department of Physiotherapy, Redeemers University, Ogun State, Nigeria
[5] Department of Physiotherapy, University of Calabar, Calabar, Nigeria
[6] Department of Physiotherapy, Faculty of Medical Rehabilitation, University of Medical Sciences, Ondo, Nigeria

Abstract

Background: Recognizing what makes some patients to be perceived as 'difficult' is a clinical sign warranting a diagnostic interpretation. However, few studies have explored difficult clinician-patient encounters in physiotherapeutic practice. The present study assesses physiotherapists' perceptions of difficult patients and their relevant management strategies in a previously unexplored context, i.e. in Nigeria.

Method: Consenting physiotherapists from eight selected hospitals in Southwestern Nigeria participated in the study. A total of 110 questionnaires were administered, and 107 were fully completed and returned (97.3% response rate). A four-section questionnaire adapted from two earlier studies was employed. Descriptive statistics of frequency and percentages were used. A chi-square test was used to check associations between variables. The alpha level was set at 0.05.

Results: Patients seeking multiple opinions from various professionals (55.1%), patients demanding the therapist's knowledge and time (53.3%), and patients unwilling to participate in rehabilitation (15.0%) were mostly perceived as difficult by the physical therapists. The relationship of a physical therapist and a difficult patient mostly involves feeling rarely at ease in presence of a patient (50.5%), and feeling rarely enthusiastic about caring for a patient (48.6%). Shifting focus away from pain (32.7%) and avoiding scheduling two difficult patients consecutively (17.8%) were two most frequently agreed management strategies. There were no significant associations between the respondents' socio-demographic characteristics and most strategies of management of the perceived difficult patient ($p > 0.05$).

Conclusion: Patients who seek multiple opinions from various health professionals regarding their condition, and patients who demand the therapist's knowledge and time are mostly considered to be difficult patients by Nigerian physiotherapists. Shifting focus away from pain and avoiding scheduling two difficult patients consecutively are the most rated strategies of management of such patients.

Key words: *difficult patients, physiotherapy, Nigeria*

Introduction

The clinician-patient relationship remains at the very heart of healthcare delivery and is fundamental to providing and receiving quality care, to the healing process, and to healing outcome improvement [1]. However, the clinician-patient relationship is a complex process of ethical interest [1, 2, 3]. When there is a tilt in the clinician-patient relationship equilibrium, and most of the times it seems to

be towards the patient, the clinician perceives the patient as difficult [4]. The difficult patient issue rests upon the assumption of an ideal clinician-patient relationship in an ideal healthcare system, in which there is mutual respect and cooperation in the effort to heal the patient [4, 5]. Thus, a patient who evokes negative emotional reactions in a therapist tends to be labelled "difficult" [6]. However, the term "difficult patient" implies that it is the patient that is the primary problem, without considering other issues related to health professionals such as poor communication skills or a power imbalance in the relationship, which may be equally important [4, 7, 8]. In the United Kingdom, physicians refer to it as a "heart-sink" feeling, i.e. a feeling brought on by encounters with patients who are confrontational, angry, unresponsive, or uncooperative [9, 10]. Since the subject of the "difficult" patient surfaced in the 1990s, it has been shown that physicians of all medical specialties find 1 in 6 patients' visits to be "difficult" [4, 11], and that such patients account for 15-30% of primary care practice population [4, 12]. A patient perceived to be "difficult" is said to exhibit such traits as unrecognized psychiatric problems, mood disorders, anxiety disorders, frustration, guilt, low satisfaction with care, poorer functional status, and unmet expectations [4, 12]. A "difficult" patient can be too different from or too similar to the doctor, or too anxiety-provoking [4, 7, 13]. A perceived difficult patient might be one who demands that the therapist provides something inappropriate, or one who feels maligned and neglected by the care giver [14, 15]. Whenever such an interaction occurs the physician/clinician can expect aggravation, frustration and, often, anger, and the results are likely to be unsatisfactory for both the therapist and the patient [7, 15].

However, it has been recognized that the physician also plays a role in what is often perceived as the "difficult" patient issue since both physicians and patients share the blame for the difficult patient [16]. Therefore, recognizing what makes some patients to be perceived as "difficult", while understanding that "being perceived as difficult" is a clinical sign warranting a diagnostic interpretation, identifying ethical problems arising in the care of the perceived difficult patient and responding therapeutically are the key elements of ethically sound care for these challenging patients [17, 18].

There have been few studies on the difficult patient encounters in physiotherapeutic practice as opposed to other health professions such as medicine and nursing [11, 19-21]. Unfortunately, patients' behavioral problems and satisfaction are some of the areas physiotherapists have found to be very difficult [22]. Researchers have suggested that in order to improve patient management skills, physiotherapists should express their emotions towards their patients more emphatically, and become more reflective of the physiotherapist-patient interaction [23, 24]. To enhance therapists' performance in managing difficult patients, it is necessary to gain specific information about the difficult patient construct and to determine the skills necessary to assist physiotherapists' perception of the difficult patient as well as strategies physiotherapists can use in the management of difficult patients [21]. The aim of this study was to assess physiotherapists' perceptions of the difficult patient as well as their relevant management strategies in Nigeria, i.e. in a previously unexplored context.

Material and Methods

Physiotherapists from two secondary and six tertiary hospitals in Southwestern Nigeria were recruited for the study using consecutive sampling in a cross-sectional survey. The selection of hospitals was based on the relatively high number of physiotherapists working in them. The selected hospitals included the Ife Hospital Unit of the Obafemi Awolowo University Teaching Hospitals (OAUTHC), Ile-Ife, Osun State; Wesley Guild Hospital, Ilesha, Osun State; Ladoke Akintola University of Technology Teaching Hospital, Osogbo, Osun State; University College Hospital, Ibadan, Oyo State; Adeoyo State Hospital, Ibadan, Oyo State; Lagos University Teaching Hospital, Idi-Araba, Lagos State; National Orthopaedic Hospital, Igbobi, Lagos

State; and Lagos State University Teaching Hospital, Ikeja, Lagos State.

The survey tool was a four-section questionnaire. The questionnaire was adapted from two sources: a questionnaire on difficult patients in private practice physiotherapy by Potter et al., and a doctor-patient relationship questionnaire by Hahn et al. [22, 25]. The content validity of the questionnaire was verified by an expert. The four sections of the questionnaire sought information about physiotherapists' perception of difficult patients and about their strategies of management of such patients. Section A included questions related to respondents' socio-demographics, Section B - patients' behavioral attitudes, Section C - relationships with the perceived difficult patient, and Section D - strategies that could help in the management of perceived difficult patients. Likert-type questions with a 6-response scale (1 = strongly disagree, 2 = disagree, 3 = do not know, 4 = agree, 5 = strongly agree) were used for Sections B and D. A different Likert-type 6-response scale was also used in Section C (from 1 = not at all to 6 = a great deal). Apart from the close-ended questions, the respondents were asked to list four behavioral attitudes they believed were exhibited by the perceived difficult patients as well as strategies that can be used to manage them.

Ethical approval was obtained from the Ethics and Research Committee of the Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC). Administrative permission was secured from the heads of the respective physiotherapy departments. Informed consent was given by all respondents following full disclosure.

Data Analysis

Descriptive statistics of frequency and percentages were used to summarize data. A chi-square test was used to check for associations between variables. Data was analyzed using SPSS Statistics (Statistical Package for Social Sciences) version 16.0. The alpha level was set at $p \leq 0.05$.

Results

A total of 110 questionnaires were administered, and 107 were fully completed and returned, yielding a response rate of 97.3%. The respondents' demographic and work characteristics are presented in Table 1. The majority of respondents were male (62.6%), and with a bachelor's degree (68.2%). Most respondents (85%) practiced in a teaching hospital and in an orthopedics unit (33.6%). The distribution of behavioral attitudes common to perceived difficult patients is presented in Table 2. Patients seeking multiple opinions from various professionals (55.1%) and patients demanding the knowledge and time from the therapist (53.3%) were mostly perceived as difficult patients, followed by patients unwilling to participate in rehabilitation (15.0%) and non-compliant with instructions (5.6%). 87 respondents provided answers to questions on behavioral attitudes of perceived difficult patients. The highest ranking were patients with psychosocial factors (62.1%), while egocentric patients, patients with previous bad experience, patients with multiple physical factors, long waiting time for treatment, environment, and over-expectation of treatment each ranked at least 1.2% (Table 3). In terms of relationships with perceived difficult patients, physiotherapists who rarely felt at ease when with a patient, and physiotherapists who rarely felt enthusiastic about caring for a patient amounted to 50.5% and 48.6%, respectively (Table 4). The distribution of strategies of management of perceived difficult patients is presented in Table 5. Shifting focus away from pain (32.7%) and avoiding scheduling two difficult patients consecutively (17.8%) were the most agreed strategies of management of perceived difficult patients.

Table 1. Respondents' socio-demographic and work characteristics

Variable	Frequency	Percentage
Sex		
Male	67	62.6
Female	40	37.4
Education		
BA/BSc	73	68.2
MSc	32	29.9
PhD	2	1.9
Years of work experience		
< 1 year	27	25.2
1-2 years	7	6.5
3-5 years	19	17.8
6-10 years	22	20.6
> 10 years	32	29.9
Place of work		
Teaching hospital	91	85
Specialist hospital	10	9.3
General hospital	6	5.6
Designation		
Assistant/deputy director	5	4.7
Chief physiotherapist	8	7.5
Principal physiotherapist	5	4.7
Senior physiotherapist	25	23.4
Physiotherapist	35	32.7
Intern	29	27.1
Area of specialization		
Orthopedics	36	33.6
Neurology	22	20.6
Pediatrics	7	6.5
Obstetrics and gynecology	4	3.7
Cardiopulmonary	2	1.9
Community	2	1.9
Others	34	31.5

Table 2. Distribution of behavioral attitudes perceived as common to 'difficult' patients

Perceived behavioral attitude	Agree	Undecided	Disagree
	%		
Unwilling to participate in rehabilitation	15	6.5	78.5
Thinks someone else is to be blamed for pain	25.2	16.8	57.9
Thinks he/she knows much about his condition	31.8	9.3	58.9
Expects you to do everything for him/her	15.9	12.1	72.0
Non-compliant with instructions	5.6	6.5	87.9
Demands your knowledge and time	53.3	17.8	29.0
Tries to be in control of the clinician	18.7	11.2	70.1
Skeptical of the usefulness of treatments	38.3	13.1	48.6
Arrives late for treatment or fails to attend	24.3	16.8	57.9
Seeks multiple opinions from various professionals	55.1	12.1	32.7
Lacks motivation in physiotherapy	35.5	18.7	45.8
Seems to overdo prescribed exercises	43.0	15.9	41.1
Negative thinker	20.6	18.7	59.8
Unhappy with treatment	22.4	17.8	59.8
Unhappy with life in general	29.9	12.1	57.9
Confused	42.1	15.9	42.1
Helpless/hopeless	42.1	18.7	39.3
Low self-esteem	44.9	15.9	39.3
Obsessive	27.1	18.7	54.2
Over-talkative	38.3	20.6	41.1

Table 3. Frequency of listed factors believed to contribute to a patient being perceived as difficult

Factor	Frequency	Percentage
Complaining patients	4	4.6
Poor education	3	3.5
Good education	3	3.5
Egocentric	1	1.2
Labile emotions	4	4.6
Previous bad experience with a physiotherapist	1	1.2
Familiarity with treatments	2	2.3
Multiple physical factors	1	1.2
Financial constraints	7	8.1
Poor communication	4	4.6
Long waiting time for treatment	1	1.2
Environment	1	1.2
Over-expectation of treatment	1	1.2
Psychosocial factors	54	62

Table 4. Relationships of physiotherapists with perceived difficult patients

Physiotherapists' relational behaviors	Never	Rarely	Occasionally	Frequently
How much do you look forward to this patient's next visit?	24.3	45.8	18.7	11.2
How frustrating do you find this patient?	9.3	40.2	20.6	29.9
How manipulative is this patient?	12.1	35.5	25.2	27.1
How often is it difficult to communicate with this patient?	7.5	35.5	20.6	36.4
How much at ease do you feel when with this patient?	13.1	50.5	19.6	16.8
How time consuming is caring for this patient?	8.4	19.6	16.8	55.1
Do you find yourself secretly hoping that this patient will not return?	26.2	25.2	13.1	35.5
How enthusiastic do you feel about caring for this patient?	17.8	48.6	14.0	19.6
To what extent are you frustrated by this patient's vague complaints?	12.1	32.7	16.8	38.3

Table 5. Distribution of strategies for managing perceived difficult patients

Management strategy	Agree	Undecided	Disagree
		%	
Providing explanations	2.8	4.7	92.5
Using visual aids	7.5	11.2	81.3
Active listening skills	6	15	79.4
Using interpreters	1.9	6.5	91.6
Gaining patient's confidence	5.6	11.2	83.2
Setting appropriate goals with the patient	2.8	10.3	86.9
Making the patient active in the process	3.7	9.3	86.9
Shifting focus away from pain	32.7	18.7	48.6
Encouraging to motivate patients	11.2	11.2	77.6
Teaching patients self-management skills	0	12.1	87.9
Referring to other health professionals	7.5	12.1	80.4
Liaising with other health professionals	5.6	15.9	78.5
Avoiding scheduling two difficult patients consecutively	17.8	20.6	61.7

The strategies the respondents used for managing difficult patients are shown in Table 6. A total of 48 respondents attempted these questions, with the factor of patient's relatives ranking the highest (20.8%), while factors such as dialogue, being strict, group therapy, good clinical record, noting individual differences, holistic approach, free treatment, prayer and truth ranking reached at least 2.1% each. Similarly, the factors believed to contribute to the strategies of management of perceived difficult patients are listed in Table 6. Strategies that sought to engage relatives (20.8%) and provide counselling (10.4%) were the most frequently used ones to manage perceived difficult patients. Associations between

respondents' agreement on strategies of management of difficult patients and qualifications are presented in Table 8. There was a statistically significant relationship between gaining patients' confidence and gender ($\chi 2 = 8.996$; $p = 0.011$), and between the use of visual aids and educational qualifications ($\chi 2 = 7.612$; $p = 0.022$). The association between respondents' agreement on strategies of management of perceived difficult patients and work experience is presented in Table 9. A statistically significant association was found between avoiding scheduling two difficult patients and therapists' years of experience ($\chi 2 = 6.942$; $p = 0.031$).

Table 6. Frequency of factors believed to contribute to the strategies of management of perceived difficult patients

Management strategy	Frequency	Percentage
Patience	3	6.3
Counselling	5	10.4
Being friendly	2	4.2
Being strict	1	2.1
Dialogue	1	2.1
Empathy	3	6.3
Good clinical approach	3	6.3
Group therapy	1	2.1
Good clinical record	1	2.1
Being understanding	3	6.3
Composure	2	4.2
Noting individual differences	1	2.1
Relatives	10	20.8
Holistic approach	1	2.1
Free treatment	1	2.1
Prayer	1	2.1
Encouragement	2	4.2
Truth	1	2.1
Education	3	6.3
Task oriented rehabilitative procedures	1	2.1
Finances	1	2.1
Spending more time with the patient	1	2.1

Table 7. Association between respondents' agreement on strategies for managing perceived difficult patients and gender

Strategies for management of perceived difficult patients	Male n (%)	Female n (%)	χ^2	*p*-value
Providing explanations	1 (1.5)	2 (5.0)	1.744	0.418
Using visual aids	3 (4.5)	5 (12.5	2.354	0.308
Active listening skills	3 (4.5)	3 (7.5)	1.883	0.390
Using interpreters	1 (1.5)	1 (2.5)	0.374	0.829
Gaining patient's confidence	1 (1.5)	5 (12.5)	8.996	0.011*
Setting appropriate goals with the patient	1 (1.5)	2 (5.0)	1.548	0.461
Making the patient active in the process	1 (1.5)	3 (7.5)	2.591	0.274
Shifting focus away from pain	22 (32.8)	13 (32.5)	0.667	0.717
Encouragement to motivate patients	4 (6.0)	8 (20.0)	5.325	0.070
Teaching patients self-management skills	0 (0.0)	0 (0.0)	0.277	0.559
Referring to other health professionals	4 (6.0)	4 (10.0)	1.717	0.424
Liaising with other health professionals	3 (4.5)	3 (7.5)	0.888	0.642
Avoiding scheduling two difficult patients consecutively	9 (13.4)	10 (25.0)	5.466	0.065

*Statistically significant at $\alpha = 0.05$

Table 8. Association between respondents' agreement on strategies for managing difficult patients and education level

Management strategy	Bachelor's degree n (%)	Higher degree n (%)	χ^2	*p*-value
Providing explanations	2 (2.7)	1 (2.9)	0.337	0.845
Using visual aids	6 (8.3)	2 (5.9)	7.612	0.022
Active listening skills	2 (2.7)	4 (11.8)	3.763	0.152
Using interpreters	2(2.7)	0 (0.0)	2.082	0.353
Gaining patient's confidence	6 (8.2)	0 (0.0)	4.775	0.092
Setting appropriate goals with patients	2 (2.7)	1(2.9)	1.045	0.593
Making the patient active in the process	4 (5.5)	0 (0.0)	2.800	0.247
Shifting focus away from pain	22 (30.1)	13 (38.2)	2.190	0.334
Encouraging to motivate patients	8 (11.0)	4 (11.8)	1.424	0.491
Teaching patients self-management skills	0 (0.0)	0 (0.0)	0.007	0.934
Referring to other health professionals	7 (9.6)	1(2.94)	2.617	0.270
Liaising with other health professionals	5 (6.9)	1 (2.94)	0.770	0.681
Avoiding scheduling two difficult patients consecutively	14(19.2)	5 (14.7)	5.367	0.068

Table 9. Association between respondents' agreement on strategies of managing perceived difficult patients and work experience

Management strategy	< 10 years n (%)	> 10 years n (%)	$\chi 2$	p-value
Providing explanations	2 (2.9)	1 (2.6)	0.040	0.980
Using visual aids	4 (5.9)	4 (10.3)	1.950	0.370
Active listening skills	4 (5.9)	2 (5.1)	3.185	0.203
Using interpreters	2 (2.9)	0 (0.0)	2.464	0.292
Gaining patient's confidence	4 (5.9)	2 (5.1)	0.822	0.663
Setting appropriate goals with patients	3 (4.4)	0 (0.0)	1.777	0.411
Making the patient active in the process	4 (5.9)	0 (0.0)	2.679	0.262
Shifting focus away from pain	21 (30.9)	14 (35.9)	0.284	0.868
Encouraging to motivate patients	8 (11.8)	4 (10.2)	0.130	0.937
Teaching patients self-management skills	0 (0.0)	0 (0.0)	0.206	0.650
Referring to other health professionals	3 (4.4)	5 (12.8)	2.643	0.267
Liaising with other health professionals	4 (5.9)	2 (5.1)	0.042	0.979
Avoiding scheduling two difficult patients consecutively	8 (11.8)	11 (28.2)	6.942	0.031

Discussion

This study assessed physiotherapists' perception of difficult patients and their strategies for managing these patients. The distribution of behavioral attitudes common to perceived difficult patients revealed that the highest-ranking attitudes were patients seeking multiple opinions from various professionals, and patients demanding the therapist's knowledge and time. These findings do not concur with those in a similar study by Potter et al. [22] who identified patients who do not take responsibility for themselves, are aggressive towards the physiotherapist regarding their injury or rehabilitation, think they know it all and are ill-informed, and are dependent on a particular treatment and/or physiotherapy as the highest-ranking behavioral attitudes exhibited by difficult patients. The perceived behavioral attitudes of difficult patients elicited from the open-ended questions in this study showed that psychosocial factors were the highest-ranking. This finding is consistent with the results by Steinmetz et al. who identified the diagnosis of psychosocial problems as one of the attributes of a difficult patient [26]. Contrariwise, some other studies on physicians placed much less emphasis on psychosocial factors [25, 27]. This is understandable given that physicians are the primary providers of care for patients with psychosomatic problems and are, therefore, better trained to handle such cases than physiotherapists. In fact, it has been suggested that teaching physiotherapists basic psychosocial skills that could be usefully applied to physiotherapy management would be both appropriate and necessary [28].

This study indicates that behavioural problems such as negative thinking, unhappiness with treatment, unhappiness with life in general,

confusion, helplessness/hopelessness, low self-esteem, and obsession are among the most often perceived behavioural attitudes of the difficult patient. These findings are supported by research among other health professions. Lorber in a hospital-based study on doctors and nurses found patients with behavioural problems overlying their medical condition to be problematic and labelled them deliberately deviant [19]. Similarly, Steinmetz and Tabenkin, who interviewed family physicians, reported that patients with behavioural problems were more difficult than those with complex medical problems [11].

This study identified complaining patients, poor education, good education, egocentric patients, labile emotional patients, previous bad experience with physiotherapists, familiarity with treatments, multiple physical factors, financial constraints, poor communication, long waiting time for treatment, environment, over-expectation of treatment and psychosocial factors as attributes of a difficult patient. These were additional factors that may be particular to the physiotherapeutic community as they were not the rating factors in earlier research [22].

Shifting focus away from pain and avoiding scheduling two difficult patients after one another were the most agreed strategies for managing difficult patients. Some other management strategies observed in this study corroborated findings from a study among family physicians [11]. These included communication skills of gaining rapport, active listening, providing an adequate explanation of the treatment process, along with referral or involvement of others in physiotherapy management. Furthermore, the present study identified such strategies for managing difficult patients as patience, counselling, being friendly, being strict, using dialogue, empathy, good clinical approach, group therapy, good clinical record, being understanding, composure, noting individual differences, patient's relatives, holistic approach, free treatment, prayer, encouragement, truth, education, task oriented rehabilitative procedures, finances, and spending more time with patients. The patient's relatives came on top of the listed strategies for management, which could be seen as a result of close relationship between family members in society.

The results of the present study can contribute to the evolving literature related to physiotherapist-patient interactions and promote self-reflection and self-awareness among physiotherapists. Physiotherapists' training in basic psychological skills applicable in management of difficult patients is most appropriate and necessary. In addition, physiotherapists should improve their communication skills and learn behavior-modification techniques in dealing with difficult patients. Further research is necessary to verify the findings of this study among a larger number of physiotherapists, for example on a nationwide basis, and among those in the private sector and other specialty areas. It is also important to explore patients' perceptive abilities, 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.

Conclusion

Patients seeking multiple opinions regarding their condition from various health professionals, and patients demanding the therapist's knowledge and time are mostly considered to be difficult patients by Nigerian physiotherapists. Shifting focus away from pain and avoiding scheduling two difficult patients consecutively were the highest-ranking strategies of management of such patients.

BIBLIOGRAPHY

1. Dunn M. At the moral margins of the doctor–patient relationship. The concise argument. *Journal of Medical Ethics* 2019; 45(3): 149–150.
2. Oghumu S. N., Kubeyinje O. S., Okhuahesuyi E., Nicholas R. O. Difficult Medical-Encounters: Health Professionals in a Tertiary Hospital Perspective on the Geriatric Syndromes. *Nigerian Hospital Practice* 2020; 25(5-6): 58–65.
3. Adler H. M. Toward a bio-psychosocial understanding of the patient-physician relationship; an emerging dialogue. *Journal of General Internal Medicine* 2007; 22 (2): 280–285.
4. Mota P., Selby K., Gouveia A, Tzartzas K., Staeger P., Marion-Veyron R., Bodenmann P. Difficult patient–doctor encounters in a Swiss university outpatient clinic: cross-sectional study. *BMJ Open* 2019; 9: e025569.
5. Greiner K. A. Patient-provider relations: Understanding the social and cultural circumstances of difficult patients. *InBioethics Forum* 2000; 16(3): 7–12)
6. Steinauer J. E., O'Sullivan P., Preskill F., Ten Cate O., Teherani A. What Makes "Difficult Patients" Difficult for Medical Students? *Academic Medicine* 2018; 93(9): 1359–1366.
7. Asanova A., Khaustova O. Typical difficult situations in doctor-patient interactions. *Psychosomatic Medicine and General Practice,* 2018; 3(3): e0303125.
8. Williams S., Harrison K. Physiotherapeutic interactions: A review of the power dynamic. *Physical Therapy Reviews* 1999; 4(1): 37–50.
9. Ward M., Cook S. When Communication Breaks Down: Handling Hostile Patients. *Medical Clinics of North America* 2022; 106(4): 689–703.
10. O'Dowd T. C. Five years of heart-sink patients in general practice. *BMJ* 1988; 297(6647): 528–530.
11. Steinmetz D., Tabenkin H. The 'difficult patient' as perceived by family physicians. *Family Practice 2001;* 18(5): 495–500.
12. Jackson J. L., Kroenke K. Difficult patient encounters in the ambulatory clinic: clinical predictors and outcomes. *Archives of Internal Medicine* 1999; 159(10): 1069–1075.
13. McCarty T., Roberts L. W. The difficult patient. In: Rubin R. H. (ed.) *Medicine: A primary care approach.* Philadelphia: WB Saunders; 1996: 395–399.
14. Hardavella G., Aamli-Gaagnat A., Frille A., Saad N., Niculescu A., Powell P. Top tips to deal with challenging situations: doctor-patient interactions. *Breathe (Sheff)* 2017; 13(2): 129–135.
15. Herbert C. P., Grams G. D. Working with the Difficult Patient. *Canadian Family Physician* 1986; 32: 1899.
16. Schafer S., Nowlis D. P. Personality disorders among difficult patients. *Archives of Family Medicine* 1998; 7(2): 126–129.
17. Byyny R. L. The Joy of Caring. The Pharos/Spring 2018, available at https://www.alphaomegaalpha.org/wp-content/uploads/2021/03/2018-2-Byyny.pdf.
18. Roberts L. W., Dyer A. R. Caring for "difficult" patients. *Focus* 2003; 1(4): 453–458.
19. Lorber J. Good patients and problem patients: conformity and deviance in a general hospital. *Journal of Health and Social Behavior* 1975; 1: 213–225.
20. Whitenack D. D., McGaghie W. C. Towards an empirical description of problem patients. *Family Medicine* 1984; 16(1): 13–15.
21. Gerrard T. J., Riddell J. D. Difficult patients: black holes and secrets. *BMJ: British Medical Journal* 1988; 297(6647): 530.
22. Potter M., Gordon S., Hamer P. The physiotherapy experience in private practice: the patients' perspective. *Australian Journal of Physiotherapy* 2003; 49(3): 195–202.
23. Gyllensten A. L., Gard G., Salford E., Ekdahl C. Interaction between patient and physiotherapist: a qualitative study reflecting the physiotherapist's perspective. *Physiotherapy Research International* 1999; 4(2): 89–109.

24. Gard G., Gyllensten A. L. The importance of emotions in physiotherapeutic practice. Physical Therapy Reviews 2000; 5(3): 155–60.
25. Hahn S. R., Thompson K. S., Wills T. A., Stern V., Budner N. S. The difficult doctor-patient relationship: somatization, personality and psychopathology. *Journal of Clinical Epidemiology* 1994; 47(6): 647–57.
26. Steinmetz D. The problematic physician-patient encounter. *Harefuah* 1992; 122: 357–359.
27. Goodwin J. S., Goodwin J. M., Vogel A. V. Knowledge and use of placebos by house officers and nurses. *Annals of Internal Medicine* 1979; 91(1): 106–10.
28. Potter M., Grove J. R. Mental skills training during rehabilitation: Case studies of injured athletes. *New Zealand Journal of Physiotherapy* 1999; 27: 24–32.

Received: November 2022
Accepted: December 2022
Published: December 2022

CORRESPONDENCE

Chidozie Emmanuel Mbada
Department of Health Professions, Faculty of Health and Education,
Manchester Metropolitan University, United Kingdom
E-mail: c.mbada@mmu.ac.uk