

NURSES PERCEPTIONS OF DIFFICULT PATIENTS

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ABSTRACT

The purpose of this article was to explain and describe how professional nurses in the health services experience difficult patients. A qualitative, descriptive research design was adopted. Data were collected by means of narratives, written by professional nurses who met the sampling criteria. The data analysis was done according to the protocol suggested by Tesch. Four major categories were identified. The first major category, namely patient factors, brought the following sub-categories to the fore: physical aspects and appearance; psychological factors; attitude factors; social factors and knowledge of the patient. The second major category, namely nursing factors, includes the following sub-categories: skills and experience, training and attitude. The third category, namely the situational factor, exists of the sub-category management, while the fourth category exists of one sub-category, namely that difficult patients do not exist. A literature control was done to verify the results. Conclusions and recommendations were made.

OPSOMMING

Die doel van hierdie artikel was om te verduidelik en te beskryf hoe professionele verpleegkundiges in gesondheidsdienste moeilike pasiënte ervaar. 'n Kwalitatiewe, beskrywende navorsingsontwerp is gebruik. Data is ingesamel deur die gebruikmaking van narratiewe deur professionele verpleegkundiges wat aan die steekproefkriteria voldoen het. Die analise van die data het aan die hand van Tesch se voorgestelde protokol plaasgevind. Vier hoofkategorieë is geïdentifiseer. Die eerste hoofkategorie, naamlik pasiënt-faktore, bring die volgende subkategorieë na vore: fisiese aspekte en voorkoms; psigologiese faktore; houdingsfaktore; sosiale faktore en kennis van die pasiënt. Die tweede hoofkategorie, naamlik verpleegkundige faktore, sluit die volgende subkategorieë in: vaardighede en ondervinding; opleiding en houding. Die derde hoofkategorie, naamlik situasionele faktore, bestaan uit die subkategorie bestuur, terwyl die vierde hoofkategorie een enkele subkategorie behels, naamlik dat daar nie moeilike pasiënte bestaan nie. 'n Literatuurkontrolle is gedoen om die navorsingsresultate te verifieer. Gevolgtrekkings en aanbevelings is gemaak.

INTRODUCTION AND BACKGROUND

Throughout the course of their professional lives nurses are encountering a variety of people, in a variety of contexts and for a variety of reasons. During these social interactions they need to be able to relate to other people, especially those in their care whom nurses call patients (Stein-Parbury, 2000:3). In a study on patient satisfaction regarding the nursing care they received while hospitalised, some of the patients remarked that they did not want to ring the call bell for help or ask nurses for assistance because they did not want to be seen by the nurses as difficult patients (Roos, 1999:158).

The existence of the "unpopular", "problem" or "difficult" patient is well-researched and described in health-related literature abroad (Breeze & Repper, 1998:1301). Johnson and Webb (1995:467) argue that social evaluations are not done in a clear manner and that evaluative labels (like "difficult patients") become flexible, depending upon the social context. Little written information is known about the perceptions of nurses towards difficult patients in the South African setting, except for an article by Oosthuizen (2000).

Stein-Parbury (2000:38) indicates that it might be regarded as unrealistic that nurses will like every patient with whom they come into contact. When patients are seen by nurses as being difficult, it may have an undesirable impact on the patient-nurse relationship and the outcome of nursing care. Olsen (1997:516) suggested that earlier studies indicated that the nursing care for difficult patients is less supportive than for patients not seen as difficult. The nurse-patient relationship is different from other business relationships where salespersons are interacting with customers, whereas patients as persons who are in need of health care are in a vulnerable position. Nurses need to display sensitivity for the vulnerability of patients and maintain therapeutic helpful relationships with them (Stein-Parbury, 2000:3). Kus (1990:65) suggests that caring for unpopular patients might also lead to job dissatisfaction among the nurses, leading to absenteeism, insomnia, withdrawal and anorexia. Some nurses may be unaware of these negative feelings towards some of their patients. Talking and writing about it may make them conscious of their feelings and they may be able to deal with these negative feelings in a more beneficial way for both the

patient and themselves.

PROBLEM STATEMENT

The problem statement can best be described by means of the following narrative:

The scene is the daily handing over of the patients' report between night and day shifts in a busy surgical ward in a provincial hospital. When reporting on Patient X, a sixty-year old patient who has had a bilateral mastectomy the previous day for malignancy, the night nurse said that she is glad to go home, because "Mrs X was really difficult during the night". According to the night nurse, Mrs X rang the call bell a few times during the night, asking something for the pain or to help her change position. There were only three student nurses on duty in that ward. They were very busy, having had a number of postoperative patients to care for and also admitting and preparing three other theatre cases for emergency surgery during the night. The professional nurse was rotating between four wards.

When the night supervisor was doing her rounds at 05:00, Mrs X complained that she was ringing her bell for "hours" before being attended to by the nurses. She also complained that she could not sleep due to the noise of the theatre trolleys and the nurses admitting patients. The night supervisor drew the attention of the night nurse to the fact that Mrs X's daughter was married to Doctor Y, the departmental head of surgery. She was sure that when this complaint reaches the ears of Doctor Y, he would definitely report this case to the hospital manager who would want an explanation from the night nurse. The night nurse felt rejected. They worked hard throughout the night, having had no time to sit down even once for a cup of coffee. Every time they were doing rounds, Mrs X was "sleeping like a log". When she rang the bell, they attended to her requests as soon as possible. They could not always give her the prescribed postoperative analgesic straight away, because they had to wait for the professional nurse to lock it out for them. The night nurse remarked that they had nursed many other patients who had the same operation before. The other patients did not complain about pain as much as Mrs X. They thought that she might use her illness to win the sympathy of her relatives.

From the above narrative it is clear that the night nurse experienced feelings of frustration. She felt that she was blamed for not giving enough attention to Mrs X, while she thought Mrs X was comfortable and well-cared for. She accused Mrs X as being “difficult”, and by so doing the responsibility for the incident was shifted to the patient.

RESEARCH QUESTION

The following research question was asked by the researcher:

How do professional nurses perceive difficult patients whom they have to deal with within health care settings?

OBJECTIVE

The objective of this research was:

- to explain and describe the perceptions of professional nurses regarding difficult patients whom they have to deal with within their health care situations.

RESEARCH DESIGN AND METHOD

A qualitative descriptive research design had been used to conduct this research. The focus of this research was to obtain data that would facilitate the understanding of the experience of the professional nurses regarding patients perceived by them as being difficult.

Population and sampling

The target population consisted of post-basic nursing students attending the laboratory sessions (practical component) for the course in Health Services Management at a university. They attended the sessions at centres in Pretoria, Cape Town, Bloemfontein, Port Elizabeth and Durban. The target population was culturally representative of the larger South African population. They all spoke and understood either English or Afrikaans. The sample consisted of persons who met the mentioned criteria of the population and that were willing to participate in the research.

Data collection

The identified students were asked to write a brief nar-

rative, answering the following central question, namely: “How do you view or perceive a difficult patient?”

The researcher created a context where the participants could respond freely by means of the following:

- Participants were asked to participate voluntarily in this research project. In most of the centres the researcher was not present, as the research question had been put to the prospective participants by two colleagues.
- The participants were asked not to write any identifying data on their response. It was made clear to them that they would in no way be penalised if they decided not to participate in this research.
- They handed in their narratives as a group, by putting it on the desk while the researcher or other research assistants were not present.

Data analysis

Ten of the 81 narratives were written in Afrikaans. The protocol described by Tesch (1990:142-145) had been followed and included the following steps:

- In order to get an overall picture, the researcher read through all the narratives, making notes of striking ideas.
- The narratives were studied again, this time focussing more on the theme than on the content. When a theme was identified, it was written in the margin.
- The related themes were grouped together on a separate paper. Three columns were drawn on another paper. One column emanated all the themes that emerged regularly, the second column included the themes that appeared infrequently but seemed to be important for the research, while the last column consisted of all the other themes.
- The researcher read through the narratives again, checking the list of themes against the narratives to ensure that all the categories were identified.
- The most descriptive words were then chosen for the themes, turning it into categories and sub-categories.
- All the available narratives (data) were then divided into categories and sub-categories.
- All the data belonging to a specific category

were arranged together. At this point attention was given to the content and the data. The data were identified and summarised. At this stage the data chunks that were written in Afrikaans were translated into English.

Measures to ensure trustworthiness

Several methods were used to evaluate and document the data quality. Firstly the researcher made use of person triangulations by obtaining data from various professional nurses. Space triangulation was achieved by collecting the data on the same concept at multiple venues and investigators' triangulation was obtained by asking another experienced qualitative researcher to help analyse and interpret the data (Polit & Hungler, 1999:428).

Ethical measures

Ethical measures included the following:

- Informed consent was obtained before participants started to write their narratives. It was stressed that participation is voluntary and that they could withdraw at any time.
- Confidentiality and anonymity was ensured by requesting participants not to make identifying comments on the narratives.
- The results of the research would be made available by means of publication (Strydom, 1998:23-36).

Limitations

Limitations identified for this study were as follows:

- The population from which the sample was drawn is not representative of all the professional nurses in South Africa, but only of the students registered for the particular course at that specific university.
- It may be possible that some of the participants described their perceptions of difficult patients in a way they felt was professionally correct and not how they actually perceived them.

RESULTS AND DISCUSSION OF RESULTS

An overview of the major categories and sub-categories of the perception that professional nurses have of difficult patients is presented as Table 1.

CATEGORY 1: PATIENT FACTORS

The professional nurses who participated in this study identified a variety of factors relating to the patient that might provoke the feeling that the patient is difficult.

Physical aspects and appearance

Some of the participants considered the degree of illness of patients as a determining factor whether they will be seen as being difficult or not. This was reflected in the following narrative: "*Often patients who are very ill are not difficult patients, but patients who are not seriously ill become demanding and difficult because they are not that ill. They become bored and find fault easily. They are frustrated and try to get the attention of the nursing staff by ringing the bell often with silly requests*".

Contrary to this point of view, another participant remarked that patients who are very ill need a lot of attention and request a lot of pain tablets. In other cases the participants linked difficult patients to the type of illnesses the patients suffer from, for example "*... a diabetic patient who is repeatedly admitted to hospital and stays for a long time, who does not want to test urine at the said time and is not interested in injecting himself with insulin*".

Another participant gave an example of terminally ill patients who "*... are anxious, depressed and have a fear of death. They end up being irritated and uncooperative*".

Kelly and May (1982:148) refer to numerous studies by Altschul (1972), Ghodse (1978), Stockwell (1972) and Towell (1975) who supported this belief that there exists a positive relationship between an illness type and difficult patients. When nurses perceive the illness to be the result of the behaviour of the patient such as heavy smokers that have lung cancer or persons contracting HIV/AIDS from having unsafe sex, the nurses might feel these patients get what they deserve (Kus, 1990:64; Carveth, 1995:176).

Table 1: An overview of the major categories and sub-categories of the perception of professional nurses of difficult patients

Major category	Sub-category
1. Patient factors	<ul style="list-style-type: none"> ● Physical aspects and appearance ● Psychological aspects ● Attitudinal factors ● Social factors ● Knowledge level of the patient
2. Nursing staff factors	<ul style="list-style-type: none"> ● Skills and experience ● Training ● Attitudinal
3. Situational factors	<ul style="list-style-type: none"> ● Management of the health service
4. There are no difficult patients	<ul style="list-style-type: none"> ● Difficult patients do not exist

Sometimes it is more the nursing care required by the condition of the patient that makes it difficult for the nurse to deal with the patient. *“Sometimes we call them difficult because we experience difficulty in managing their conditions, for example, as a casualty nurse we usually call patients with multiple injuries difficult. You find that everything attempted on him is difficult due to the extent of the injury. The type of injuries he sustained can make it difficult to intubate, commence CVP or even an ordinary intravenous line”.*

Another participant offered a different description of a difficult patient as being *“... dirty and untidy”.*

Kus (1990:62) and Kelly and May (1982:149) support this view by stating that patients with low social value and their state of cleanliness and attire influence staff opinion.

Psychological aspects

The participants were aware of psychological aspects that may influence patients and turn them into “difficult patients”. They identified fear, denial and withdrawal to

be of importance in this sub-category. A participant described a difficult patient as being *“... somebody who has fears about hospital treatment”.* On the contrary another participant remarked that a patient could be seen as difficult when she *“Kept on raising problems even though she looks well, due to fear of discharge”.*

Brook (1993:48) describes the latter situation as the need for illness that has the upper hand over the desire for recovery. The patient knows that something is seriously wrong, but desperately wants to believe that it is physical and not mental.

Patients can react with denial when they refuse to accept a diagnosis, talk about it or be treated for it: *“When a patient is denying her diagnosis and prognosis because he/she would not be involved in her treatment”.* English and Morse (1988:26) found that patients who denied their diseases (especially those with diabetes, hypertension or heart conditions) were perceived by nurses as being extremely difficult. In cases like that the nurse will not receive any cooperation from the patient. Withdrawal can also be problematic to the professional nurse wanting to render nursing care, for ex-

ample, "... a patient who withdraws when you try to involve him/her in the care plan".

According to Duxbury (2000:9) withdrawal may be something a patient actively chooses to do or it may not be a conscious decision. Some nurses may view withdrawal in a positive light, as patients are less demanding.

Patients sometimes display attitudes like uncooperativeness, dissatisfaction and aggression. Such a difficult patient was described as one "... who does not want to take part in any self-care activity; who always thinks that it is the nurses' duty to help him in everything as long as he is under their care, even if the nurses help him by giving him education so that he is able to help himself".

The real reason for such uncooperative behaviour may, however, originate from cultural differences as a participant worded it: "... the patient may display an uncooperative behaviour because she is in a strange place where she does not even understand the languages used".

Stein-Parbury (2000:248) believes that culture has a vast influence on behaviour and influences the way people understand and express pain. Patients were dissatisfied when they could not understand the language that the medical and nursing personnel speak (Roos, 1999:159).

Attitudinal factors

Some of the participants linked the difficult patient to dissatisfaction, writing that "... a difficult patient is never satisfied, even if you have done what he requested, at the time that he requested it".

In some cases difficult patients are seen as aggressive and rude, using abusive language to hospital personnel, demanding instead of requesting services from the hospital staff. Other researchers, like Collins (1994:118), describe the need for staff training in the prevention and management of aggressive behaviour of "difficult patients". Nield-Anderson, Minarik, Dilworth, Jones, Nash, O'Donnell and Steinmiller (1999:32) urge nurses to be aware that aggression is often a response to fear, anger and powerlessness. Dewar and Morse (1995:962)

perceive this type of behaviour as an indication of the patient's failure to endure. Patients that are making unreasonable demands, such as requesting a sick certificate when not ill or asking for medication when their illness does not warrant it, may be seen as difficult.

Other attitudes and behaviours that participants used to describe difficult patients were nagging, threatening to report the nursing personnel to their managers, being manipulative in bribing nursing staff, being selfish and lying. These characteristics of difficult patients are well-described and supported by Duxbury (2000:12).

Indications of assertive behaviour for some of the professional nurses were when a patient "... report mistakes of nurses to the matron and his doctor" or "... badly influence other patients to rebel against nurses".

Contrary to these negative feelings that assertive behaviour of patients create, Duxbury (2000:17) believes that a greater understanding of the needs of the patients can be facilitated if patients are encouraged to express their needs in a mature way.

Social factors

Characteristics such as age, marital status and income factors determine the social value of persons and patients. Nurses may perceive a patient of low social value as being less desirable, or unpopular, than those with high social value (Kus, 1990:62). The social status persons hold may be the reason for their difficult behaviour, according to one of the participant's description of a situation: "... a patient who is well-known in the community, who expects superior treatment whilst hospitalised. This kind of patient does not realise that there are rules and regulations in the hospital that have to be adhered to, for example, visiting hours, restrictions of visitors and no smoking policy" and "... patients who feel that they are more important or better than others and feel that they should be treated special (to get special treatment)".

The occupation of patients may also impact on their behaviour as patients. In the words of two of the participants "... often medically-orientated people are difficult patients, for example doctors, nurses, radiologists. They are frightened, fearful and often tend to hide their

insecurities and fear by being demanding and aggressive to the nursing staff” and “... a patient can get difficult when he is removed from his known environment for instance a farmer who is hospitalised for the first time”.

Ironically one participant describes a difficult patient as follows: “*I think nurses are difficult patients, especially if you know that person, because it makes you feel uncomfortable. Nurses are expecting perfect service. Most of the time nurses don't want to bother the nursing staff and do not ask for help. This makes it difficult to satisfy them*”.

Religious and cultural beliefs can cause patients to refuse blood transfusions or being treated by a person from an opposite gender or culture. Participants might perceive this refusal as being difficult.

Lack of communication skills on the side of a patient may provoke the type of behaviour that nurses call “difficult”. An example of a difficult patient is illustrated by “... *somebody who does not listen to other people's views and is very defensive in answering questions from staff members*”.

Sometimes nurses have the impression that the patients do not know what they want when they are not able to state their problems clearly and are uncertain about their rights. In other instances it is not the patient who is difficult, but the “... *relatives may tend to be difficult especially if they are learned*”.

Some of the participants perceived patients also as having their own problems originating from home, work or social behaviour resulting from drug or alcohol abuse like “... *the patient may be having his own personal and social problems*”.

Knowledge

The participants clearly described two distinct groups of difficult patients relating to the knowledge that the difficult patient has. Firstly “... *a patient who 'knows too much' about medication and their rights; they will tell a new nurse which tablets to give to them. Though right, the nurse will feel awkward and humiliated*” but contrary to that, also “... *a difficult patient is one who does not understand anything that is explained to him,*

irrespective of how many times it is explained”. Some of the participants expressed their resistance to give information to patients by describing difficult patients as the patient who “... *wants to know everything about his being at the hospital since he wants to know about his diagnosis and prognosis, medication and its action on his body, what blood test is done and why*”.

Nurses do not want to be questioned by the patients and their relatives about their acts (and omission). English and Morse (1988:31) mention that a patient in their research remarked that the nurses were either afraid to tell them anything or did not know the answers. A study by Breeze and Repper (1998:1307) indicates that patients are defined as “difficult” when they pose a threat to the control and competence of the nurse.

According to Roos (1999:183) patients are still treated in a paternalistic way and in many instances patients do not receive enough information to make decisions in a knowledgeable manner. Oermann and Templin (2000:171) emphasise that patient education makes up an important component of quality of care.

The prevailing message of these narratives is that there are a number of patient factors present that may make nurses to believe that some patients are “difficult patients”.

CATEGORY 2: NURSING FACTORS

Some of the participants looked further than the patient and also identified factors relating to the nursing staff that may be the cause of difficult patients.

Skills and experience

The experience as well as the skills that professional nurses have may have an influence on the behaviour of the patient in a health care setting. As one participant put it: “... *according to my experience, even the 'sweet patient' can be difficult, depending on the situation. A sweet patient may be difficult because she has fallen into the hands of an inexperienced nurse who has no skills*”.

Kus (1990:64) supports this by giving an example of a paediatric nurse who has to help out in a coronary care unit due to staff shortages. Patients in the coronary

care unit may present with needs beyond the abilities and skills of this nurse. Because the nurse feels incompetent, she may also dislike the patient. When patients threaten the nurse's control and competence, they are often defined as "difficult" (Breeze & Repper, 1998: 1307).

Training

The training that the professional nurse received helps with interactions and interpersonal relationships between patients and professional nurses. One of the participants referred to this as follows: "As a student I nursed a patient that had leukaemia - she was always ungrateful, rude, and sad, never laughed, was never satisfied and always wanted an explanation. At that time of my career I did not understand her and classified her as a very difficult person/patient. I changed my opinion years after I qualified as a psychiatric trained nurse. I then realised what her illness had done to her. Now I have a different perception of her actions".

Attitudinal

Sometimes it is the attitudes of the nurses and their portrayal of the patients that makes it seem as if the patients are difficult. If one can understand that all individuals are different and are entitled to their own opinion and to respect that in all patients/people one's perception of them may also change. "In most cases nurses like to nurse or give nursing care to patients who do not know their rights".

In certain situations a nurse may cause a patient to be 'difficult', for example "... an overworked, frustrated nurse who cannot cope with the workload" or "... a lazy nurse who does not want to pursue patients' requests".

One of the participants believed that the nursing staff should have adequate knowledge of the different personality types and how to handle different age groups.

Data from this study are supported by Breeze and Repper (1998:1306) whose view is that nursing intervention could have a positive or negative effect upon the care experience of the "difficult" patient. This author regards time and skills as being important.

CATEGORY 3: SITUATIONAL FACTORS

Some of the factors identified by the professional nurses in this study can be categorised as situational factors.

Management

The situational factor identified by the professional nurses in this study relates to management.

The lack of quality can be linked to "difficult" patients. One of the participants reflected on "... My observation that most of the patients whom we call 'difficult' actually want nursing care or service that is lacking. Sometimes it is both lack of service and lack of understanding of the patient by the service provider when the patient demands his rights".

According to some of the professional nurses participating in this study, there are also factors concerning the admission or lack of information of patients that may cause the patient to be regarded as "difficult". "... A difficult patient is a patient who didn't get time to allay his anxiety on admission" and "... procedures are not explained to the patient". Patients need information and reassurance on admission in order to obtain their cooperation.

Roos (1999:129) regards nurses as key figures in providing patients with the necessary information about hospital routine and procedures.

CATEGORY 4: THERE ARE NO "DIFFICULT PATIENTS"

Some of the professional nurses who participated in this study were of the opinion that there are not "difficult patients": "According to my view, there is no 'difficult patients'. What you see as 'difficult' is what you don't understand. When a patient is assertive, she/he is classified as inquisitive. A non-assertive patient will be classified as a good patient. When she or he is aggressive, then she/he is classified as the most difficult due to the fact that some or all of her/his needs are not met and that has driven the patient to be aggressive".

An assertive patient wants to be empowered. Breeze and Repper (1998:1309) argue that only an empowered nurse could empower a patient. Often nurses describe patients to be difficult because they themselves

experience feelings of powerlessness: "Patients are not just difficult, there is always a reason why a patient can be regarded as being difficult - or termed to be by nursing personnel. Reasons may be social, emotional, and political or even the approach of a health care worker to a patient."

Nield-Anderson *et al.* (1999:33) support this view, stating that any patient may become aggressive, depending on the circumstances. Another perspective on this topic is "*There is no difficult patient for as long as you understand the uniqueness of a patient. Empathise with him/her, provide the patient with information relevant to the condition find out and correct misconceptions and allay his/her anxieties. Explain every activity carried out on him/her, providing counselling and support and maintains good interpersonal relations*". Responding to an article in a journal, a reader (McEntee, 2000:16) expresses her concern that medical staff may inappropriately label patients' behaviours as being "difficult". Before starting to label patients, it must be made sure that the standards of good nursing care had been met.

RECOMMENDATIONS

It seems to be unrealistic to expect that all nurses will always like all the patients in all circumstances. This may leave nurses feeling guilty.

- Reflection on the situation and talking it over with colleagues may help the nursing professionals to find ways to work with problems and potential problem cases.
- The development of self-awareness among nurses seems to play a major role on searching for solutions to this problem. These skills should not only lead to the better understanding of patients, but also develop self-awareness that plays a major role in the professional growth of the nurse.
- Nurses need to understand the uniqueness of people. Establish good nurse-patient rapport by encouraging patients to openly express their feelings. Develop an empathetic listening skill to understand how the patients experience their illness and hospitalisation. Talk to patients about their anxiety and establish a trusting relationship. Find out and correct patients' misconceptions and provide the patients with the necessary information to empower them.

- Health professionals should be aware of the rights of patients, especially the rights of patients regarding information on their illnesses, medication and treatment. To consider patients as difficult when asking information is denying them this right and is also not an effective way of gaining the cooperativeness of patients.

CONCLUSION

The narratives that were analysed indicated that the majority of professional nurses acknowledge the existence of the "difficult patient". Their views indicate that there are different factors contributing to the development of the concept "difficult patient". These factors mainly revolve around patient- and nurse-related factors.

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