What Makes "Difficult Patients" Difficult for Medical Students?

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Abstract

Purpose
Physicians can find it challenging to provide high-quality care to "difficult patients." While studies support that medical students also find some patients "difficult," little is known about why they do or how being a student affects their perceptions. The authors conducted this study to gain a deeper understanding of students' experiences with "difficult patients" to inform clinical teaching about effective patient communication and patient-centered care.

Method
In 2016, the authors conducted interviews with fourth-year medical students, who were asked to describe patient interactions in which they felt negative emotions toward the patient, as well as describe the clinical setting and their feelings. The authors audiorecorded and transcribed the interviews. Then, using a constructivist grounded theory approach, they reviewed the transcripts, coded the data using a codebook they had developed, and grouped the codes into themes.

Results
Twenty-six students (of 44 volunteers and 180 students invited) were interviewed. Students described negative feelings toward patients and patients' behaviors, which were exacerbated by three situations related to their role and expectations as learners: (1) patients' interference with students' ability to "shine"; (2) patients' interference with students' expectations of patient-centered care; and (3) students' lack of the tools or authority to improve patients' health.

Conclusions
Educators should consider these findings, which can be explained by the professional identity formation and goal orientation theory frameworks, as they teach medical students to provide high-quality care for patients they find "difficult."

Researchers have concluded that patient–physician communication, a critical component of health care quality,[1] is associated with patient satisfaction and positive health outcomes, including medication adherence, functional status, and lower mortality.[2] High-quality, patient-centered communication requires that physicians establish rapport, communicate respect, consider the patient's perspective, and demonstrate empathy,[3] all of which can be challenging when interacting with patients toward whom physicians feel negative emotions. These patients are often labeled as "difficult."[4–7] Medical students also feel negative emotions, such as frustration, toward patients, but little is known about their experiences, so we cannot create strategies to support students' skill development to handle these challenging circumstances.

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Primary care physicians label up to 30% of their patients as "difficult."[4–8] These patients include those who are psychiatrically and/or medically ill; have complex social circumstances and lack support; have vague symptoms or conditions with little or no likelihood of a cure; behave in angry, manipulative, or hostile ways; challenge or decline recommendations; are interpersonally difficult; and have high utilization of health care services.[5,6,9–14] Additionally, patients who are considered "difficult" report lower-quality clinical interactions.[4,6]

Medical students, residents, and early-career physicians are more likely than other physicians to label patients as "difficult,"[6,15–17] and they struggle with caring for these patients.[17,18] We must address these challenges because students play a critical role in the communication between patients and teams and because providing training in handling these interactions should prepare students for their future practice. While some have suggested that educators focus on training students to care for "difficult patients,"[11,17,19–21] there are limited studies of students' experiences to inform curricular development.

Reports in the literature provide insight into the types of patients and interactions that medical students consider difficult, but these reports have little information about why students find them challenging. A recent analysis of reflection essays found that medical students' "difficult patient" experiences, similar to practicing physicians' experiences, included interactions with patients who were angry, uncooperative, or disinterested; talked too much; or had chronic pain, among other behaviors.[17] Students described feeling angry and frustrated in many of these interactions, but they did not explain what caused these negative emotions. In workshops supporting verbal reflections about challenging interactions during obstetrics–gynecology clerkships, medical students discussed patients who abused drugs or alcohol, did not comply with recommendations, and made what they perceived to be irresponsible reproductive health decisions.[18]

A gap exists in the literature regarding how medical students experience interactions with "difficult patients" within their role as learners and within the clinical learning environment. Professional identity formation, which explores both psychologically and

sociologically how students acquire their physician identity, might help us understand how students experience these interactions.[22,23] As medical students try to act like physicians but still cannot practice independently and therefore must interface with their supervisors or teams, they may find particular types of patients especially challenging and experience interactions with them differently from practicing physicians. The purpose of this study was to explore how students understand their experiences of "difficult patient" interactions, anticipating that these data will inform curricular development and strategies for supporting clinical learning, to teach students to more effectively communicate with patients who challenge them.

Method

Study design

We conducted interviews and based our qualitative analysis of the transcripts on constructivist grounded theory, a methodological orientation in which researchers analyze how individuals develop subjective meanings of their experiences.[24] We considered professional identity formation as a potential framework to explain our findings but did not know if it or another theoretical framework would fully explain students' experiences. This uncertainty justified our use of a grounded theory approach.

Participants and setting

We recruited fourth-year medical students from an urban medical school in the western United States, just before graduation, to participate in our study. This timing increased the chances of the students giving honest answers since there was no risk to their residency placement or evaluation. Students had interacted with patients across all four years of medical school in various settings, so we expected that they would be able to reflect back on the spectrum of patients they had encountered during their training.

Interview guide

We derived our interview guide from studies of physicians' interactions with "difficult patients," specifically using this information to guide how we asked students to describe the patient interactions in which they felt "negative emotions" toward the patient.[11] We used two framing questions. First, we asked students to describe in detail two different patients toward whom they felt negative emotions, including the clinical setting and their feelings. Second, we asked whether they had ever noticed patterns in the types of patients and interactions they found to cause negative emotions. We piloted our interview questions with a group of faculty colleagues to ensure that the questions were clear. During the interviews, we included additional probes that captured the themes that had emerged from the previous interviews, as we noticed them during our transcript analyses, consistent with grounded theory.

Procedures

In February 2016, we e-mailed all fourth-year medical students with an invitation to participate in our study. Each student received an information sheet about the study. Thirty-nine students replied to our initial invitation; of these students, 21 were available during our interview slots and participated in our study. Then we sent a second invitation to the students who had not responded to our initial e-mail; it included a link to sign up for the five remaining available interview slots. Once these slots were filled, we sent no further invitations because we had gathered sufficient data to describe the themes.

From February to April 2016, two authors (J.E.S., F.P.) with prior training in qualitative methods interviewed students using an in-depth, semistructured methodology. Interviews were conducted either in person or by telephone and lasted between 40 and 75 minutes, and each participant received a $25 gift card. All interviews were audiotaped and professionally transcribed. The transcripts were deidentified. We used Dedoose 7.0.22 (SocioCultural Research Consultants, LLC, Los Angeles, California) for our analysis of the interview transcripts.

The institutional review board at the University of California, San Francisco, School of Medicine considered our study exempt.

Data analysis

During the interviews, we used a constant comparison approach,[24] identified themes, and explored a few areas in more depth, specifically the aspects of students' experiences that were related to their role as learners and their position within their teams. To improve the quality of the interviews, we reviewed the first six transcripts to explore the extent to which the interviewers were leading the students and solicited feedback from two noninterviewer authors (P.O., A.T.). We stopped conducting interviews when no new patterns emerged from the data and we had adequate evidence to describe the themes, thus achieving theoretical sufficiency.[24]

Three authors (J.E.S., A.T., and F.P.) analyzed two interviews to create our initial codebook. We then applied these codes to a third interview, revised the codebook, and analyzed two additional interviews. We made final codebook revisions, primarily collapsing codes but also adding a few new codes. We used the final codebook for our analyses, coding at the sentence level. Two authors (J.E.S., F.P.) each coded half of the interviews and reviewed the other's codes to make sure they were in agreement. Through frequent discussions, all authors participated in grouping the codes into themes that explained medical students' experiences with "difficult patients." Each author had input on the representative quotes included below.

Researcher reflexivity

The research team consisted of physicians, educational researchers, and a research associate trained in public policy. Most interviews were conducted by the first author (J.E.S.), a professor in the Department of Obstetrics and Gynecology who works with a small number of medical students but does not have an administrative role or assign grades to students. Her experience as a medical student, physician, clinician–educator, and facilitator of small-group reflections[18] may have influenced the collection and interpretation of the data; it is possible that students were less comfortable talking with her because of her status or more comfortable because of her shared history and experience facilitating these discussions. In the iterative analysis, the other members of the team who were not involved in clinical education provided additional perspectives to that of the physician first author. They are experienced qualitative researchers and are familiar with students' experiences in medical education and concepts related to professional identity formation. Collectively, these experiences

may have influenced their interpretation of the data.

Results

We interviewed 26 of the 44 students who volunteered, from the 180 fourth-year students we invited to participate. Thirteen (50%) were women, and the mean age was 29 (range 25–34). They were entering diverse specialties, with the largest subset (7; 27%) going into internal medicine. Students described between 2 and 8 specific patients toward whom they felt negative emotions.

Students described these patient interactions as challenging and difficult for them and their teams; many patients had complex social circumstances, chronic disease, psychiatric illness, and/or substance use disorders. Students often described patients with "unfixable" problems; who were angry with or mean to care providers; declined the recommended treatments; were thought to have caused or exacerbated their own health problems; could not or would not communicate with the students; and were perceived to be drug seeking. Students often described their emotions in these interactions as "frustrated" or "annoyed," and frequently their experience was dominated by feeling powerless to help the patient.

We identified three themes related to the tensions that caused or exacerbated students' negative feelings toward patients, all of which pertained to their role and expectations as medical students (see List 1). These themes are (1) patients' interference with students' ability to "shine"; (2) patients' interference with students' expectations of patient-centered care; and (3) students' lack of the tools or authority to improve patients' health. We elaborate on each of these themes and include representative quotes below.

Patients' interference with students' ability to "shine"

Nearly all students described at least one interaction in which they felt frustrated with patients who lowered their chances of "shining" and receiving a positive evaluation. Students perceived that these patients prevented them from fulfilling the roles that were required to obtain an honors grade. These expected roles within the team included knowing the patient well, efficiently collecting and presenting information, and saving the team work.

List 1

Themes Describing Medical Students' Experiences With "Difficult Patients" and the Expected Behaviors and Roles That Contributed to Their Negative Emotions, University of California, San Francisco, School of Medicine, 2016

Patients' interference with students' ability to "shine"

Students perceived that patients prevented them from fulfilling the roles that were required to obtain an honors grade.

- The student should know the patient well, efficiently collect information and data before presenting, and build rapport with the patient.
- The student should present in a succinct way.
- The student should prevent extra work for the residents.
- The student should communicate clearly with the patient and family, answer all questions, and know everything about the patient.
- The student should diffuse angry feelings in the family and patient.
- The patient should be seen by the patient as the primary physician.

Patients' interference with students' expectations of patient-centered care

The patient–physician relationship students expected was negatively affected by patients' behaviors.

Patient dimensions

- The patient should be happy and appreciative.
- The patient should want to get healthy.

Relationship dimensions

- The student should trust the patient.
- The patient should trust the student.
- The student should keep control of the interaction.
- The student should establish an emotional connection and rapport with the patient.

Students' lack of the tools or authority to improve patients' health

Students lacked the characteristics needed to fill the physician role.

- The physician should have competence, knowledge, and skills.
- The physician should have power and authority.

The roles they expected in interactions with patients included establishing rapport, diffusing anger, and being considered the primary physician. Students also described challenging patients as those who thwarted their ability to contribute to and not be a burden to the team and to care for the patient effortlessly.

As suggested by the quotes in Table 1, students described times when challenging patients made it difficult for them to fulfill these expected roles, therefore threatening their ability to obtain an honors grade. Angry and uncooperative patients impeded their ability to collect information adequately and/or efficiently, which made it difficult for them to present succinctly and demonstrate that they were doing "the one job they had." Additionally, students described times during rounds when the patient would "surprise them" by saying they did not know the plan or provide additional information the student did not know, making it look like the student had not done "[her or his] job." Students also felt that their preceptors would think they were not doing a "good job" when they did not diffuse situations with angry patients or families, and they were frustrated with patients who required them to burden their residents with extra work.

In general, students' concerns about their grades prevented them from asking the residents or attendings to help. They also described not wanting the residents to find out how hard they were working with their challenging patients. As one student described:

> I want the outcomes to be good but I don't necessarily want them to see what it took me to get there because you want the resident to be like, "He was independent; he got his work done. The patients were happy.… He was comfortable with it. He felt natural," and if it's "He was hard working but he stayed way later than everybody else and we're not really sure what took him so long," that's not what I thought they'd actually want.

Table 1

Medical Students' Experiences With "Difficult Patients" When Patients Interfered With Students' Ability to "Shine," University of California, San Francisco, School of Medicine, 2016

Theme	Representative quotes
Students perceived that patients prevented them from fulfilling the roles that were required to obtain an honors grade.	
The student should know the patient well, efficiently collect information and data before presenting, and build rapport with the patient.	• As a female medical student, he wouldn't talk to me the first couple days. I would be like, I'm going to examine you, just going to power through this anyway. I'd ask him questions and he'd either not answer or say no, but when my male resident would examine him he would be more talkative, and give him answers. So every morning when I presented on this patient I would be like, subjective, the patient doesn't talk to me. I felt like I wasn't able to do a good job and I felt like it reflected on me poorly because I had an uncooperative/sexist patient. • So, interviewing her, I had to like go through this translator and there was no way to ever redirect her or get her back to the point. Like I would ask a very yes and no question and I'd get back this very long repetition of her entire story so far in terms of coming into the hospital and I can't actually interrupt it. And it's frustrating because I keep thinking, oh, my gosh, like I'm only supposed to be in here for maybe 20 minutes at most before I need to go and talk to my preceptor and I can't get even the most basic information out of her.… When you're [in] the ED and there's this big line, a patient's coming in, you want to help the team [through] it and get patients through and you don't want to be the one who kind of slows everything down or is seen as needing more help or not being efficient enough. And when you're on your third year, like, you know, you're on prerounding or whatever and you do your presentation, that's your time to shine as a student. And if you haven't gotten the information or you weren't able to finish whatever your task was, then it's like, oh, you didn't do this one job you had.
The student should present in a succinct way.	• That's the role if you're a good med student. What you do is you have a succinct presentation for surgery. There is a succinct presentation and you maybe give a shot at what the plan will be and if that plan includes addressing specific questions of the family because they're not going to sit there for half an hour and talk about all their issues.… My toolbox was listen and summarize to the attending. There was nothing to summarize and they didn't want to be listened to.
The student should prevent extra work for the residents.	• Again, it's really the—ultimately, it's just this feeling that I'm not as capable as I could be, right? I think ultimately it is this feeling of admission. Also, worried that I would give my resident more work, right? This feeling like, "Oh, I have this incompetent sub-I. I have to—he's given—you know, he can't step up to it. Now, I have to deal with this." A lot of it was just desire to please the R2 so that I could take care of this really difficult patient and shine, you know?
The student should communicate clearly with the patient and family, answer all questions, and know everything about the patient.	• I think it was, I'd talk to her about why we were doing what we were doing in the plan, and she'd always agree to it and seemed okay with it, and we discussed compromises and how we could best treat her pain, but of course, when we came back in for rounds, she'd be like, "Oh, no one told me anything." And I felt frustrated, because here I was trying to do my best for her, and here she was basically saying, like, I hadn't done what I was supposed to do. And so, that was really hard for me. • Then come out and surprise me, and that's somewhat embarrassing because I'm supposed to know everything about this patient even though that's unrealistic because I'm sure I could have the same conversation with someone tomorrow and say different things, or even in five minutes.
The student should diffuse angry feelings in the family and patient.	• I think I wanted it to go well as a sign of I'm doing a good job, and it felt like this huge thing just blew up, and you know, I think I knew it wasn't a reflection on me, but there was some part that this would have been nice if this would have been a huge success and I could have really worked with her. • I'm not really sure what they're mad about and I don't know what to do. It made me look powerless in front of the attending, which you don't want to do. You want to look like you're together and you want it to look like you know what you're doing.

These types of patients and interactions sometimes made the students feel that they were not able to make the work look effortless.

Additionally, students felt that patients whose problems were considered "social" and not "medical" might affect their evaluation. One student said:

> I feel like obviously the threat of getting evaluation, getting honors, means that I feel like I have to impress people. To impress people—this is my thought process. To impress people I have to solve problems. To solve problems, they have to be problems I can solve. If there's a physical issue I can't solve, I get frustrated. If there is a pneumonia that I can give antibiotics for, and know the course, and know the drug, and know the time frame, then I feel good about it … I want to fix things. I feel like fixing things gets me honors. If I can't fix them, I can't get honors.

Students were especially frustrated with patients who were considered "social admissions" or who had extended stays for "social" indications for these reasons.

Some students described consciously deciding to not worry about getting an honors grade and to focus on learning from the challenging patient interaction. Occasionally, this decision was in the context of a rotation when the student was no longer concerned about her or his performance. For example, one student said, "It wasn't really about performing or—I'm sure if I did the sub-I earlier, it would have been." Other students made this decision when they had continuity with attendings, specifying that they

felt they would have another chance to demonstrate their competence. Occasionally students described patient interactions without mentioning concerns about evaluation.

Patients' interference with students' expectations of patient-centered care

Students described frustration when their experiences countered the patient or physician behaviors they desired or the patient–physician relationships/interactions they expected (see Table 2). For example, students described specific behaviors they expected of or desired in a patient—they wanted patients to be happy and/or appreciative. One student said, "It's much easier to interact with people when they're excited to see you and appreciate you." Students also expected patients to want to be healthy. One said: "I can't do my job if you're not going to participate, or if you don't want to be healthy, why are you here? You shouldn't be in the hospital if you don't want the treatments."

Students described wanting to experience a close emotional connection and rapport with patients. These students experienced frustration when their expectations of the patient–physician relationship or interactions were not met. One student said:

> I felt hopeless because none of the things I was doing was making my rapport with him better. Which was really frustrating because it's like, you know, I've done the [preclinical communication course] stuff. You know … I've basically listened to him, I listened to his concerns … but then it was like a one-way road where I was just doing things for him, but there was … no rapport, I believe, from his side. He wasn't trying to build a relationship with me.

Students were also disappointed when they could not easily establish trust with their patients, contrary to their expectations. This trust was bidirectional—they were disappointed when the patient did not trust them and also when they did not trust the patient. For example, students did not want to "question the validity" of their patients' stories when there were "discrepancies." The challenging patient interaction then was one that failed to meet students' expectations of patient-centered care.

Students' lack of the tools or authority to improve patients' health

Students yearned to experience the full ideal of the physician—to have competence, knowledge, skills, power, and authority to independently care for patients. However, as they were in a learner role but practicing to be in a physician role, they were frustrated because they lacked some of these characteristics (see Table 3). Students generally described instances in which they were not equipped or logistically permitted to manage a patient's pain. One student, describing an imagined conversation with a patient, said:

> You're frustrated with me, as a patient, because you're not feeling helped. I'm frustrated because I'm trying to take on the responsibility and be your primary person but I don't have the tools or quite enough power, yet, to be the one that can help you.

In describing another case, the same student said, "My value was an information relayer but not as someone who can do something or cause action to happen."

Students also described times when they lacked knowledge, such as being unable to answer patients' questions, which caused confusion with patients. One student said:

> There's a lot of knowledge I didn't have. A patient would ask me a question, and I could venture a guess, and the team would come and say something entirely different, and that would be confusing to the patient.

Students often conveyed a desire to be in the role of the physician, yet their struggles with not having knowledge, decision-making power, and other authority kept them in the role of "spectator."

Finally, as described above, these patients had a myriad of complex psychiatric and chronic diseases and very complex social circumstances. Overlying all of the above themes, students experienced feelings of powerlessness to help patients improve their health status; this powerlessness was not specifically related to their lack of authority or competence as students but, rather, stemmed from the complexity of patients' cases.

Discussion

In line with the findings from other studies,[17,18] we found that students were similar to practicing physicians,[10,11,13] in terms of the kinds of patient interactions that evoked negative feelings. In our study, however, students' negative feelings were affected by several factors that were outside the patient interaction but central to their status and role as a medical student, including their concerns about evaluation and their disappointment when they could not provide direct patient care. Additionally, students experienced frustration when their hopes that the patient–physician relationship would be patient centered[3] were not realized. Thus, their identities as medical students and their professional identity formation process affected how they responded to these experiences with "difficult patients."

Professional identity formation, or the process of adopting a professional identity, requires both individual psychological changes and collective socialization processes.[22,23] As Cruess and colleagues[23] described, this socialization process in medicine is complex, requires students to play the role of physician, and is affected by positive and negative emotional experiences. Rather than thinking of professional identity formation as a longitudinal process that spans multiple stages of training, Jarvis-Selinger and colleagues[22] proposed that it involves multiple, successive identities. As students go about their work, their identities are "constructed and co-constructed" as Monrouxe[25] described, and affected by cultural expectations, role modeling, and relationships. Students are simultaneously learning both what it is to become a doctor and what it is to be a medical student, and, during their clerkships, they must "come to understand their place in the community of practice and must reposition their learning" relative to patient care.[22] According to our findings, students' interactions with "difficult patients" highlighted the tension between their learner and physician identities; students were very concerned about their learner identity and felt thwarted in their professional identity development when they were faced with "difficult patients."

The professional identity formation process also requires that students feel increasingly competent, which in turn

Table 2

Medical Students' Experiences With "Difficult Patients" When Patients Interfered With Students' Expectations of Patient-Centered Care, University of California, San Francisco, School of Medicine, 2016

Theme	Representative quotes
The patient–physician relationship students expected was negatively affected by patients' behaviors.	
Patient dimensions	
The patient should be happy and appreciative.	• I mean, I think like you just feel more excited to like go see the patient in the morning because like you have good news to give them and you know the family's going to be happy. And like you kind of sell this like hope to them, you know? And it's just, you know, it's much easier to interact with people when they're like excited to see you and like appreciate you and things like that. • And with this guy, I just could not form any type of connection. And maybe it was selfish, but I just felt like usually I was good at connecting with people. And then, with this guy, I just could not reach him at all. And then, I've seen this before with many other patients, that they would just bounce in and out of the emergency room or the hospital, and it felt like—you know, I know people can't just, like, give up alcoholism, like, right away. Some people can, and good for them, but most people can't. That wasn't the issue. It was just, he knew that he had a problem, but he didn't want to address it, despite me, you know, kind of breaking my back when I had, like, four other patients, and I was calling and calling even when he wasn't my patient anymore to try and figure out what was going on with him, and, like, didn't hear anything. It was just a little frustrating.
The patient should want to get healthy.	• I think it's just hopeless and futile. It's like my job here is to try to help you be healthy and reach these goals, especially if it's in the hospital or something. It's like you're here because you're sick and you need help, but you're not—I think it's just really frustrating, like I can't do my job if you're not going to participate, or if you don't want to be healthy, why are you here? You shouldn't be in the hospital if you don't want the treatments. The hospital is the place you come to have people do things to help you be healthier, and if you don't want to do those things, then why are you here? But you can't leave because you're sick. I just feel like frustrated. • He always feels like the care is really good even though we didn't do that much for him medically. He actually said, "I want to go to a treatment program. I don't want to use crack anymore." He was receptive. There were similarities and issues that he shared with the other patients I talked about, but he was more receptive, and I realize it's unfair of me to say that felt better, but it felt better.
Relationship dimensions	
The student should trust the patient.	• That's—so, that's part of the frustration, is when I feel this conflict of—you know, I think, as a provider, I don't want to be suspicious of people when they report things, right? And I think one of the challenges in psychiatry is that it's all subjective. And it's hard sometimes to reconcile maybe discrepancies in the story that make you question the validity. And that just feels crappy.
The patient should trust the student.	• I think sort of losing the patient's trust is like the biggest thing in my mind, at least. And I think, also, as a medical student, we're like, you don't know what you're talking about most of the time anyway. And it's like the more that you feel like you need to like, you know, backtrack on what you said or like not seem like you know what you're talking about, like that I think can be hard in terms of building patient rapport.
The student should keep control of the interaction.	• I think it's just when there's things kind of out of my control. I mean, that happens all the time as a med student. And like you get told to do this or that, your schedule is determined by somebody else. But then when I come in with a patient that's like, okay, I'm going to do my thing, like I know that I'm good with talking with patients and doing my exams and thinking about them. And then you walk in and like the patient has another agenda going on, like they're going to yell at me whether or not I want them to.
The student should establish an emotional connection and rapport with the patient.	• But I guess I felt like hopeless because none of the things I was doing was making my rapport with him better. Which was really frustrating because it's like, you know, I've done the [preclinical communication course] stuff. You know, I've—you know, I've basically listened to him, I listened to his concerns, you know, but then it was like a one-way road where I was just doing things for him, but there was no, you know, no rapport, I believe, from his side. He wasn't trying to build a relationship with me. And that was—I felt a bit helpless because I thought, as a doctor, you know, this is what I'm supposed to do, right? Like even if it's just a hospital stay, you know, two, three days, I'm supposed to have some kind of relationship with him where I hopefully can get him not to come back to the hospital in a week or two, right?

makes them feel more secure both in their role and as they integrate the identity of a physician with their previous identities.[23] In our study, students often did not feel competent and may even have felt less secure in their role-playing as physicians, exacerbating their frustration with challenging patients.[23] In exploring how medical students form their professional identity in relation to discourses of competence and caring, MacLeod found that, while both were important and not in opposition, medical students tended to prioritize competence over caring.[26] We found that students wanted to be and be seen as both competent and caring while they acted as the ideal physician and/or medical student, and they perceived that some patients made either or both less possible. Students expressed disappointment, for example, when they could not establish rapport or a close emotional connection with a patient, which made them feel more negatively toward that patient. Similarly, even though they were not surprised that they lacked authority, their

Table 3

Medical Students' Experiences With "Difficult Patients" When Students Lacked the Tools or Authority to Improve Patients' Health, University of California, San Francisco, School of Medicine, 2016

Theme	Representative quotes
Students lacked the characteristics needed to fill the physician role.	
The physician should have competence, knowledge, power, and authority.	• Like, people are in pain, and then they're like, "Oh, I need something more; this is not helping." And, I mean, like the orders are in for a Q2 or Q4, whatever, and they're like, "I need something stronger or something right now," and you can't put in orders, which won't change, for all the safety reasons. But that's something frustrating. Like, you find the nurse … and then you look through the order meds. "Is there anything else we can give them?" And there's nothing, and then you have to text your resident, and then be like, "Can you put in a pain medication?" And then the patient's kind of screaming in the corner, yelling at you.
The physician should have competence, knowledge, skills, and authority.	• I think that was challenging because I still don't have the prescribing power, yet. So, I can't make promises to your pain and then it was also a lack of experience and understanding of I don't know how much I should offer to treat this pain. If you are a chronic pain person, me giving you more of this maybe isn't a good idea. Then, there's also a lot of people that say, "Treating pain's super important."… So, there was still that frustration of I'm doing the things I've been taught that should help you and it's not helping you. You're frustrated with me, as a patient, because you're not feeling helped. I'm frustrated because I'm trying to take on the responsibility and be your primary person but I don't have the tools or quite enough power, yet, to be the one that can help you. The uncertainty of myself and these are the tools I have and they don't work for you. • But it made me feel incompetent because I couldn't give them like a firm plan or really any guidance about what was coming. I'd just say like, "Oh, maybe this or maybe this or maybe this thing will happen. And I'm not sure. We're going to wait for this or, you know, I have to do this thing before I can tell you for certain about this. But it just made me feel like I—made me feel, I guess, more—I mean, maybe this is appropriate, but more like a spectator than a provider.

disappointment in doing so sometimes exacerbated their negative feelings.

Students found some patients particularly challenging because of their concerns about the impact the patient could have on their evaluation. Goal orientation theory focuses on why students engage in learning exercises, which can be oriented toward either mastery (learning the skills) or performance (demonstrating their abilities to evaluators).[27] We found that many students were performance-oriented and/or responded to a strongly performance-oriented clinical learning environment, and they sometimes attributed the difficult nature of an interaction to the patient. We also found that this performance orientation often prevented students from seeking help from a supervisor, a finding consistent with those of other studies.[28,29] This performance orientation meant that some students preferred patients with "medical" and/or "fixable" problems so that they could "shine" in providing care. Students' discomfort with patients with "social" and/or "unfixable" problems and with uncertainty has been well documented,[30,31] and those physicians who are less comfortable with psychosocial challenges are more likely to label patient encounters as difficult.[7] Some students did describe times when they were in a mastery orientation, not concerned about getting an honors grade, and focused on the interaction as a learning opportunity (e.g., in rotations outside their chosen specialty), but these instances were less prevalent.

Considering that students' identity formation, their hopes for patient interactions, and their performance orientation affected their emotions toward patients, how can educators support learning in difficult interactions? We recommend that educational strategies focus on helping students learn from, gain competence in, and develop their professional identity through these interactions.[17,21,32] Educators might promote a mastery orientation and deemphasize or simply acknowledge a performance orientation in clinical learning environments. Students' focus on earning positive evaluations, instead of mastering the skills in the interaction, supports the recommendation from Bleakley and Bligh and others to "overhaul" the clinical learning environment to "an authentic patient-centred model that shifts the locus of learning from the relationship between doctor as educator and student to the relationship between patient and student, with expert doctor as resource."[33,34]

Our study had a few limitations. First, we interviewed only 26 students at one institution; however, we did reach theoretical sufficiency during those interviews, allowing us to describe themes related to students' experiences. Second, because the students were interviewed at the end of medical school, they may have been subject to recall bias. In addition, only one-quarter of the invited students responded to our e-mail, and it is possible that the students who felt particularly strongly about their education in patient communication were more likely to respond. However, we had a balance of genders and a distribution of specialties in the participant pool. Next, students' accounts may have been affected by the interviewer, responding differently to a nonphysician than to a faculty member. Our cross-sectional study design prevented us from drawing conclusions about whether there were differences in responses by clerkship site or whether students' experiences changed over time. Finally, we found the professional identity formation and goal orientation frameworks to be well aligned with our findings, and we focused on the learning and patient care implications, but other theories, such as impression management, and personal implications, such as student stress and burnout, also may have been relevant and could be explored further.

As we prioritize professional identity formation in medical education, we might consider challenging patient interactions as key teaching moments[17,21,22,32,35] and opportunities to help shape students' professional identity.[23,25,36–38] With support, these experiences—such as when patient interactions challenge learners' expectations or evoke negative emotions—offer opportunities for reflection, awareness, and criticism of students' assumptions, growth, and transformative learning.[39] Additionally, supporting a mastery-oriented learning environment will help students develop competence in communication skills. If educators can better support students in these inevitable interactions with patients who challenge them, students will be better able to provide high-quality care to all patients in the future.

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