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A Qualitative Exploration of Favorite Patients in Primary Care

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Abstract

Objective—To ascertain whether physicians have favorite patients, their experiences with such patients, and how such relationships may influence patients and physicians.

Methods—Semi-structured key informant interviews with 25 primary care internists practicing in several clinic settings at a large academic medical center.

Results—The term ‘favorite patient’ raised concerns regarding boundaries and favoritism. Nevertheless, most participants (22/25) reported having favorite patients. For many physicians, favorite patients were not necessarily the most compliant patients, or those most similar to them. Instead, favorite patients were often very sick patients and/or those who have known their physicians for a long time. Many of these relationships were defined by experiences that strengthened the patient-physician bond. Participants felt that the favorite patient bond had a positive effect on patients and physicians (“*it improves my day*”). Physicians also discussed their challenging patients unprompted. Participants voiced that being cognizant of having favorite and challenging patients help to prevent favoring the care of certain patients over others.

Conclusions & Practice Implications—Primary care physicians value patient relationships and benefit from deep bonds. A better understanding of how favorite patients affect primary care physicians could help inform and improve relationships with all patients.

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1. Introduction

The patient-physician relationship is an important aspect of clinical care. Patients who like their physicians more are more satisfied with their care and less likely to want to change physicians. There is a large literature on factors associated with why people like some more than others, from shared similarities [1], culture [2], to how much people are liked by others [3]. In friendships and romantic relationships, people are often attracted to people who are most like them [1,4]. It is not clear whether this applies to patient-physician relationships. Previous research has revealed that physicians have higher levels of respect for older patients and like those in better health more than other patients [5–7]. The concept of physicians liking their patients or vice versa has been considered in the context of boundary crossing for physicians and therapists [8–11] and the dangers of treating some patients better than others [12,13]. Yet within the bounds of professional conduct, mutual liking by patients and physicians is associated with a more positive affective state for both parties after the encounter, the length of the relationship, and mutual respect. Much attention has been focused on the impact of relationship breakdowns between patients and physicians and how best to address difficult relationships, but the converse has never been systematically examined. It is not clear if physicians view their favorite patients the same way as patients they like, and whether or how such preference influences physicians, patients, and the care that is delivered.

Though little has been written about favorite patients, the converse phenomenon has received greater attention in the medical literature [14–16]. Earlier studies and commentary used highly charged terms such as ‘heart sink’ [16,17] and ‘hateful patients’ [18] to describe the phenomenon, while more recent literature employs terms such as ‘challenging,’ ‘difficult’ [19–21] or ‘high maintenance’ [20] patients. Their labels have shifted over time, but the effects of these patients on physicians are similar: these patients engender feelings of anger, exasperation, and frustration over not knowing how to help these patients [14,15,17,20].

Just as understanding the negative extreme may help improve physician well-being [15], so might an investigation of positive experiences with favorite patients, as well as how these relationships affect patients and patient care. To address this gap, we conducted an exploratory study using semi-structured interviews with primary care physicians with three aims: to understand physician perceptions of the ‘favorite patient’, to understand who their favorite patients are, and to examine what effects, if any, favorite patients have on patients and physicians.

2. Methods

2.1 Participants

Participants were faculty members and fellows from the Division of General Internal Medicine at a large, academic medical center; all primary care physicians in the Division, practicing at several clinical settings, were eligible and invited to participate via email. This group was chosen on their presumed ability to meaningfully reflect on their experiences with patients in primary care. Half of the invited physicians (50%) participated in the study. An iterative sampling approach was used where faculty members were invited in waves; initial non-respondents were also contacted in waves until the interviews reached saturation (i.e., not every non-respondent received a second invitation). Interviews reached saturation when the interviewer heard similar responses from the respondents, the number of new nodes created tapered, and the researchers became empirically confident that there were no new themes to discover [22].

2.2 Procedure

Semi-structured interviews were conducted by one researcher (JLL). The interviewer was known to three of the 25 participants as a collaborator on unrelated projects. The research team comprised experts in primary care, patient-provider communication and qualitative research and members made critical contributions in design and concept (AWW, JLL, MCB, SMD), data collection (JLL), analysis and interpretation of data (AWW, ERP, JLL, SMD, ZDB), and manuscript revisions (AWW, JLL, MCB, ZDB). Study concept and design Interviews were conducted in person when possible; 2 were conducted by phone. The interview guide had 8 questions (e.g. “What does the term favorite patient mean to you?”) with detailed probes designed to elicit participant perspectives on defining ‘favorite patients,’ examples of favorite patients, and interactions with patients. The questions were driven by literature on liking [1,3,4], teamwork [23], difficult patients, and theories of countertransference [24,25], with input from the study team. Interviews ranged from 20 to 49 minutes (mean: 30 minutes). The interviewer took detailed notes during interviews and audio-recorded all but three (due to technical failure). Interviews and notes were de-identified, transcribed, and entered into NVivo software (NVivo for Mac, version 10) for analysis.

Participants were compensated with a \$50 gift card. The study was reviewed and deemed exempt by the Johns Hopkins Bloomberg School of Public Health institutional review board.

2.3 Data Analysis

The study utilized the Giorgi method of data analysis, as modified by Malterud [26] to develop descriptions and notions related to human experiences— in this case, experiences in primary care. Each interview transcript was analyzed independently by two investigators (JLL and ERP), first by noting an overall impression of the interview, then identifying and coding each meaning unit using NVivo [26]; the units were then organized into groups as themes emerged. The interview guide was compared with the notes and transcript to support and refine the analysis in this iterative process. Disagreements in coding were resolved by consensus with a third independent investigator (AWW).

3. Results

Interviews were completed with 25 participants. The participants were predominantly white (84%) and about half were female (56%); 2 participants were fellows (8%) and the remainder were attending physicians. Four major themes, each with its subsections, emerged from review of the transcripts: (1) perspectives on favorite patients, (2) characterizing favorite patients, (3) effects of the favorite patient relationship, and (4) challenging patients (Table 1).

3.1 Physician Perspectives on Having ‘Favorite Patients’

3.1.1 Quantifying Favorites—A unified definition of the term ‘favorite patient’ is not yet established in the medical literature, and participants had a range of reactions to the idea. The majority (22 of 25) claimed to have favorite patients in some form. Some had a clear, pre-conceived idea while others had not considered the term until the interview but upon reflection, recognized favorite patients in their practices. As one participant explained:

I hadn’t really thought, “who’s my favorite patient?” ... But in thinking about this there are certain [people] that pop up that I think, “oh yeah, she’s totally one of my favorite patients.”

The few physicians (3 of 25) who rejected the term entirely and said they had no favorites did so because to them, the term implied acts of favoritism or favoring certain patients over others and they did not feel it applicable to their practice of medicine. These physicians liked many of their patients and the patient experiences they spoke of were similar to those of others in the sample, but they did not relate to the idea of having favorite patients. Of those that had favorite patients, half the participants identified ‘favorite patients’ as a type of patient—those that they liked and got along with for a variety of reasons, with many of this type over a career, while the other half identified ‘favorite patients’ not as a type, but a handful of exceptional patients over a career.

3.1.2 Relationship to Physician Motivation—The participants in this study overwhelmingly enjoyed their interactions with the majority of their patients, and felt driven to help them. As one participant said, “*Part of the reason I do this job is because I want to help people.*” They discussed looking forward to seeing patients they know, checking up on patients, solving medical challenges, and improving patient health. Respondents enjoyed being entrusted with the care of patients.

Regardless of how many favorites they had, participants liked most of their patients. Thus, favorite patients represent not just people they like, but those that they like more than others. As one participant explained, “*I genuinely like people. For me to have someone who rises to the favorite level means they have to be super special.*”

3.1.3 Relationship to Physician Role—Participants raised the notion of boundaries as they discussed their work, often in relation to the limits of their positive regard and appropriate behavior within the bounds of the patient-physician role. While participants expressed undeniable fondness for their patients, describing favorites as “like family,” or “like old friends,” many were also careful to draw distinctions, many noting that they would

not socialize with patients outside of the clinic and that they would not have family members or close friends as patients. One participant summarized the contradiction this way, *“I’m trying to figure out how to define this. I don’t do things outside of the office, I don’t do Facebook or any social media with patients. But at the same time, I do feel like I’m their friend.”*

Participants also discussed the patient-physician role and how they approached patient care. Physicians often used the term “it’s not about me” to indicate that their interactions are focused on the patient and meeting the patient’s needs, regardless of their (the physician’s) feelings toward them—both favorable and unfavorable. Favorite patients can complicate these distinct roles and boundaries. Yet despite the need for boundaries and a concerted effort to focus on patients, many felt having favorite patients was an unavoidable part of their job. As one participant said, *“It’s human nature to like some people more than others. It just is. To suggest that’s not the truth is sticking your head in the sand.”*

3.2 The Favorite Patient

3.2.1 Attributes of Favorite Patients—For many physicians, favorite patients were not necessarily the most compliant patients, or those most similar to the physicians in socio-demographic characteristics. Many favorites were neither. Instead, some participants spoke of similar personality traits, outlooks, of “something that clicked” between their personalities; others noted admirable qualities in their favorite patients. As one participant explains:

Some of it is their personality, some of it things we have in common, and some of it is their stories... they’re favorites for [different reasons] just like you have different children and you like your children all equally, but they’re different.

Accordingly, participants described their favorite patients with an array of positive terms that represented “something enjoyable” about the patients, such as “smart,” “lovely,” and “memorable.” Humor, or being entertaining, was prized by a few, but not mentioned by others. Many, but not all, commented that their favorite patients handled difficult circumstances gracefully. Despite this range, there were two characteristics that were true of almost every favorite patient: they were long-time patients and they were very sick. However, depending on how long a physician has been at a particular practice, the length of the “long-time” relationship varied from a year to decades.

3.2.2 Interactions with Favorite Patients—Participants described their interactions with favorite patients as warm and engaging. Many favorite patients revealed stories about their histories, families, and interests in these encounters and often asked after their physicians and families, though interviewed physicians noted being careful not to disclose too many personal traits about themselves. Rather than blindly following or rejecting physician orders, many favorite patients had dialogues with their physicians regarding their treatment and effective working relationships with open communication. One participant shared this, for example:

[When my favorite patient has] an issue with [taking medications I prescribed], she had a very thorough discussion with me. I could understand her point of view and she could understand mine and we struck a compromise.

Because so many favorite patients were long-time and very sick patients, participants spent more time with them than they had with other patients. Oftentimes, these favorite patient-physician interactions involved a crisis, such as a hospitalization or a health issue that warranted repeated visits through which a bond was crystallized. As a participant summarized, *“If I had to think of a theme, it would be [going through] some challenge—some major illness—that we were able to partner and work through and have a better outcome on the other side.”* These interactions often had satisfying outcomes for physicians, especially when they were able to address the needs of their favorite patients.

3.3 Effect of the Favorite Patient Relationship

3.3.1 Effect on Physicians—Participants generally spoke of the effects of their relationships with favorite patients in positive terms—noting, for example, *“honestly, it improves my day to see them.”* A few cited specific lessons they learned in caring for their favorite patients, such as learning to resist solving every issue. Yet becoming attached to favorite patients also came with emotional consequences: losing favorite patients caused grief. *“Sometimes it’s mildly painful,”* one participant remarked, *“and sometimes it’s very painful when somebody you really like quits your practice.”*

3.3.2 Perceived Effect on Patients—Physicians believed that their patients, too, appreciated the bond. One participant described her favorite patient as *“brightening at our visits,”* while another said, *“he treasures me, just like I treasure him.”* Aware of the depth of these bonds and the potential effects on their judgment, most participants prefaced their responses with statements about trying to treat all their patients equally. Yet some of those that tried to treat patients equally also admitted devoting extra effort to the care of their favorite patients. Participants perceived the extra effort to be manifest in small things—such as returning a call or doing paperwork faster. Participants also spoke of partaking in life events, like attending a wedding or speaking at a favorite patient’s funeral, that they would not do for every patient that they liked.

Regarding patient care, the most tangible perceived benefits to favorite patients might be that, given their status as medically complicated patients their physician spend a significant amount of time with, their physicians know their circumstances very well. As a result of this knowledge, the physicians become the person best suited to take care of their patients. One participant described it this way:

I have a patient who gets non-cardiac related chest pains and she goes to the ER once a month and they always do something that she doesn’t need because they don’t know her. I know her, and I’m just not going to send her to the ER for that because I know what it is.

3.4 Challenging Patients

3.4.1 The Opposite of Favorite—In discussing favorite patients, participants inevitably made unprompted comparisons to their most challenging patients. Reinforcing the notion that these physicians generally liked their patients, participants noted having more favorites than challenges. Perspectives on challenging patients were less varied than that of favorite patients and interactions with challenging patients were characterized by not being able to work well together. These patients often struggled with mental illness; participants described these patients as lacking an understanding of the limits of what a physician can do and demanding services inappropriate for their care. More so than with favorite patients, participants used emotionally charged words to describe the effect of challenging patients on them, such as being “worn down,” and having a “cringe reflex.” Participants also described these patients as “sucking the life out of you” and “taking a pound of flesh.”

3.4.2 From Challenging to Favorite—Many participants spoke of how formerly challenging patients became their favorites. Often, the change was accompanied by both the passage of time and a change in perspective on the physician’s part as they realize how they can best help challenging patients. For example, several participants spoke of realizing the therapeutic effect of the visit itself for challenging patients. One participant describes the experience this way:

[There was one woman who] started as someone I dreaded seeing because she was constantly running out of her pain medication. [...] I had a total shift when I realized that she actually didn’t come in for pain medication. [...] She just wants someone to see her through. I would do relaxation exercises [with her]- stuff I had never learned in medical school but learned throughout my life. [...] She was so appreciative of those things— she was one of my favorite.

Other physicians learned to deal with challenging patients by taking a global perspective and recognizing that challenging patients can change, noting:

I’ve been doing this a long time. [I] know that they’ll go through a bad period where they’ll be complaining and depressed and I’ll not enjoy seeing them, but if I wait enough they’ll come out of it. That’s a perspective I didn’t have earlier on.

Beyond having a better understanding of their patients and how to help them, physicians also spoke of transitioning patients from challenging to favorite as a necessary coping mechanism, so that there is something to look forward to with all patients. One participant explained:

I’m trying to convince myself that the challenging patient is the most gratifying if I have a good attitude about it. It’s necessary for survival to redefine favorite as you go through a medical career. Because if you face a day when you can’t stand a patient, you’re really shooting yourself in the foot and you need to overcome it.

4. Discussion and Conclusion

4.1 Discussion

By illuminating how primary care physicians view the concept of favorite patients and their own favorite patients, this study begins to define a previously unexamined phenomenon. We found that participants did not necessarily perceive favorite patients to be those most similar to them, instead, favorite patients were often people whose physicians had known a long time, and whose personalities ‘clicked’ with their physician. While previous studies have established that physicians had elevated liking for healthier patients [6], favorite patients in this study were often those who are sicker or had faced medical adversity together with their physician. Physicians found their relationships with many patients to be rewarding—not just their favorite patients—indeed many patients share traits with favorite patients, but not everyone is considered a favorite. Favorite patients were perceived to benefit from their physician relationships primarily from being better known by their physician, and physicians also reported that favorite patients enhanced their own professional experiences.

The primary care physicians interviewed in this study felt they had more favorite patients than they do patients perceived to be challenging. Just as negative reactions to challenging patients are often triggered by physicians’ own experiences and reactions to patient attributes rather than the attributes themselves, physician perceptions of favorite patients are different for everyone. Favorite patients exhibited a variety of positive characteristics and were often dissimilar from their physicians. The interviews help define two key circumstances that are conducive to building a strong patient-physician bond—the passage of time through years, or even decades, of relationship building, and dealing with a difficult health problems that required more acute interactions. Participants were thoughtful about their approaches to patient care and tried not to treat patients differently regardless of their feelings. While challenging patients can be transformed and become favorite patients, favorite patients did not seem to lose their status.

Physicians benefitted from having favorite patient relationships and noted that these patients made their work gratifying. Some patients were also perceived to benefit from favorite patient-physician relationships, though participants thought that these differences in patient care were slight. For physicians, the notion of being partially sustained by these positive relationships, of the favorite patients “helping outweigh the bad,” find resonance with the literature on physician burn out, which suggests that physicians who perceived reciprocity from their patients may be less susceptible to burn out [27]. The findings also suggest that beyond merely having favorite patients, reflections on these relationships are also important and in line with the exercises that promote physician resilience like self-monitoring, gratitude, and reframing [28–30]. For physicians dealing with both favorite and challenging patients, acknowledging their patients’ effects on them can also help their ability to give appropriate care to all patients.

Even though participants did not share any experiences in which their judgments were distorted because of their attachment to their patients, and many thought themselves capable of making undistorted judgments, they were nevertheless aware of the consequences of being too attached to their patients and raised these concerns, especially in regards to the

boundaries that they draw in their patient-physician relationships. The literature on VIP (“very important person”) patients—patients whose social status lead their physicians to deviate from usual care—highlights the physician urge to treat certain patients differently from others, particularly when the patient is a close friend, family member, colleague, or bears gifts, and the dangers in doing so [12,31,32].

While the strength of this study is in its detailed descriptions of physician experiences with favorite patients, there are several limitations. First, we recognize that by only focusing on participants who were affiliated with a large, urban, academic medical center, we might have a limited view of the heterogeneity of primary care physician perspectives on favorite patients. We tried to consider a variety of experiences by including participants who practiced in several different clinic settings. Despite this, these academic respondents were very reflective and self-aware, and a few cited published works of their colleagues on patient-physician relationships in their interviews. While it is possible that the reflections of these respondents may differ from those not as acutely aware of the literature, their experiences with the patients did not appear to be demonstrably different.

Second, because this study was designed to explore the phenomenon of favorite patients, the term ‘favorite patient’ was introduced to the participants to frame the discussions. While participants were asked to define favorite patients by their own experiences and attitudes, the term did not evolve naturally from the data.

Third, there may be social desirability bias in the responses. It is possible that physician remarks on their interactions with favorite patients reflected their desired perceptions of the relationship and might not reflect their actual behavior or their patients’ intent. Physicians may, for example, underestimate the extra effort they exert on their favorite patients or overestimate how much their relationships benefit the patients. Nevertheless, this study provided us with unique insights into the concept of favorite patients previously unavailable in the literature.

4.2 Conclusion

Just as everyone likes some people more than others, physicians have patients that they like more than others. Most often, favorite patients are not necessarily similar to their physicians in socio-demographic characteristics, instead, they are characterized by a long-term relationship with their physicians and shared experiences with their physicians. Recognizing the existence of favorite patients allows physicians to be mindful about the patient-physician relationship. Future work on this subject could assess the role of the favorite patient-physician relationship in shared decision making and choice of treatment.

4.3 Practice Implications

While it would not be realistic to recommend physicians that they should treat all patients as favorite patients, this research does provide several insights for primary care physicians. Given the positive effects favorite patient relationships have on physicians, and that few, if any, experienced downsides for the overall patient population, our findings suggests that acknowledging and being reflective about having favorite patients may help primary care physicians regard their practices positively. While celebrating the benefits of these

relationships, physicians should also be aware of how their patients respond and that favorite relationships do not adversely affect the patient experience. Many patients worry about trying to please their physicians, and patient confidence in their care may also be weakened by the belief that their care is not as good as those of other patients [6].

For patients, our findings shed light on the duality of the patient-physician relationship and how best to work with their primary care physicians. Rather than striving to be favorite patients, patients should realize the two-way nature of their relationship with their physicians. Reinforced by physician comments like “it’s not about me,” and their discussions of open communication between patients and physicians, patients should be empowered by their role in shaping the patient-physician relationship. These observations are in line with tips from organizations like the American Heart Association that advise patients on how best to be engaged and advocate for their own care [33,34]. The crucial role time plays in the favorite patient-physician relationship, and the added knowledge that comes from time, also point to the importance of having a usual source of care and the possibility of developing deep bonds with a primary care physician.

For educators and health systems, the findings of this study illustrate the variety and strength of the bonds between patient and physician. The varied experiences of the participants and their diverse judgments in how they draw boundaries in their patient relationships also suggest a need for careful consideration of differential patient access to physicians and of boundary-setting. Although it remains to be tested, reflections on the benefits of the favorite patient relationship could also inform efforts to reduce professional burnout by focusing on the positive aspects of clinical care.

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Table 1

Summary of Interview Themes

Theme	Subtheme	Summary	Example
Perspectives on 'Favorite Patients'	Quantifying favorites	While a few participants claimed to have no favorites, the rest were divided between those who had many and those with only a few.	"I don't think I could name them. I have so many that I like so much."
	Physician motivation	Physicians like and are motivated to help people; favorite patients are people they like even more.	"I do this job because I want to help people and enjoy helping them. I like to see patients who I seem to help."
	Physician role	Physicians see distinct roles for themselves and their patients; friendships and favorite patients can blur the boundaries of those roles.	"I don't do things outside of the office, I don't do Facebook or any social media with patients. But at the same time, I feel like I'm their friend."
Favorite Patients	Attributes	Favorite patients have a number of positive characteristics; most often, they are long term patients who have significant illnesses.	"Some of it is their personality, some of it things we have in common, and some of it is their stories... they're favorites for [different reasons]."
	Interactions	Favorite patients have effective working relationships and open communications with physicians and a bond often forged through going through a health crisis together.	"If I had to think of a theme, it would be people with whom there was some challenge [...] that we were able to partner and work through."
Effects of the Favorite Patient Relationship	On physicians	Favorite patients have a positive effect on physicians, but losing these patients can be painful.	"Honestly, it improves my day to see [my favorite patients]. I value their presence."
	On patients	Favorite patients enjoy seeing their physicians and their physicians know them well; some may have better access to their physicians than other patients.	"There is a truth to the fact that my favorite patients probably hear back from me more rapidly than my less favorite patients."
Challenging Patients	Opposite of favorite	Least favorite patients do not understand the limits of what physicians can do for them and demand inappropriate services; often, these patients have mental illnesses.	"There are certain patients that I groan when I see them on my list [They're the] worried-well or somatizers or patients who create problems that aren't necessarily there."
	Physician self awareness	Physicians are aware how having favorite and least favorite patients may affect their judgment, and believe that recognizing their feelings helps them to treat patients equally.	"The more important things is to acknowledge that there is something about a patient that is less appealing [...] and then say, 'But I still have to give them the appropriate attention and think through the problem like I would if I felt differently about them.'"
	Once challenging patients	Favorite patients do not fall out of favor, but some least favorite patients become favorites over time.	"Patients who I never thought I would even come to like grow into some favorites [through the] shared experience of knowing them for over a decade."