

**ENDING THE DOCTOR-PATIENT RELATIONSHIP:  
AN INVESTIGATION OF THE REMOVAL OF PATIENTS  
FROM GENERAL PRACTITIONERS' LISTS**

Thesis submitted for the degree of  
Doctor of Philosophy  
at the University of Leicester

by

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June 2002

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## ABSTRACT

T N Stokes

### **Ending the doctor-patient relationship:**

#### **An investigation of the removal of patients from general practitioners' lists**

The removal of a patient from a general practitioner's (GP's) list offers unique insight into 'what happens' when a doctor decides to end his/her relationship with a patient.

The study aim was to obtain a detailed description of the process of removal as perceived by both practitioner and patient and to place removal in a wider framework of theory in relation to the 'difficult' doctor-patient relationship.

Semi-structured interviews were undertaken with twenty-five Leicestershire GPs and twenty-eight patients who had been recently removed from a GP's list. Analysis was conducted using the constant comparative method.

GPs account for why they remove patients using the narratives of removal as 'divorce', 'breaking the rules', and removal as 'sanction'. These narratives constitute a form of strategic interaction in which the GP presents him/herself as acting as any 'good' GP would when the boundary rule of 'affective neutrality' between GP and patient has been breached or when faced with a 'bad' patient who 'breaks the rules' of conduct of the doctor-patient encounter. The patients account for their removal using the narratives of the 'good' patient, 'bad' GPs and 'good' GPs and removal as a threatening event. The narrative of removal as a threatening event demonstrates that removal causes a high level of emotional distress and threatens a person's identity as a 'patient'. The patients use the narratives of the 'good' patient and the 'bad' GP and 'good' GP in a strategic manner to accomplish valid patienthood. The patients assert their identity as a 'patient' by showing that they have behaved according to the lay rules of conduct of the patient-doctor relationship even though the removing GP 'breaks the rules'.

These findings are used to develop a model of ending the doctor-patient relationship in general practice and to make policy recommendations on removal.

## ACKNOWLEDGEMENTS

This work was conducted while I was a clinical lecturer in general practice in the Department of General Practice and Primary Health Care, University of Leicester. The post was funded by NHS Executive Trent and the Scientific Foundation Board of the Royal College of General Practitioners funded the research reported here.

Numerous individuals have helped me with this research. The most important are the patients and general practitioners who gave up their time to talk about a sensitive subject. They shared their experiences and opinions with us and trusted us to report their views while maintaining confidentiality.

I am indebted to my two co-supervisors, Dr Mary Dixon-Woods (Department of Epidemiology and Public Health) and Dr Robert McKinley (Department of General Practice and Primary Health Care), for their invaluable support, encouragement and constructive criticism at each stage of the study. Special thanks should also go to Dr Kate Windridge who recruited and interviewed the patients.

The research would not have been possible without the support and encouragement of Leicestershire Health Authority. Ms Colette Braidwood helped set up the health authority database used in this study and her support was crucial when the recruitment strategy for patients had to be changed early into the project. The Leicestershire Local Research Ethics Committee, under the chairmanship of Dr Robert Byng, offered prompt and helpful advice throughout the recruitment stage of the project. I am also grateful to the Leicestershire Local Medical Committee for their support. Others who deserve particular mention are Dr Lucy Smith, who provided statistical advice, and the secretaries who transcribed the interviews: Mrs Pauline Green, Miss Vicki Cluley and Mrs Raj Gill.

The thesis is dedicated to my wife Jo and our first child, whose conception and gestation has coincided with the writing up of the thesis.

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## **Chapter 1**

### **LITERATURE REVIEW**

#### **1.1 Aims and objectives of the study**

This thesis has as its focus an investigation into the removal of patients from general practitioners' (GPs') lists. Removal offers a unique insight into what happens when the doctor-patient relationship 'goes wrong' and a doctor decides to end his/her relationship with a patient. The thesis presents, as its primary source of data, a qualitative study of the perspectives of GPs and removed patients. This study is used to obtain a detailed description of the process of removal as perceived by both practitioner and patient and to place removal in a wider framework of theory in relation to the 'difficult' doctor-patient relationship.

The thesis describes the epidemiology of patient removals in Leicestershire using a retrospective review of routinely collected health authority data for the previous calendar year. These data provide context, confirm the size of the problem of removal and inform the sampling strategy employed to recruit both patients and GPs into the qualitative study. The qualitative study aims to access, by means of semi-structured interviews, the accounts of patients who have recently been removed from GPs' lists and GPs' accounts of removing patients. The GPs fall into two groups: those who are interviewed about a specific named patient (who has also been interviewed) and those who are selected from the quota sampling frame set up using

the health authority data. The subset of interviews where both GP and patient talk about the same removal event will be treated as 'paired' data.

The thesis should be seen as an example of a general practitioner furthering his own academic discipline's understanding of the doctor-patient relationship by employing theory and concepts originating in the sociology of health and illness. It may be described as 'theory informed' research (Harding and Gantley, 1998). In essence, the research addresses a problem of importance to clinicians and policy-makers and uses relevant sociological theory to 'make sense' of both parties retrospective accounts of 'what happened'. My aim of obtaining a detailed description of the process of removal is pragmatic: a better understanding of the process of removal as perceived by both practitioner and patient may inform policy recommendations as to how the removal of a patient from a GP's list should be conducted. I also, however, aim to place removal in a wider framework of theory and practice in relation to the 'difficult' doctor-patient relationship and how relationships may be ended. This allows me to develop and test second-order theory (Schutz, 1953) of the doctor-patient relationship (e.g., the 'rules' of the relationship) using the first-order explanations ('obvious' or 'common sense') of removal used by each particular patient or GP. In pursuing this agenda I adopt an interpretive approach (Denzin, 1989) and attempt to 'make sense of, or interpret, phenomena in terms of the meanings people bring to them' (Denzin and Lincoln, 1998: 3).

The thesis comprises seven chapters. Chapter 1 reviews the relevant general practice and sociological literature in relation to the aims and objectives of the thesis. It appraises the existing literature on the removal of patients from GPs' lists, considers

removal in the context of a 'difficult' relationship between patient and GP and shows how sociological perspectives can be brought to bear on the 'difficult' doctor-patient relationship. Chapter 2 provides a detailed account of the way the qualitative research, that forms the main body of original research for this thesis, was conducted and summarises the theoretical position I have taken with regard to the interviews and the analysis.

There are four results chapters. Chapter 3 presents a descriptive epidemiology of removals from GPs' lists in Leicestershire for one calendar year. Chapter 4 presents the themes that emerged from an analysis of the GPs' retrospective accounts of removing patients from their lists given to a fellow GP and researcher. Chapter 5 presents the themes that emerged from an analysis of the patients' retrospective accounts of being removed from a GP's list given to a non-medical researcher. In chapter 6 I build on my analysis of the GPs' and patients' accounts of removal by exploring the subset of 'paired' interviews in which both the GP and the patient give their retrospective account of 'what happened'. I present these data as three case studies. These case studies allow me to tell each party's story about 'what happened' and to conduct a cross-case (GP-patient) comparison of the themes generated from an analysis of each separate set of GP and patient interviews.

In chapter 7 I draw together the findings of my study. I first discuss the general methodological issues that underpin the conduct of the research. I follow this with a discussion of how the substantive theoretical areas reviewed in chapter 1 are modified as a result of the findings of this study. I also review the implications of the

work for clinical practice and health policy and make policy recommendations on removal based on my empirical findings.

## **1.2 Introduction**

This chapter reviews, in three sections, the relevant general practice and sociological literature in relation to the stated aims and objectives of the thesis.

The first section summarises official guidance on removal and reviews the existing research literature on the removal of patients from GPs' lists. The removal of a patient from a GP's list who has not moved outside the practice area implies that the GP has experienced some 'difficulty' in the doctor-patient relationship.

I will, in the second section, consider how the 'difficult' doctor-patient relationship, including the ending of the doctor-patient relationship, has been conceptualised in the general practice literature. I will argue that much of this literature draws on notions of patient-centred medicine and sees the 'difficult' doctor-patient relationship as attributable to an inability to establish either 'common ground' between patient and doctor and/or to establish a long-term 'therapeutic' relationship with a patient. The 'difficulty' is constructed as a failure in the interaction between doctor and patient and is deemed rectifiable by the doctor receiving further training in communication and/or counselling skills.

Lastly, the third section will consider the insights that interpretive sociology can bring to the 'difficult' doctor-patient relationship. These insights focus on the power differential between doctor and patient, the concept of 'good' and 'bad' patients and doctors and the nature of relationship 'breakdown' between doctor and patient.

I will conclude by proposing that the removal of patients from GPs' lists is not of interest solely as a contemporary health policy issue in the U.K. Research into this area also has the potential to further our understanding of how the doctor-patient relationship may be ended and to shed light on how power is generated and maintained in the relationship.

### **1.3 The removal of patients from general practitioners' lists**

This section will present and discuss official guidance on the removal of patients from general practitioners' (GPs') lists and will critically appraise the existing literature on removal.

#### *1.3.1 Terms of service for GPs and official guidance on removal*

Under a GP's terms of service 'a doctor may have any person removed from his list'. Doctors are not obliged to state their reasons for requesting the removal of a patient from their list either to the patient, or to the Health Authority, which is obliged to notify the patient (Department of Health, 1989, 1992). Patients should be given seven days' notice of removal, but in exceptional circumstances patients can be removed immediately if they cause actual violence or who 'behave in such a way that the

doctor has feared for his or her safety'. If a removed patient is unable to find another GP who will accept him/her, then the Health Authority will allocate ('assign') him/her to a GP. There is no mention in the terms of service as to the 'minimum period' an allocated patient should be kept on the new GP's list. In most areas local negotiation between the Health Authority and the Local Medical Committee (LMC) has resulted in a normal minimum period of allocation – one, three or six months – although this does not have statutory force (Ainsworth, 2001).

The removal of patients from a GP's list has become an increasingly contentious issue over the last five years. It has prompted speculation in the national press (Dignan, 1998; Yamey, 1999) that the frequency of patient removals is increasing and that GPs remove patients because they do not wish to spend time dealing with 'difficult' patients or because they cost the GP income by not agreeing to have their children immunised or to have a cervical smear. Patient advocacy groups have also been vocal in their criticism of the current situation. The Association of Community Health Councils, for example, has argued that it would be in the interests of both patients and GPs if reasons for removal were given to patients (Association of Community Health Councils for England and Wales, 1994). The medical profession itself has also recognised that removing patients without informing them of the reasons for removal may not constitute good practice. Both the General Practitioners Committee (GPC) of the British Medical Association (BMA) (General Practitioners Committee of the British Medical Association, 1996, 1999) and the Royal College of General Practitioners (RCGP) (Royal College of General Practitioners, 1997) have issued detailed guidance for members on this subject and their key recommendations are summarised here. It should be emphasised that this guidance has no statutory

force and represents what two official medical bodies think GPs 'ought' to do when faced with a 'difficult' patient.

**(a) General Practitioners Committee (GPC) guidance on removal**

The GPC sees removal as an 'exceptional and rare event, and a last resort in an impaired patient doctor relationship' (General Practitioners Committee of the British Medical Association, 1996). The sole criterion for removal should be 'irretrievable breakdown' of the relationship, except in the special case of violent or 'threatening' behaviour by the patient. The GPC recommends that the decision to remove should only be made after careful consideration, and that consideration should first be paid to transferring the patient's care to another GP in the practice (with the patient's consent) or that the patient should be 'persuaded' that it would be 'better for all concerned' if the patient found a new GP practice. The GPC also suggests that the GPs should consider using the practice-based complaints procedure (Department of Health, 1994) to give the patient prior notification of the difficulties the GPs are experiencing with the patient and to discuss ways the patient may modify their 'inappropriate' behaviour. Once these strategies have been exhausted and removal has been decided upon, the GPC recommends that GPs should normally send a letter 'briefly outlining' the reasons for removal to the patient. This is recommended for three reasons: it is a common courtesy; it may help the patient become aware of the need not to misuse services in the future; and it will help to avoid public speculation about the doctor's motivation for making a removal. The need for the GPs to consider how removal may look to 'outside observers' is also emphasised elsewhere in the guidance.

**(b) Royal College of General Practitioner's (RCGP) guidance on removal**

The RCGP guidance is the product of the College's Patients' Liaison Group, a body which has both medical and lay members. The aim of the guidance is to 'minimise the distress to patients and GPs when the doctor-patient relationship irreparably breaks down' (Royal College of General Practitioners, 1997). The RCGP believes that the relationship between doctor and patient should be a therapeutic and beneficial one and that 'successful communication' is fundamental for such a relationship. The RCGP recognises, however, that:

*Occasionally patients persistently act inconsiderately and their behaviour falls outside that which is normally considered to be reasonable. In such circumstances there may be a complete breakdown in the doctor-patient relationship (Royal College of General Practitioners, 1997: 6).*

The RCGP proposes that a series of steps should be taken by a general practice in order to restore the relationship or, failing that, to facilitate the constructive removal of the patient from the GP's list. The first step should be a discussion of the problem both within the practice and with the patient. An attempt should be made to determine possible reasons for the patient's behaviour (e.g., mental illness) and also to elicit the patient's perspective and interpretation of the situation. The practice should also consider whether its own organisation of patient care is contributing to the problem (e.g., a receptionist with poor communication skills). If discussion with the patient fails to resolve the problem then the general practice should advise the patient to consider seeing another GP within the practice or to register with a different practice. If the patient is removed then the RCGP suggest that the practice should consider writing to the patient informing him or her of the decision and the reason for removal from the list.

The RCGP also provides guidance on when it is ‘reasonable’ to remove a patient from a GP’s list and when it is ‘not reasonable’ to do so. They propose three situations that justify removal: violence (physical violence, threatening violence, verbal or racist abuse); crime and deception; and distance (where a patient has moved out of the designated practice area and has failed to register with another GP). They recommend that removal is never justified when a patient is: ‘exacting or highly dependent’; exhibits high levels of anxiety or ‘demand’ about perceived serious symptoms; or where ‘preference is displayed by a patient in relation to age, gender, ethnic origin, religion or sexual orientation.’<sup>1</sup> The RCGP also recommends that removal is ‘not normally justified’ when a patient’s decision on clinical matters is at variance with that of the GP, or when a patient persistently questions practice standards or makes a complaint via the in-house complaints system.

(c) Summary of the guidance

Both sets of guidance have much in common. They both emphasise that removal is a rare event that should only be undertaken as a ‘last resort’ by GPs and should be a consequence of ‘irretrievable’ or ‘irreparable’ ‘breakdown’ of the doctor-patient relationship. Neither set of guidance offers a detailed definition of ‘irretrievable breakdown’. The GPC guidance, however, offers a brief description of how removal should be handled and arguably pays more attention to the fact that adverse media publicity could result for GPs if they remove patients ‘in haste’ and without giving patients reasons for their actions. The RCGP guidance adopts an explicitly patient-centred approach and implies that the likelihood of removal can be minimised if the

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<sup>1</sup> This is unclear in the guidance. I assume it relates to the patient’s preference in terms of the characteristics of the GP.

GPs and practice staff have good communication skills, explore the patient's perspective and negotiate a mutually acceptable solution.

### *1.3.2 Existing literature on removal*

In contrast to the detailed guidance as to what GPs 'ought' to do, little empirical research has been carried out with removed patients. In particular, although the act of removing a patient by a GP suggests a problematic or 'failed' doctor-patient relationship, no published research has addressed this issue. What research does exist falls into two groups: descriptive epidemiology of removed patients and exploration of the process of removal from a social policy perspective.

#### (a) Descriptive epidemiology of removed patients

Information on the epidemiology of removed patients has been generated by analysis of routinely collected Health Authority data (O'Reilly *et al*, 1998a, 1998b; Munro and Skinner, 1998) and by questionnaire surveys of removed patients (Perry, 1995; Macleod and Hopton, 1998a, 1998b) and GPs (McDonald *et al*, 1995; Pickin *et al*, 2001; O'Reilly *et al*, 2001).

O'Reilly *et al* (1998a) carried out a descriptive epidemiological study of patient removals in Northern Ireland using routinely collected data held by the Central Services Agency over the ten year period 1987-1996. They found that 6,578 patients were removed at GPs' request between 1987 and 1996. This equated to 3,920 removal decisions (defined as the decision by a GP to remove a patient and/or members of the same household) by GPs, a rate of 2.4 per 10,000 person-years. A tenth (11%) of removed patients had a repeat removal and 16% of first removal

decisions were followed by allocation to another practice. As far as trends over time were concerned, their results were inconclusive: rates of removal were constant between 1987 and 1991, decreased for the two years 1992 and 1993 and increased for the years 1994-1996. Patients who were removed as part of a family accounted for 61% of removals, the remainder (39%) being individual removals. The very young (0-4 age group) and young adults (20-45 age group) had the highest rates of removal; most of the very young were removed as part of a family. The authors do not report any sex differences. Removal rates were higher in urban areas: in particular disadvantaged and densely populated areas with high population turnover were associated with higher rates of removal. Broadly similar findings have been reported in a study of routinely collected health authority data in Sheffield for the years 1991-1996 (Munro and Skinner, 1998). In a related study, O'Reilly *et al* (1998b) suggest that fundholding status led to an increase in the rate of removing patients, but the effect size is small and difficult to interpret.

Postal questionnaire surveys of removed patients have been carried out (Perry, 1995; Macleod and Hopton, 1998a). These studies are, however, unpublished and suffer from low response rates. Perry (1995) reported a postal survey of patients who were removed from GPs' lists in Kent in 1994 (34% response rate) and found that 'quite a high proportion' suffered from a chronic illness. Similar findings were reported in Lothian (26% response rate) (Macleod and Hopton, 1998a) where responders reported low socio-economic status and low health status. The three most commonly cited health problems were mental illness (anxiety/depression), drug dependency and problems with alcohol. These studies therefore raise the question as to whether

removed patients' physical and psychological health and social circumstances are worse than those of non-removed patients.

Postal questionnaire surveys have also been used to try and ascertain GPs' attitudes and beliefs towards patients who have been removed from their lists. Two recent national surveys of GPs have been published (Pickin *et al*, 2001; O'Reilly *et al*, 2001). Pickin *et al* (2001) surveyed a random sample of 1000 GPs in England and Wales in April 2000 (76% response rate) to ascertain the current scale of, and GPs' reasons for, removal of patients from their lists. They found that in the previous 6 months, 40% of practices had removed one or more patients. The most common reason for removal given by the GPs (59%) was violent, threatening or abusive behaviour on the part of the patient. They also reported that the majority of those GPs (83%) who had removed a patient in the previous six months had given the patient a reason for the removal, either in writing or in person. A similar survey was carried out by O'Reilly *et al* (2001) of all GP principals in Northern Ireland in 1999 (85% response rate). They found that 'alleged violence or threatening behaviour (including verbal abuse)' was the most common reason for removal given by the GPs (50%), in common with the findings of Pickin *et al* (2001). Interestingly, they also found that a majority of the GPs (81%) felt that there should be continuance of the right to remove a patient without having to provide a reason.

These surveys can be criticised on methodological grounds (Stokes *et al*, 2001). A criticism of both studies is that their survey instrument is not based on any prior qualitative investigation of removal. As a result they may have inappropriately limited the number, range and type of reasons for removal specified in their

questionnaire. It is also notable that Pickin *et al* (2001) fail to consider ‘breakdown’ in the doctor-patient relationship as a possible reason for removal. A further criticism is that the respondents may be especially prone to giving publicly acceptable reasons for removal in this type of survey.

In conclusion, the current evidence suggests that although patient removals occur relatively infrequently, a sizeable minority (40%) of general practices remove at least one patient every six months (Macleod and Hopton, 1998a; Pickin *et al*, 2001). Patient removals are either individual or group (family) removals. Young adults appear to have higher rates of removal, as do people living in deprived urban areas. Some work has suggested that removed patients are of low socio-economic status and have poor health status, although these findings must be treated with caution.

Descriptive studies are clearly an essential starting point to research in this area, and are important in informing sampling strategies for qualitative research. But a descriptive epidemiological study on its own is unlikely to further our understanding of the process of patient removal by GPs. As the RCGP has noted (Royal College of General Practitioners, 1997), the circumstances leading up to removal are often complex and, I would argue, poorly understood. Such issues are best explored using qualitative research (Britten *et al*, 1995; Murphy *et al*, 1998; Stokes *et al*, 2001).

(b) A social policy perspective on the process of removing patients from GPs' lists

The unpublished report of Macleod and Hopton from the Edinburgh University Department of General Practice presents a pilot study of the process of removing patients from GPs' lists (Macleod and Hopton, 1998a). Macleod and Hopton's work is important for two reasons. First, they set their research findings within a social policy perspective which distinguishes it from the other, mainly epidemiological, work in this area. Secondly, the authors use qualitative research methods involving a series of semi-structured interviews with GPs and patients to try to understand the process of removal from the perspective of both the GP and the patient.

The starting point of Macleod and Hopton's (1998a, 1998b) study was that 'patient removals are best seen as critical incidents which arise from a range of problems and difficulties which GPs and patients face and are worthy of study because a removal indicates that something has gone wrong' (Macleod and Hopton, 1998b: 1). The authors conducted a small number of in-depth semi-structured interviews with GPs who had recently removed a patient from their list, and with patients who had recently been removed from a GP's list. Their aim was to interview GP and patient 'pairs' in order to be able to compare and contrast 'two sides of the story'. Themes that emerged from the interviews that were 'paired' were that GPs should have the right to remove patients from their lists, but not without some accountability and that the system could be misused, for instance to remove 'high cost' patients. The themes from the separate interviews are presented in boxes 1.1 and 1.2.

Macleod and Hopton (1998a) conclude that GPs should not lose the right to remove patients from their lists but that there is a need for a review of current policy on

patient removals and that this review should consider the need for the following: greater collective professional accountability for this right; development of collective responsibility for patients whom GPs find exceptionally difficult to work with; and the development of patients' rights in respect of being removed from a GP's list.

Macleod and Hopton (1998a) provide a very useful starting point to understanding the process of removal from the perspective of both the GP and the patient. It should be emphasised that they approach the subject from a social policy perspective: they are not primarily concerned with exploring issues relating to the doctor-patient relationship. The chief criticism of their study relates to the extent to which they are justified in drawing their conclusions from a rather limited evidence base. They interviewed eight patients and eight GPs. Of these only one interview consisted of a GP-patient 'pair' in which each party gave their account of the same removal event. It seems unlikely this would have allowed them to reach theoretical saturation (when further interviewing adds little to the themes already collected) for both the patient and the GP interviews. In addition, the study lacks important information about how the data was analysed. In particular there is no description as to how the data were processed and how the themes were developed (Boulton *et al*, 1996; Murphy *et al*, 1998).

**Box 1.1 Themes from the GP interviews (n=8)  
(Macleod and Hopton, 1998a):**

- Some patients cause distress to GPs through behaviour that is violent or threatening or abusive or perceived to be so;
- Some patients behave in such a way that does not allow GPs to practise what is professionally regarded as best care or to manage patients within existing professional expertise;
- GPs feel that their relationships with patients can sometimes break down irrevocably. For the most part the term 'breakdown in the doctor-patient relationship' was used without elaboration or explanation by the GPs. A more detailed analysis of the interviews revealed that this could involve: GPs feeling too threatened and distressed to manage a patient professionally, GPs being unable to put aside their personal feelings and act professionally, GPs being exhausted by patients and needing a break, and GPs unsure whether a patient was honest or not;
- The use of removal as a final sanction means that from the GPs' perspective they perceive no possibility of other means of negotiation or reconciliation.

**Box 1.2 Themes from the patient interviews (n=8)  
(Macleod and Hopton, 1998a):**

- For some patients, being removed from the list is a very negative and stigmatising experience;
- Patients' perceptions of the doctor-patient relationship do not mirror those of the doctors and they do not share the view of the relationship as problematic or of having broken down irrevocably;
- It is a cause of considerable distress for some patients that they have no means of pursuing why they were removed or any redress;
- It is a cause of considerable distress for some patients either that were not given a reason for removal or that they do not understand or accept the reason for the removal;
- For some patients, being removed from a GP's list raises concerns about future access to health care.

#### **1.4 The ‘difficult’ doctor-patient relationship in general practice**

The published guidance on removal (General Practitioners Committee of the British Medical Association, 1996; Royal College of General Practitioners, 1997) reviewed in section 1.3 views removal as the consequence of a ‘break down’ in the relationship due to previous difficulties between the GP and the patient. Quite what these difficulties might be is not spelt out in detail but the RCGP guidance (Royal College of General Practitioners, 1997) suggests that patients should be seen as ‘difficult’ when they exhibit persistently ‘unreasonable’ behaviour. Drawing on surveys of GPs (Pickin *et al*, 2001; O’Reilly *et al*, 2001) such behaviour could encompass verbal abuse or ‘inappropriate’ requests for services such as home visits. The RCGP argues that the likelihood of removal can be minimised if the GPs and practice staff have good communication skills which will enable them to explore the patient’s perspective on his/her behaviour and to negotiate a solution to the difficulties acceptable to both GP/practice staff and patient. In addition, the RCGP places these recommendations in the context of a ‘therapeutic’ doctor-patient relationship.

These two concepts – being able to negotiate a mutually acceptable solution to difficulties and the ‘therapeutic’ relationship – are central to the concept of ‘patient-centred’ medicine (Stewart *et al*, 1995). The next section will review how ‘patient-centred’ medicine has been constructed in the general practice literature. I shall argue that patient-centred medicine is a problematic concept and one which offers an incomplete framework for understanding difficulties between patient and doctors. My argument will draw on empirical research from general practice.

### *1.4.1 Patient-centred medicine*

Patient-centred medicine can be seen as a 'reformist' approach to medicine that attempts to address both the sociological critique of 'biomedicine' and the consumerist proposition that the patient 'knows best' (May and Mead, 1999; Lupton *et al*, 1991). Academic GPs in undergraduate and postgraduate departments of general practice have been particularly keen to promote its values (McWhinney, 1989; Dowrick *et al*, 1996) and it is now widely accepted that doctors should practise patient-centred medicine (Stewart, 2001). There is also a growing body of empirical research which attempts to define the key components of a 'patient-centred approach' (Mead and Bower, 2000; Little *et al*, 2001) and to establish whether or not it has a positive effect on health outcomes (Stewart, 1995a, 1995b).

Although Balint in the 1950s differentiated between doctors practising 'illness-centred medicine' and 'patient-centred medicine' (Balint, 1964, 1969; Balint and Norell, 1973) it was not until the mid-1970s that these ideas were the subject of empirical research. Byrne and Long (1976) sought to discover what patterns of behaviour doctors appeared to follow in their consulting rooms and the degree to which the patterns were repetitive among doctors. They performed a content analysis on a sample of 2,500 audio-taped U.K. GP/patient consultations. They concluded that the doctor-patient relationship could be described as a continuum ranging from 'patient centred', when the emphasis is on the doctor using the patient's knowledge and skills to 'doctor-centred', when the emphasis was on the doctor using his/her own special skills and knowledge. 'Patient-centred' doctors tended to listen, clarify and interpret the patient's problems and permitted patients to make their own decisions regarding treatment. 'Doctor-centred' doctors, in contrast, focused on

gathering information on the patient's problems by specific closed questions and decided upon the appropriate course of treatment for the patient. They also noted that doctors tended to use the same style when observed across a range of consultations.

Bryne and Long thus offered empirical support for the idea of 'doctor-centred' versus 'patient-centred' medicine as practised by doctors and were themselves of the opinion that a 'therapeutic' doctor-patient relationship necessitated a patient-centred approach. The last twenty years have seen the term 'patient-centred' medicine used in a variety of different ways (Mead and Bower, 2000) and only recently has there been any attempt to define it in terms of the tasks that should be achieved in each doctor-patient encounter.

Such a task-orientated definition is provided by Stewart and colleagues who propose a model of patient-centred clinical method with six interconnecting components (Weston and Brown, 1995) (box 1.3).

A key aspect of this model is that it fits with a skills-based approach to the doctor-patient encounter as defined as a single consultation episode. In this approach, the components of patient-centred medicine can be seen as achievable if the doctor has the necessary skills or competences to be able to, for example, explore the patient's illness experience and find 'common ground' regarding management. If these tasks are not achieved at the end of the consultation then the problem is seen as lying with the doctor and is seen as remediable through the doctor receiving further training in consultation skills (Tuckett *et al*, 1985; May and Mead, 1999). From the point of view of removal, the two key components of patient-centred medicine which need to

be considered are ‘finding common ground regarding management’ and ‘enhancing the patient-doctor relationship’. I shall take each of these components in turn, discussing their properties and how they have been dealt with in the general practice research literature.

<p><b>Box 1.3      The components of the patient-centred clinical method (Weston and Brown, 1995):</b></p> <ul style="list-style-type: none"><li>• Exploring both the disease and the illness experience, including patients’ ideas and concerns about what is wrong with them and their expectations of the doctor;</li><li>• Understanding the whole person: the ‘person’ (life history and developmental issues) and the context within which illness has occurred (e.g., the patient’s family);</li><li>• Finding common ground regarding management: both patient and doctor should reach agreement on the nature of the problem and what should be done about it;</li><li>• Incorporating disease prevention and health promotion into the consultation;</li><li>• Enhancing the patient-doctor relationship: the doctor should establish an effective long-term relationship with the patient;</li><li>• ‘Being realistic’ in terms of managing one’s time efficiently for the benefit of patients.</li></ul>
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**(a) ‘Finding common ground’**

Weston and Brown (1995) offer this definition of both patient and doctor mutually ‘finding common ground’:

*Developing an effective management plan requires physician and patient to reach agreement in three key areas: (a) the nature of problems and priorities, (b) the goals of treatment and (c) the roles of the doctor and patient. Often, doctors and patients have widely divergent views in each of these areas. The process of finding a satisfactory resolution is not so much one of bargaining or negotiating, but rather of moving towards a meeting of minds or finding common ground. This framework reminds physicians to incorporate patients’ ideas, feelings, expectations, and functions into treatment planning (Weston and Brown, 1995: 28).*

The implication of this formulation is clear. If the doctor is able to determine and incorporate patients' ideas and expectations into his management plan then both parties should be able to 'reach agreement' on an appropriate course of action. This is true even if both parties enter the consultation with divergent views as to what each wish to achieve. This idea of finding 'common ground' finds expression in the related concept of 'shared decision making'.

'Shared decision-making' refers to the process by which doctors collaborate with patients in making management decisions (Charles *et al*, 1997; Elwyn *et al*, 1999). Charles *et al* (1997) have defined 'shared decision-making' as occurring when: a) both patient and doctor are involved; b) both parties share information; c) both parties take steps to build a consensus about the preferred treatment and d) an agreement is reached on the treatment to implement. 'Shared decision-making' is currently seen as requiring the same skills-based approach that was devoted to exploring patients' ideas, concerns and expectations in the 1980s (Pendleton *et al*, 1984) and research has already defined the necessary competences to achieve this goal (Towle and Godolphin, 1999; Elwyn *et al*, 2000).

There is, however, little evidence that 'finding common ground' or achieving 'shared decision-making' actually occurs in routine general practice consultations. These conclusions come from two landmark studies in British general practice: Tuckett and colleagues' *Meetings Between Experts* (Tuckett *et al*, 1985) and the recently published work by Britten and colleagues on doctor-patient communication about drug therapy (Barry *et al*, 2000; Barry *et al*, 2001; Britten *et al*, 2000; Stevenson *et al*, 2000).

Tuckett *et al* (1985) sought to explore the extent to which ideas can be shared in general practice consultations. They specifically investigated what ideas were mentioned by the doctor to the patient and vice versa; how far these ideas were mutually explored and elaborated; and how far patients shared their doctor's understanding. As far as methodology is concerned, Tuckett *et al* used an innovative 'mixed methods' approach combining earlier qualitative (Stimson and Webb, 1975) and quantitative (Ley *et al*, 1973; Ley *et al*, 1976) approaches to the doctor-patient encounter. Their argument was that the qualitative approach to the consultation 'had been difficult to interpret because statistical relationships are not available and the representativeness of case examples is unclear' (Tuckett *et al*, 1985: 31). In contrast, the quantitative approach had been notable for an absence of theory and for paying little attention to what ideas are communicated by doctors and patients. Tuckett *et al* therefore undertook a study of 1,302 consultations conducted by 16 doctors to 'allow a systematic and quantitative analysis'. They also undertook 328 interviews with patients. Tuckett *et al*'s overall finding was that most of the consultations studied were 'one-sided'. Doctors and patients did not manage to achieve a dialogue and were not able to share or exchange ideas to any great extent. Thus 'successful' consultations were those in which both parties had similar views on the nature of the problem and proposed management plan at the outset. In contrast, 'unsuccessful' consultations resulted from both patient and doctor having divergent views which were not resolved during the consultation as the doctor did not determine what the patient felt was wrong with him/her and what should be done about it. On the basis of these findings, Tuckett *et al* proposed that both doctor and patient need to learn how to share ideas more effectively and argued that 'shared understanding' was a skill that could be learnt through doctors receiving appropriate training in

communication techniques. In this model, the 'expert' patient, like the 'expert' doctor, is seen as reasonable and rational and the patient simply needs to be allowed to tell the doctor what he/she thinks is wrong and what should be done about it. The key implication for managing difficulties in the doctor-patient relationship is that failure to reach a 'shared understanding' results from a failure *on the part of the doctor* to treat a patient as an 'expert'.

In their recent work on doctor-patient communication, Britten and colleagues (Barry *et al*, 2000; Barry *et al*, 2001; Britten *et al*, 2000; Stevenson *et al*, 2000) utilise a qualitative approach, which has much in common with Stimson and Webb's classic sociological study of British general practice in the 1970s: *Going to see the doctor* (Stimson and Webb, 1975). A particular strength of Britten and colleagues' work is that they treat the doctor-patient encounter as a process that encompasses interviews with patients before their consultation, audio-taping of the consultation itself and interviews with patients after the consultation. Sixty-two patients were recruited from 20 general practices in south east England and the West Midlands. Britten and colleagues (Stevenson *et al*, 2000) specifically sought to ascertain whether or not Charles *et al*'s (1997) model of 'shared decision making' was used by GPs and patients. They found that there was little evidence that both patient and doctor are involved in decision-making or share information. GPs appeared surprised to be asked by the patients about their views on the medication being prescribed and, vice versa, patients appeared to be reluctant to share their reluctance to receive a prescription with the GP. As a consequence it was not possible to achieve a consensus about the preferred treatment or to reach a joint agreement on which

treatment to implement. The authors themselves noted that their findings were in agreement with those Tuckett *et al* (1985).

It is a matter of concern that, a decade and a half after the publication of *Meetings Between Experts* (Tuckett *et al*, 1985), the recommendation that doctors and patients should share ideas in the consultation still does not appear to be implemented in routine general practice consultations. The reasons for this appear to have remained largely unexplored. One key problem is that the model makes a series of assumptions and conditions but makes few recommendations on what should happen when these are not met. For example, this model of patient-centred medicine fails to consider the possibility that the patient may not be ‘expert’; and it is unclear what the GP should do when dealing with a patient who is not rational or reasonable, or when faced with a patient with whom the GP has attempted to negotiate a jointly acceptable management plan but the patient is unable or unwilling to see the GP’s point of view.

#### (b) ‘Enhancing the patient-doctor relationship’

Moving onto the second relevant tenet of patient-centred medicine, Weston and Brown (1995) offer this definition of enhancing the patient-doctor relationship:

*When doctors see the same patients time after time with a variety of problems, they acquire considerable personal knowledge of them that may be helpful in managing subsequent problems. At every visit, in the context of continuity of care, physicians strive to build an effective long-term relationship with each patient and to use the relationship for its healing potential. Physicians (using personal self-awareness, as well as the basic tools of effective relationships: unconditional positive regard, empathy, and genuineness) attend fully to patients and their needs without always having to interpret or intervene (Weston and Brown, 1995: 29).*

Thus the long-term ‘personal’ relationship that may develop between doctor and patient is seen wholly in positive terms as allowing a ‘therapeutic’ relationship to

develop. The latter draws on the psychotherapeutic concept of the ‘therapeutic alliance’ with the belief that it is necessary and sufficient for a therapist to display empathy, genuineness and unconditional positive regard to effect therapeutic change in clients (Mead and Bower, 2000). In U.K. general practice this approach to the doctor-patient relationship is associated with the psychoanalyst Balint’s (1964) seminal *The Doctor, His Patient and the Illness*. Balint himself coined the phrase ‘mutual investment company’ to refer to the importance of the relationship as ongoing and therapeutic:

*It is on this basis of mutual satisfaction and mutual frustration that a unique relationship establishes itself between a general practitioner and those who stay with him ... we termed it ‘a mutual investment company’. By this we mean that the general practitioner gradually acquires a very valuable capital invested in his patient and, vice versa, the patient acquires a very valuable capital bestowed in his general practitioner (Balint, 1964: 249-250).*

In general practice, such a relationship is possible if the GP sees the same person over a series of consultations *and* adopts this therapeutic stance. This is termed relational or personal continuity (Freeman *et al*, 2000). Since the 1950s, however, the likelihood of a patient seeing the same doctor for repeated consultations has reduced because of the decline in ‘single-handed’ GPs and the concomitant rise in ‘group’ general practices. This has raised the questions as to whether ‘personal care’ is actually being delivered by GPs (Baker, 1997).

It should be emphasized that patient-centred medicine does not attribute difficulties in the long-term relationship solely to the ‘difficult’ behaviour of patients. Rather, following Balint (1964), it deals with difficulties in the long-term relationship by identifying the problem in terms of difficulties in the interaction between doctor and patient. Both parties are seen as contributing to the creation and maintenance of a

'problematic' interaction (Norton and Smith, 1994; Smith, 1995; Platt and Gordon, 1999). But, as with 'finding common ground', patient-centred medicine focuses on the way in which the *doctor* can change his behaviour to achieve a more satisfactory outcome – either in terms of achieving a 'considerable though limited change in personality' (Balint, 1964: 121) using the medium of a Balint group (Balint, 1969) or by teaching the doctor appropriate counselling skills (Norton and Smith, 1994; Squier, 1990).

Balint (1964) offered an explanation of the 'difficult' patient in terms of the interaction between doctor and patient and highlighted the existence of a particular group of 'problem' patients - what he termed 'fat envelope' patients. Balint saw such patients as having a 'difficult' relationship with their GP. He identified such patients as exhibiting 'problematic' behaviour such as frequent attendance at the surgery and frequently changing their doctor and 'problematic' illnesses such as somatisation.

More recently, such patients have been conceptualised as 'heartsink' patients:

*There are patients in every practice who give the doctor and staff a feeling of 'heartsink' every time they consult. They evoke an overwhelming mixture of exasperation, defeat, and sometimes plain dislike that causes the heart to sink when they consult (O'Dowd, 1988: 528).*

#### *The 'heartsink' patient*

Mathers (1993; Mathers *et al*, 1995) has conducted empirical research into the 'heartsink' phenomenon, describing it in terms of three related factors: patient, doctor and doctor-patient relationship. He undertook a study in which the experience of 'heartsink' patients by an urban sample of GPs was investigated and compared with

their experience of a control group of patients using semi-structured interviews and self-administered questionnaires.

His chief findings were as follows. 'Heartsink' patients were most likely to be middle-aged female patients who frequently attended their GP with either multiple symptoms which did not resolve with medical treatment or psychological or psychosocial problems. As far as the doctors were concerned 'heartsink' patients were commonly associated with feelings of 'angry helplessness' and four explanatory variables were identified as being associated with the number of 'heartsink' patients that a GP reported: the greater the patient workload, job dissatisfaction of the GP and lack of appropriate postgraduate qualifications, the more 'heartsink' patients were reported; the more training in counseling and communication skills that the GP had received, the fewer 'heartsink' patients were reported.

The doctor-patient relationship with 'heartsink' patients was perceived by GPs as being different than that of the control patients in several respects. 'Heartsink' patients were perceived as less willing to work in partnership with their doctors and as having more difficulty in doing so. 'Heartsink' patients also had a lack of clarity about roles and responsibilities. They were perceived as looking more to the doctor for solutions to their problems than control patients and less frequently taking the lead in the doctor-patient relationship. 'Heartsink' patients themselves reported that they were conscious of the GP 'hurrying them up' in the consultation but otherwise did not differ significantly from control patients in their perceptions of the doctor-patient relationship. Mathers's final observation was that there was a greater 'mismatch' in perception of the doctor-patient relationship between GPs and their

'heartsink' patients than between GPs and their control patients. He concluded that the 'heartsink' patient is a problem for the GP, not the patient, and argued that a reduction in the number of 'heartsink' patients reported by GPs could be achieved by a reduction in workload and more training in counselling/communication skills (Mathers and Gask, 1995).

The existence of the 'heartsink' phenomenon should make one wary of assuming that relational continuity – when the GP sees the same person over a period of time - always leads to a 'therapeutic' relationship with benefits for both practitioner and patient. Furthermore, there is no prospective longitudinal research which has explored the process by which relational continuity develops and what its outcomes are for both parties (Freeman *et al*, 2000). Drawing on GPs' experiences of the 'heartsink' phenomenon, it seems reasonable to postulate that relational continuity can lead, in certain circumstances, to one party in the relationship disliking the other party to the extent that the relationship is either ended and/or there are adverse outcomes for either patient or GP. But, as with 'finding common ground', patient-centred medicine simply suggests that the number of such situations can be reduced by the doctor receiving training in counselling skills. It is silent as to what should happen in the relationship when, in spite of training in counselling skills, the doctor still views the patient with intense dislike.

### (c) Summary

In this section I have presented Stewart *et al*'s (1995) model of 'patient-centred medicine' – a model that is widely used in the general practice literature - and have reviewed two key components relevant to the removal of a patient from a GP's list:

‘finding common ground’ and ‘enhancing the doctor-patient relationship’. The general practice discourse of patient-centred medicine proposes that difficulties with patients can be best conceptualised as a defect in the consultation skills of the individual doctor. This can be remedied by further training in communication or counselling skills (May and Mead, 1999). Patient-centred medicine is unclear as to what the doctor should do if faced with a patient who is unable or unwilling to see the GP’s point of view or who evokes in the doctor a strong feeling of dislike. My review of the empirical literature suggests that these components may represent the views of a professional elite (‘academic’ GPs and the RCGP) as to how GPs ‘ought’ to behave rather than describe how practitioners actually manage their seven minute consultations. As such, they may be more rhetoric than reality (Dowrick *et al*, 1996).

### **1.5 Sociological perspectives on the ‘difficult’ doctor-patient relationship**

I propose that sociological perspectives can help further our understanding of the ‘difficult’ doctor-patient relationship. My argument is that the general practice discourse around ‘patient-centred’ medicine is inadequate in two respects. First, as discussed in section 1.4, there is limited empirical evidence from the general practice research literature to show that doctors use this approach in practice and it may be simplistic to assume that difficulties can always be resolved through improving the consultation and/or counselling skills of individual GPs. Second, as argued here, ‘patient-centred’ medicine offers an inadequate conceptualisation of the ‘difficult’ doctor-patient relationship as it fails to adequately consider issues identified as important in the doctor-patient relationship by sociology. These key issues are: the

power asymmetry between patient and doctor; the fact that doctors make moral and affective judgements about patients in their day-to-day work and the nature of relationship ‘breakdown’ between doctor and patient.

### *1.5.1 Power and the doctor-patient relationship*

*Power is the ability to affect the actions or ideas of others, despite resistance (Olsen and Marger, 1993: 1).*

Patient-centred medicine argues that, for doctors to consult in a ‘patient-centred’ manner, they need to shift the balance of power away from the doctor and towards the patient (Mead and Bower, 2000). It talks of the need to move away from the ‘paternalistic’ doctor-patient relationship proposed by Parsons (1951), in which ‘doctor knows best’, to one of ‘mutual participation’ (Szasz and Hollender, 1956) or ‘partnership’ (Coulter, 1999) where power and responsibility are shared with the patient. Such a trend is justified in terms of the rise of the patient as an active ‘consumer’ of health care (Lupton, 1997b) and may lead to better health outcomes for patients (Stewart, 1995b). The medical literature, however, fails to offer a definition of ‘power’ other than in terms of the ‘competence gap’ that is said to exist between medical ‘expert’ and ‘uninformed’ patient and offers little insight into how power is produced and maintained in the doctor-patient relationship. It assumes that the balance of power can be shifted in the direction of the patient by training the doctor to develop the competencies demanded by patient-centred medicine (Stewart *et al*, 1995; Towle and Godolphin, 1999).

In this section I shall offer a brief definition of the forms of social power and review how power has been conceptualised in the doctor-patient relationship. I shall review

four key approaches to power in the doctor-patient relationship: functionalist; conflict; Goffmanian; and Foucauldian approaches. Taking an interpretive position, I shall argue that there is a need to conduct empirical research that pays attention to the ways in which power is produced and maintained in different types of doctor-patient encounters. My analysis draws on Lupton's (1994) review of power relations in the medical encounter and Maseide's (1991) argument that power is necessary and constitutive for adequate medical practice.

**(a) Social power**

**Box 1.4      The key forms of social power (Olsen and Marger, 1993; Olsen, 1993) and the doctor-patient relationship:**

- *Force*. The actor brings pressure to bear on the intended recipient by giving or withholding specific resources. An example of coercive force in the doctor-patient relationship might be the doctor threatening to remove a patient from his list unless the patient adopts a more 'appropriate' pattern of service use;
- *Dominance*. The actor carries out a set of established activities or social roles on a regular basis. In the consultation the doctor continually re-enacts his/her role of a GP and has internalised the informal rules necessary for the maintenance of this role. The patient, in contrast, may have less awareness of the role they are to play or the rules that underlie such a role;
- *Authority*. Authority involves the right to issue directives to others who must accept them. To exercise authority, an actor draws on a grant of legitimacy made by the recipients as a basis for issuing authoritative directives. According to Weber (1993) such legitimate authority may rest on *rational* knowledge or expertise; *legal* rights; *traditional* beliefs and values and *charismatic* appeal by revered leaders. Clearly, the authority of the GP primarily draws on technical expertise - the 'competence gap' - but also draws on legal rights (for example, the right of a GP to compulsorily admit a patient to hospital under the Mental Health Act), traditional beliefs and charismatic appeal;
- *Attraction*. Attraction lies in the ability of an actor to affect others because of who he or she is. For the other party to be affected he/she needs to cognitively identify with the actor, have positive affective feelings towards the actor and attribute charisma to the actor (belief that the actor possesses some kind of special or unique qualities). In the doctor-patient relationship such attraction may be shown when a patient feels that the doctor has done something 'wonderful' for them (e.g., 'saved my life').

Olsen and Marger (Olsen and Marger, 1993; Olsen, 1993) provide a clear and concise definition of the key forms of social power that exist in modern societies. Social power can take one of four forms, although any specific encounter may involve more than one form, and I have applied these to the doctor-patient relationship (box 1.4). Authority is viewed as the most stable form of power and discussions of power in the doctor-patient relationship have generally focused on the exercise of authority through technical expertise.

#### (b) The functionalist perspective

The functionalist perspective sees social relations in the doctor-patient encounter as products of a consensualist society, in which the social order is maintained through certain individuals acting in defined roles and performing certain functions. This perspective is best known through Parsons' (1951) elucidation of the functions of the 'sick role'. Parsons perceives illness as a 'deviant' position in the social structure and one which needs to be controlled by another social group, the medical profession. The role of the patient ('sick role') consists of two rights and two responsibilities. As far as rights are concerned the patient is allowed exemption from normal activities and is regarded as being in need of care. The responsibilities are that the patient must want to get better as soon as possible and should seek medical advice and co-operate with the doctor. The doctor, in his/her professional role, also has rights and responsibilities.

As far as rights are concerned, the doctor is allowed to take a history from and examine patients, to have professional autonomy and to occupy a position of authority in relation to the patient. The responsibilities are that the doctor is expected

to apply a high degree of skill and knowledge, act for the welfare of the patient rather than for self-interest, be objective and emotionally detached and be guided by the rules of personal practice.

Parsons' model has three key features. First, he was chiefly interested in using his model of the doctor-patient relationship as an illustration of his theory of social systems rather than developing a model based on observations of 'real' consultations. As Bloor and Horobin (1975) note, Parsons' model is an 'ideal type' - it does not seek to specify what empirical reality is, but rather to selectively describe it in a conceptually unambiguous manner. Second, the power relationship between patient and doctor is asymmetrical: the doctor occupies a dominant position in the relationship by virtue of specialist knowledge and the patient merely co-operates (a 'competence gap' exists between doctor and patient). Third, it views the roles of the doctor and patient as complementary in relation to shared values and expectations and to the maintenance of the social system. If patients are typified as compliant, passive and grateful of the care they receive, then the other side of the coin is that doctors are typified as competent, altruistic and emotionally detached from the care they provide.

Thus in Parsons' model of the doctor-patient relationship a power differential between practitioner and patient is necessary to the functioning of the social system. It allows the authority of the doctor to be established (primarily through his technical expertise) and encourages compliance on the part of the patient. The complementary nature of the doctor's and patient's roles does not allow for the expression of conflict.

### (c) The conflict perspective

In contrast to the functionalists' consensual approach to the doctor-patient relationship the conflict perspective sees all such relationships as inherently problematic. This position was first articulated by Freidson (1961, 1970):

*The separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other. This seems to be inherent in the very situation of professional practice (Freidson, 1961: 175).*

Lupton offers this summary of the conflict theorists' position:

*Like the functionalists, political economists see medicine as a moral exercise, used to define normality, punish deviance and maintain social order, but where the two approaches differ is that the latter school of thought believes that this power is harmful rather than benevolent and is abused by the medical profession (Lupton, 1994: 9).*

Howard Waitzkin, a leading theorist in this area, argues that medical encounters tend to convey ideological messages supportive of the current social order, that these encounters have repercussions for social control, and that medical language generally excludes a critical appraisal of the social context (Waitzkin, 1989). The doctor-patient relationship can be viewed as a micro-political situation, in which information control by the doctor is used to maintain patterns of medical dominance and subordination (Waitzkin and Stoeckle, 1976).

A criticism of the conflict approach is that, like functionalism, it can be seen as theoretically driven rather than grounded in observations of 'real' consultations. Furthermore, it offers little insight into specific 'difficult' doctor-patient relationships as it sees all such relationships as inherently problematic. The importance of the conflict approach, by raising issues of professional power and dominance, is that it

has sensitised researchers working from an interpretive perspective to incorporate such structural determinants of individual's actions in their research.

(d) The Goffmanian perspective

Both the functionalist and conflict perspectives may be classed as structuralist. That is, they see social behaviour as being conditioned or shaped by forces which reside at the level of society as a whole (Cuff *et al*, 1990). This approach has also been defined as '*macro-level*' as it emphasises the way in which political, economic and institutional factors influence clinical encounters between patients and doctors (Wright and Morgan, 1990). An alternative approach, one which Goffman used, is to hold that an analysis of social behaviour must start from 'the point of view of the actor', that is, the understandings that the participants in a social situation have of what the situation is and what their place is within it. Such an interpretive approach has also been defined as '*micro-level*' as it emphasises the importance of determining and interpreting patients' and doctors' actions and retrospective accounts of clinical encounters.

From an interpretive perspective power is *not* seen as some fixed property imposed at macro level. Rather, power is seen to result from the interaction of the participants in any given social encounter. Goffman wrote widely on the 'micro-structure' of social interaction (Strong, 1983; Manning, 1992) and his proposition that the social order is upheld through recurrently validated rules of conduct (Goffman, 1967a) is of key importance here. Manning (1992) offers this concise summary of Goffman's view of social rules:

*Goffman characterized social rules as invisible, underlying codes governing our behaviour. These codes are primarily constraints. Goffman distinguished substantive and ceremonial rules: the former are of importance in their own right, the latter not so. Most of his work focused on ceremonial rules. Rules simultaneously regulate and constitute the structure of social interaction, usually as background assumptions. Asymmetrical rules exercise power. Often rules surface as reciprocal obligations and expectations (Manning, 1992: 73).*

A more detailed definition of Goffman's rules has been provided by Denzin (1970: 62-64). Substantive rules should be seen as 'rules of the civil-legal order'. Such formal rules are expressed in law or codes of ethics and govern conduct in public settings. For example, physical violence by one citizen against another is proscribed by law. Ceremonial rules, on the other hand, are 'rules of civil propriety'. Their function is to maintain the moral and social order of those expressing them. These informal rules can be viewed as 'rules of etiquette'. They govern polite, face-to-face interaction among persons when they are in both public and private settings. An example would be statements as to the 'correct' dress code for a given social encounter. Goffman was particularly interested in the ceremonial or etiquette rules of social encounters. He believed that formal and informal rules mesh together in any given social interaction to constitute the ritual or ceremonial order of the encounter. In this 'ceremonial order' each party to the encounter is presented in an idealised light – each is seen to conform to the rules governing that particular interaction. This point will become clear when I discuss Strong's (1979) 'ceremonial order' of the doctor-patient encounter later in this section.

Goffman (1967a) saw power as residing in the way parties in the encounter used asymmetric rules of conduct. In such rules one party is allowed to do something to the other party but the other party is not allowed to reciprocate in kind. For example,

the authority of the doctor is accomplished through the asymmetric rule that a patient should follow the doctor's advice. In this rule the doctor's expectation that a patient should follow medical advice is associated with the doctor's obligation to treat the patient to the best of his ability. Conversely, the patient is obliged to follow the doctor's advice but expects that the doctor will treat him to the best of his ability. Note how each party has obligations and expectations, but these are not reciprocal and sustain the power differential between doctor and patient.

Strong (1979, 1988; Strong and Davis, 1977) subjected Goffman's ceremonial order of encounters to detailed empirical scrutiny in his ethnographic study of doctor-patient interaction in hospital paediatric clinics in Scotland and the U.S. His conclusion was that the social form of the medical encounter could be described by four types of ceremonial order or role format: 'bureaucratic', 'charity', 'clinical' and 'private'. Each of these ceremonial orders had different etiquette rules governing the nature of the face-to-face interaction between parent and doctor. Strong argued that the most commonly observed format in the Scottish NHS hospital clinics was the 'bureaucratic' form of the consultation. In the 'bureaucratic' form each participant – doctor and parent - was offered an idealised public character. Every doctor was clinically competent. This competence could not be challenged by parents and was not derived from particular technical expertise, it depended simply on being a doctor. Conversely, parents, as lay people, were seen as lacking medical knowledge and passively accepting what they were told by the doctors. Every parent, however, was 'good' - loving, honest, reliable and intelligent. This fact that parents were 'good' required that the doctors reciprocate with 'medical gentility' - they should be polite to their patients and espouse the ideal of public service. Irrespective of whether a

particular doctor was competent or a particular parent was 'good', the etiquette rules of the consultation gave doctor and parent these special and complementary identities. In short, in the bureaucratic order of the clinic the doctor always 'knows best' but the parent is always 'good'.

In Strong's (1979) *Ceremonial Order of the Clinic*, power is produced and maintained in the doctor-patient relationship through this ritualised or 'ceremonial' order of the doctor-patient encounter, with its mesh of formal and informal (etiquette) rules that govern the 'correct' behaviour of doctor and patient and define the respective roles of patient and doctor. A key aspect of the ceremonial order is that it may mask marked differences in power between doctor and patient. As Stimson and Webb (1975) note:

*There is rarely any conflict in the negotiation in the consultation. Both parties generally recognise some semblance of formality and exercise restraint to prevent the encounter from completely breaking down ... verbal and non-verbal control strategies are often covert and rarely obvious or explicit. On the part of the patient, particularly, they appear to operate beneath a façade of compliance and acquiescence (Stimson and Webb, 1975: 57-8).*

In the consultation, the patient may strongly disagree with the doctor's proposed plan of management but the ceremonial order demands that the 'correct' behaviour is to accept the doctor's 'orders'. Thus the patient may listen to the doctor's advice without question, but on leaving the surgery may choose not to follow the doctor's advice. Such non-compliance is covert. Alternatively, the ceremonial order may cause doctors difficulty in dealing with 'difficult' patients such as those who abuse opiates and alcohol. Doctors may feel uncomfortable about questioning the authenticity of such patients' accounts because it breaches the 'appeal to gentility' – patients are idealised as being honest and reliable. In each of these situations there is

potential for open conflict between patient and doctor if the rules maintaining the ceremonial order are broken. Once there is open conflict then there is the possibility that either party may seek to use coercive force to make the other comply with their wishes (e.g., the doctor may threaten the un-cooperative patient with removal or the opiate-abusing patient may threaten the doctor with verbal or physical abuse to get his prescription).

Although Strong's model of the ceremonial order has been found to apply in a private oncology clinic in London (Silverman, 1984) it has not been tested in general practice. It is likely that the 'bureaucratic' order of the clinic would require modification in view of the fact the patients in general practice may idealise a 'good' GP as having particular 'personal' qualities as well as technical expertise (Calnan, 1988). Nonetheless, the notion of the ceremonial order of the clinic draws attention to the fact that power is usually not openly displayed in the doctor-patient encounter. Power is covert and operates beneath a 'façade of compliance and acquiescence'.

#### (e) The Foucauldian perspective

The Foucauldian perspective on medical power is associated with the work of Armstrong (1983) and Silverman (1987; Silverman and Bloor, 1990) and remains influential in medical sociology. It is important for three reasons. It stresses that power is necessary for the satisfactory operation of the doctor-patient relationship, offers insight into the way in which power is exerted in 'therapeutic' relationships and pays attention to the ways in which patients may resist medical power.

Lupton (1997a) offers this concise summary of the Foucauldian perspective on power:

*Power, as it operates in the medical encounter is a disciplinary power that provide guidelines about how patients should understand, regulate and experience their bodies. The central strategies of disciplinary power are observation, measurement and comparison of individuals against an established norm, bringing them into the field of visibility. It is exercised not primarily through direct coercion or violence ... but rather through persuading its subjects that certain ways of behaving and thinking are appropriate for them. The power that doctors have in relation to patients, therefore, might be thought of as a facilitating capacity or resource, a means of bringing into being the subjects 'doctor' and 'patient' and the phenomenon of the patient's 'illness' (Lupton, 1997a: 99).*

A key aspect of the Foucauldian position, then, is that power is not invested in one social group (e.g., doctors) at the expense of another (e.g., patients), as conflict theorists would argue. Rather, power is relational and invested in both patient and doctor. Like functionalists, Foucauldians argue that the power differential between practitioner and patient is necessary for practitioners to take control of the encounter to meet the expectations of both practitioner and patient – a ‘facilitating capacity’ as Lupton puts it. They also see power as locally produced and exercised through social relationships, a position which echoes the Goffmanian perspective. Maseide (1991) in his review of power in medical practice, stresses both these points and offers this concise definition of why power is always necessary in the doctor-patient relationship:

*As integrated in institutionalised forms of knowledge and reasoning, medical power is institutionally certified and legitimised. The physician is professionally trained as a competent practitioner and given status as imposer of power through authorisation ... To act as an authorised practitioner, the doctor has to control the relationship to the patient ... The impact of power is effective to the extent that the doctor and patient share a system of knowledge and assumptions that facilitates relatively conflict-free interaction and effective patient compliance (Maseide, 1991: 552-553).*

Foucauldians have applied this analysis of power to the development of the notion of 'patient-centred medicine' as discussed in section 1.4. In his *Political Anatomy of the Body* Armstrong (1983) charts the development of medical knowledge in twentieth century Britain and highlights a shift away from a medical discourse or 'gaze' that focuses on the patient's body and its pathological processes towards a discourse that focuses on the 'social space between doctor and patient' (Armstrong, 1983: 25), specifically, on the doctor-patient relationship. In this new 'discourse of the social' (Silverman, 1987: 191) the doctor-patient relationship is seen as:

*An instrument of therapy in its own right, a tool for the elucidation of the patient's condition, a confessional in which the patient is incited to speak, to reveal an authentic inner self (Silverman and Bloor, 1990: 4).*

For Armstrong (1979, 1983), a leading figure in the development of this approach to the doctor-patient relationship in general practice was Michael Balint and this new 'discourse of the social' can be seen as congruent with the aims of 'patient-centred medicine'. May (May *et al*, 1996; May and Mead, 1999) emphasizes, in his discussion of the influence of patient-centred medicine that:

*The whole point of the [patient-centred general practice] consultation is ... to reveal some degree of the interiority of the patient. The latter may be intending to discuss a sore throat, but may actually want to discuss some other problem of a more sensitive nature. It is the doctor's duty to be open to this (May *et al*., 1996: 190).*

For Foucauldians, however, 'patient-centred medicine' - with its emphasis that the doctor should listen to the patient and interpret his/her problems using a biopsychosocial approach - is not seen as redressing the power 'imbalance' between doctor and patient. Rather, a Foucauldian perspective on power stresses that 'patient-centred medicine' represents an extension of medical power: through talking about

their subjective 'experiences' the patient's 'inner self' is now visible and open to inspection by doctors in the same way that traditional history-taking and physical examination allow doctors to inspect the patient's body. Thus, as May *et al* (1996) note, 'patient-centred medicine' has allowed a patient's housing problems or relationship difficulties to become just as much an integral part of the general practice consultation as a patient's skin lesion or heart murmur.

In addition, Foucault also argued that 'where there is power there are always resistances' (Lupton, 1997: 102) and Foucauldians have paid attention to the way in which patients may resist medical or other health professional power. An important example of such work is Bloor and McIntosh's (1990) study of client resistance in female clients of health visitors. The data upon which their analysis was based consisted of semi-structured interviews with eighty working-class Glasgow women. They found that the women resisted health visitor power by using the strategies of individual ideological dissent; non-cooperation; avoidance; and concealment (box 1.5).

What is notable about all these four strategies of resistance is that they are *covert*. None of the women reported any open disagreement with the health visitor. Bloor and McIntosh note that any counter-action by the health visitor is less likely to operate if resistance is covert and, in any case, the 'appeal to gentility' may not allow the health visitor to question openly the behaviour of the client. Thus in their analysis Bloor and McIntosh not only draw on Foucauldian ideas of power/resistance but they reflect the earlier findings of Stimson and Webb (1975) that resistance is usually covert and that both parties may be bound by the 'ceremonial order' of the encounter.

**Box 1.5 Strategies of resistance used by women in relation to health visitors (Bloor and McIntosh, 1990):**

- *Individual ideological dissent* - mothers would challenge the legitimacy of the health visitor's knowledge. Personal experience of being a mother was seen as being greatly superior to the theoretical 'book' knowledge of the health visitor;
- *Non-cooperation*. This was a common strategy. It consisted of non-compliance with the health visitor's advice (e.g. when to wean a baby);
- *Avoidance*, achieved by not attending the clinic or by being out of the house when health visitor called;
- *Concealment*. Concealment was the most common form of resistance. The advantage of concealment was that it neutralized the potential for the exercise of power without explicitly challenging it in ways that would lead to penalties. It was a way of avoiding control *without* confrontation. Feeding practices that the health visitor might disapprove of were concealed or the health visitor would be given an inaccurate account of what the mother was doing.

**(f) Summary**

Sociological approaches to power in the doctor-patient relationship suggest that it is important to study the way in which power is produced and maintained in particular types of doctor-patient encounters, and also to study the ways in which both parties may resist the power being exerted by the other party. The key characteristic of power is that it is an interactive process that always resides within the consultation and the ongoing doctor-patient relationship, never in individual patients or doctors.

As Olsen and Marger (1993) note:

*A single actor may possess resources that provide a potential basis for exerting social power, but power does not exist until it is expressed in the actions of two or more actors as a dynamic activity. Both the power attempt made by the exorter and the resistance offered by the recipient are crucial in determining the actual power exercised in any situation (Olsen and Marger, 1993: 2).*

Future empirical research on the 'difficult' doctor-patient encounter in general practice thus needs to move beyond seeing difficulties as attributable to communication 'failure' on the part of the doctor. It should look at the ways such difficulties arise out of the interaction between doctor and patient and relate them to the locally produced and necessary power differential between doctor and patient.

#### *1.5.2 'Good' and 'bad' patients and doctors*

It is a key principle of medical ethics that doctors should not make moral judgements about patients and that 'clinical need' alone should determine whether the patient receives medical treatment (General Medical Council, 2001a). Doctors should not discriminate against a patient on the basis of, for example, age or sex or when the doctor believes that the patients' own actions have contributed to their condition. Official guidance on the removal of patients from a GP's list is also clear that GPs should not allow moral judgements to influence their decision to remove a patient (General Practitioners Committee of the British Medical Association, 1996; Royal College of General Practitioners, 1997).

Sociological research in a variety of clinical settings has, however, demonstrated that doctors do not always follow such 'official' medical ethics in their day-to-day encounters with patients. In 'reality', there exists an 'unofficial, moralistic taxonomy of types of patients' (Stein, 1990: 98) which determines how patients are treated by

medical and nursing staff: patients are categorised as 'good' or 'bad'. In this section I shall critically review the empirical literature on the 'good' and 'bad' patient. I shall also consider the question as to whether patients also have a moralistic taxonomy of types of doctors; there is research evidence to suggest that patients also typify doctors as 'good' or 'bad'. I will conclude that the informal or 'unwritten' rules of the doctor-patient encounter determine whether patient or doctor is viewed as 'good' or 'bad' by the other party.

(a) 'Good' and 'bad' patients

A comprehensive review of the nursing and medical literature on 'good' and 'bad' patients has been provided by Kelly and May (1982). Kelly and May identify that much of the literature concentrates on defining particular attributes on the part of the *patient* which lead nurses and doctors to regard the patient as 'good' or 'bad'. For example, patients who have a psychiatric illness and who are 'uncooperative' may be viewed as 'bad'. They note that much less attention has been paid to the *process* by which a patient comes to be labelled as 'good' or 'bad' and suggest that an interactionist approach is a more appropriate way of analysing the phenomenon. They thus suggest that patients come to be defined as 'good' or 'bad' as a result of the interaction between health care professionals and patients as opposed to there being something inherently 'wrong' with them in terms of type of illness or behaviour. This point can be illustrated with reference to two classic ethnographic studies of 'good' and 'bad' patients in accident and emergency departments: the work of Roth (1972) in the U.S. and Jeffrey (1979) in the U.K.

*Roth - Some contingencies of the moral evaluation and control of clientele: the case of the hospital emergency service*

In his study of American hospital emergency services Roth (1972) observed that staff made judgements about a patient's moral fitness and the 'appropriateness' of his attendance at the emergency service and that the care provided to the patient was affected by such judgements. For Roth, patients were seen as 'deserving' or 'undeserving' of medical care depending on their social worth. Thus 'deserving' patients were of high social status, of young age and were not responsible for their illness; whereas 'undeserving' patients were those on welfare benefits, who were elderly or who had a self-inflicted illness. 'Undeserving' patients were expected to follow doctors' orders or else be refused medical care and were given derogatory names by staff: 'garbage', 'scum' or 'liars'. Roth also showed that patients were defined by staff as 'legitimate' or 'illegitimate' depending on whether their demands fell within what was deemed as appropriate work for emergency service staff. Thus 'legitimate' patients present with a traumatic injury or as a medical emergency whereas 'illegitimate' patients present with problems that 'should' be dealt with elsewhere. Using Roth's taxonomy, 'good' patients were 'deserving' and/or made 'legitimate' demands on the service whereas 'bad' patients were 'undeserving' and/or made 'illegitimate' demands. Not surprisingly, staff were most negative about patients who were both 'undeserving' and 'illegitimate' and often told 'atrocious stories' about such patients presenting at inconvenient hours with trivial and longstanding complaints. Roth argued, like Kelly and May (1982), that it was simplistic to see 'bad' behaviour on the part of the patient as leading to a negative evaluation by the medical staff. He pointed out that the process of becoming a 'bad' patient is 'not a simple cause-effect matter, but the product of a reciprocal

relationship between the attributes of the client and the categories of the staff.' (Roth, 1972: 839).

*Jeffrey - Normal rubbish: deviant patients in casualty departments*

In his study of staff working in three English hospital accident and emergency departments Jeffrey (1979) was able to further elucidate the process by which patients came to be labelled as 'good' and 'bad'. He noted that staff used two broad categories to describe patients: 'good' or interesting and 'bad' or rubbish. 'Good' patients were synonymous with Roth's 'legitimate' patients – they made demands on the medical staff which fell within what was deemed as appropriate work. 'Good' patients were not explicitly labelled as such by staff but were defined in terms of their medical characteristics, notably in terms allowing the doctor to practise his chosen speciality.

In contrast, 'bad' patients were explicitly labelled by staff as 'rubbish' and were defined as patients presenting with 'inappropriate' complaints ('trivia'), 'drunks', 'overdoses' and 'tramps'. Such 'bad' patients also met Roth's definition of 'illegitimate' patients - as in the case of 'trivia'; or else were felt 'undeserving' of medical care as their injuries were self-inflicted - as in the case of 'drunks', 'overdoses' and 'tramps'. Jeffrey analysed the accounts given by staff as to why certain patients were 'bad' patients and his conclusion was that 'bad' patients broke the informal 'unwritten' rules of the doctor-patient relationship. He identified four rules of the encounter which were broken by 'bad' patients (box 1.6).

As Jeffrey himself noted, these rules are consistent with Parson's (1951) description of the obligations of patients in the sick role. Although he did not interview patients, Jeffrey noted that some patients appeared aware of these informal rules and attempted to demonstrate in their interactions with staff that they met their obligations. Thus a patient with a minor ailment might stress the accidental nature of the injury and why he thought it was serious enough to bring to casualty, an act which might avoid him being labelled as 'trivia'. Jeffrey observed that 'breaking the rules' of the encounter led to punishment by staff. 'Bad' patients were often kept waiting a long time for treatment, were the subject of verbal hostility and, if uncooperative, were subjected to vigorous restraint.

**Box 1.6 The 'rules' of the doctor-patient relationship in hospital A&E departments (Jeffrey, 1979):**

- Patients must not be responsible either for their illness or for 'getting better':
  - broken by 'drunks', 'overdoses' and 'tramps' (illness self-inflicted)
  - broken by 'trivia' (should have attended their GP)
- Patients should be restricted in their reasonable activities by the illnesses they report with:
  - broken by 'trivia'
- Patients should see illness as an undesirable state:
  - broken by 'overdoses' and 'tramps'
- Patients should co-operate with the competent agencies in trying to get well:
  - broken by 'drunks' and 'overdoses'

*Do 'good' and 'bad' patients exist in U.K. general practice?*

A conclusion of Roth's (1972) and Jeffrey's (1979) work is that patients in hospital accident and emergency departments come to be labelled as 'good' or 'bad' by health care professionals on the basis of whether they conform to or break the informal rules

of the doctor-patient encounter. The key question is whether such findings can be generalised to general practice.

An important early study in this area was carried out by Stimson (1976) who carried out a postal questionnaire survey of GP principals in England and Wales (63% response rate). He asked the GPs to give examples of patients who caused them the 'least trouble' or 'most trouble'. Stimson was able to dichotomise patients into 'least trouble' ('good') and 'most trouble' ('bad') according to their social group, illness, behaviour and social competence (table 1.1).

Stimson's research is now thirty years old, but its findings are consistent with other studies of 'good' and 'bad' patients in general practice (Kelly and May, 1982; Rogers *et al*, 1999b; Steinmetz and Tabenkin, 2001). Stimson noted that many of these elements of patient behaviour also featured in Parson's (1951) model of the doctor-patient relationship, and thus 'bad' patients in general practice would appear to break the same rules as Jeffrey's (1979) 'rubbish'. Although there remains little research on the construction of 'good' and 'bad' patients in general practice from an interactionist perspective, two studies have been identified: McKeganey's (1988, 1989; McKeganey and Boddy, 1988) work on opiate abusing patients and Strong's (1980) work on alcoholics.

**Table 1.1 'Good and 'Bad' patients in general practice**

<b>Category</b>	<b>'Good' Patients</b>	<b>'Bad' Patients</b>
<i>Gender</i>	Men	Women
<i>Illness</i>	Specific symptoms Organic/physical Easy to diagnose/treat/manage Medical problem Get better	Vague symptoms Psychological/psychiatric Hard to diagnose/treat/manage Social problem Do not get better
<i>Patient behaviour</i>	Undemanding Have confidence in doctor Accept limits to doctor's skill Grateful Want to get better Accept judgement of doctor Follow advice Co-operative	Demanding Do not trust doctor  Do not accept limits to his skill Ungrateful Do not want to get better Critical of doctor  Do not follow advice Unco-operative
<i>Social competence</i>	Intelligent Has 'common sense' Can 'cope' Busy/working Good home and circumstances	Low I.Q. Lacks 'common sense' 'acopic' Idle/malingerer Poor social circumstances

Adapted from Stimson (1976): 57-58.

*McKeganey - Shadowland: general practitioners and the treatment of opiate-abusing patients*

McKeganey (1988; McKeganey and Boddy, 1988) used a combination of enhanced records and semi-structured interviews to collect detailed information on 50 consultations with opiate abusers carried out by 23 Glasgow GPs. An analysis of the interview data confirmed the impression gained from the record review that the GPs were experiencing difficulty in their relationships with these patients and in addition

identified four themes: manipulation, lying, poor motivation to change and aggression. Manipulation was seen as an attempt to divert the doctor's role from that of a professional, co-operating in the treatment of an illness, towards the position of someone who could be co-opted into the maintenance of that illness. Lying was also a particular problem, as the doctor's belief that little an opiate abuser said could be taken on trust was an obstacle to the maintenance of any constructive therapeutic relationship with such patients. Motivation to change was felt to be absent, as the majority of consultations were seen as being initiated by the patients in order to obtain drugs from the doctor. The threat of violence, verbal or physical, was also seen as a constant threat in such consultations. Like Jeffrey (1979), McKeganey offers a theoretical perspective on the doctor-patient relationship of opiate abusing patients by applying Parson's (1951) functionalist model. He argues that the strong negative feelings that the GPs had towards these patients is at variance with Parson's ideal of emotional detachment. In addition, the fact that opiate abusing patients were seen as neither wanting to get better nor as wanting to co-operate with doctors meant that the GPs could not slot opiate abusers into a typical patient role.

Using Parson's model it is therefore possible to view the perception of these patients as manipulative, lying, poorly motivated and aggressive as being a judgement based partly on the actions of the patients themselves and partly on the doctors' assumptions about how patients ought to act. These latter assumptions constitute the informal rules of the doctor-patient encounter in general practice and McKeganey shows quite clearly that opiate abusing patients breach a number of these rules. Strong's (1980) interview-based work with Scottish GPs on their management of alcoholic patients detected similar themes. Strong argued that such consultations are

extremely problematic for the doctor as they break three broad principles that shape conventional medical practice: the assumption of medical expertise; the belief that medical matters fall largely within the 'natural' sphere of things; and the assumption that patients are normally motivated to comply with medical instructions.

Given the findings of Stimson (1976), McKeganey (1988; McKeganey and Boddy, 1988) and Strong (1980) it seems reasonable to conclude that GPs, like Jeffrey's (1979) accident and emergency doctors, might categorise patients as 'good' or 'bad' depending on whether they conform to or break the rules of the doctor-patient encounter. It also seems reasonable to hypothesise that such 'rule breaking' may be viewed as deviant and lead to 'punishment' of the patient by the GP. Possible options range from making 'bad' patients wait to see the GP through to removal of the patient from the GP's list. This hypothesis needs further empirical exploration.

#### (b) 'Good' and 'bad' doctors

The focus on this section has been on *doctors'* typifications of patients but, using an interactionist perspective, one would also expect patients to typify doctors into 'good' or 'bad' depending on whether they felt the doctor had conformed to or broken the informal rules of the patient-doctor encounter. There is rather less empirical research on *patients'* typifications of doctors, but three research papers describe patients' accounts of what constitutes a 'good' GP and a 'bad' GP (Calnan, 1988; Lupton *et al*, 1991; Arborelius *et al*, 1992).

Calnan (1988) conducted a qualitative study to explore, in detail, lay theories about medicine. He used a sample of 20 London women of differing social class.

Arborelius *et al*'s (1992) study was also qualitative and aimed to describe and understand patients' positive and negative experiences of GPs. Forty-six consultations were videotaped in four primary health care centres in Sweden. Afterwards the patients commented on the recorded consultations. The comments were categorized and analyzed using an exploratory qualitative approach. In contrast, Lupton *et al* (1991) surveyed 333 patients attending their GP in Sydney, Australia by means of a self-completion questionnaire. All three studies found similar definitions of what constitutes a 'good' and 'bad' GP and their findings are summarised in table 1.2.

A comparison of the properties of 'good' and 'bad' doctors suggests that Goffman's (1967a) analysis of social rules can be used to explain the findings. 'Good' GPs conform to the etiquette rules of social encounters as they treat the patient with 'respect'; in contrast, 'bad' GPs, by having a 'rude' manner and not listening to what the patient has to say, break these rules. 'Bad' GPs also do not act in accordance with Parson's (1951) obligations of doctors: they are incompetent and act for their own self-interest rather than the welfare of the patient. An additional rule of the encounter illustrated here, one not identified by Parsons, is that 'bad' GPs fail to treat patients as individuals and instead give them 'impersonal' care.

Two inferences from these research studies (Calnan, 1988; Lupton *et al*, 1991; Arborelius *et al*, 1992) are that patients have their own versions of the informal rules that govern the patient-doctor relationship and that their definition of the rules is complementary to the doctors' definition of the rules. Further research is, however, needed to explore in detail how such patients construct these rules in their day-to-day

encounters with GPs and whether, in any given encounter, both parties conform to or break these rules.

**Table 1.2 ‘Good’ and ‘Bad’ doctors in general practice**

<b>Category</b>	<b>‘Good’ Doctor</b>	<b>‘Bad’ Doctor</b>
<i>Affective</i> (interpersonal relationship)	Listens Treats you with respect  Gives a lot of time Genuine interest in patient’s welfare Treats you as a person	Doesn’t listen ‘Couldn’t care less’ attitude / rude manner Always in a hurry Only interested in making money Treat you as a patient, not as an individual
<i>Instrumental</i> (doctor’s competence & medical knowledge)	Good medical knowledge Knows what he is talking about Does not prescribe unnecessarily  If he’s not sure about it he seeks a second opinion	Poor medical knowledge Doesn’t know what is wrong with you Gives you pills without finding out why you need them or want them Ignorant and won’t admit it

Adapted from Lupton *et al* (1991: 566), Calnan (1988: 317) and Arborelius *et al* (1992: 214-215)

**(c) Summary**

An important sociological observation about ‘good’ and ‘bad’ patients and doctors is that they are the product of the interaction between patient and doctor. The informal rules that govern the doctor-patient encounter affirm the social roles of both patient and doctor and each party has, following Goffman (1967a), reciprocal obligations and expectations. As far as the doctor is concerned, to paraphrase Kelly and May (1982), the role of the ‘good’ doctor can only exist with reference to a ‘good’ patient. Thus the obligation of the doctor to treat a patient competently carries with it the expectation that the patient will comply with medical advice. Doctors symbolically

take the role of the patient both to make, and to make sense of their own role, and it is in so doing that the labelling of patients takes place. The 'good' patient is one who confirms the role of the doctor; the 'bad' patient denies the doctor that legitimation. Patients are defined as 'bad' by doctors precisely because they make it difficult for the doctor to carry out his social role. Similarly, the role of the 'good' patient can only exist with reference to the 'good' doctor. Thus the obligation that a patient should comply with medical advice carries with it the expectation that the doctor will treat the patient competently. Likewise, the 'good' doctor is one who confirms the role of the patient; the 'bad' doctor denies the patient that legitimation. Doctors are defined as 'bad' by patients because they make it difficult for the patient to carry out his/her social role.

### *1.5.3 Ending the doctor-patient relationship*

The Patient-centred medicine discourse acknowledges the fact that the doctor-patient relationship, particularly in general practice, can be seen as a long-term relationship in which both parties' perceptions of each other may change over time. This conceptualization of this relationship has been strongly influenced by Balint (1964) and is couched in psychotherapeutic terms: it allows a 'therapeutic' relationship to develop over time. Patient-centred medicine acknowledges that at times the relationship may not be 'therapeutic' as shown, for example, by the 'heartsink' phenomenon. But patient-centred medicine sees the 'heartsink' phenomenon as a problem for the doctor, not the patient, and one which can be addressed through a reduction in the GP's workload and training in counselling skills (Mathers and Gask, 1995). It has little specifically to say about what should happen when, in spite of such training, the GP still views a patient with intense dislike. In contrast, the RCGP's

guidance on removal, informed as it is by the tenets of patient-centred medicine, baldly states that the doctor-patient relationship may ‘irreparably’ break down (Royal College of General Practitioners, 1997). What is lacking is any description of the *ending* of the relationship, specifically, the process by which a patient becomes a ‘removed’ patient and what ‘relationship breakdown’ means for both practitioner and patient.

Drawing on theoretical insights obtained from interpretive sociology (G. McCall, 1970; M. McCall, 1970) I shall propose that rules and rituals govern the ending of the doctor-patient relationship as much as they govern its process. I shall then discuss the empirical evidence for such an approach, drawing on Hayes-Bautista’s (1976a, 1976b, 1976c, 1978, 1979) work on US Mexican-American (Chicano) patients and their medical practitioners. Hayes-Bautista’s work is important as it represents the only published empirical exploration of the phenomenon of ending the doctor-patient relationship. I shall conclude by using Duck’s critical review of the research literature on ending personal relationships to highlight the difficulties that may face researchers looking at the ending of the doctor-patient relationship.

#### (a) Ending a social relationship

One influential way of conceptualising social relationships has been to view them as a form of social organisation similar to small groups, bureaucracies and communities. This approach is associated with the sociologists George McCall (1970) and Michal McCall (1970) who proposed that a social relationship, like any social organization, has a history and a career that is constantly re-defined by each participant at each social encounter. As Goffman (1961) had previously proposed for social encounters,

G. and M. McCall proposed that a social relationship should also be seen as having rules and rituals governing its initiation, maintenance and ending. An important characteristic of a social relationship is that is characterized by having a focus for its members' activities and boundary rules for maintaining that focus. Boundary rules, like the rules of conduct (Denzin, 1970) discussed earlier, are partly determined by societal norms and partly emergent – that is, they are interactionally accomplished.

M. McCall (1970) offers this definition of boundary rules:

*Boundary rules of social relationships operate to protect their focus, the identities of members. First, and most basically, the boundary rules regulate the number and kind of activities to be shared by members. Second, the boundary rules screen out, in fact deny the existence of, other relationships. Third, the boundary rules regulate the number and range of identities allowed into and out of the social relationship, thus protecting and promoting intimacy (M. McCall, 1970: 45).*

Thus a personal relationship, as described here, may have intimacy as its focus with boundary rules maintaining intimacy. In contrast, the doctor-patient relationship has a different focus and a different set of boundary rules. For example, the doctor-patient relationship may require emotional detachment – what Parsons (1951) has termed 'affective neutrality' - as a boundary rule to maintain the professional objectivity that doctors require to treat their patients.

As a social relationship changes over time, a party to the relationship may become dissatisfied with the boundary rules or become alienated from its focus. Alienation occurs when one party no longer finds the focus as important as it had been previously. The alienated party may deliberately chose to break the boundary rules to indicate that there is a need to redefine the relationship. The ending of a social relationship can thus be seen as the ultimate breaking of the boundary rules in an attempt to redefine the relationship (M. McCall, 1970; Hayes-Bautista, 1976a).

(b) Hayes-Bautista - Termination of the Patient-Practitioner Relationship:  
Divorce, Patient Style

Hayes-Bautista's research on US Mexican-American (Chicano) patients in the 1970s used an interpretive approach. Its aim was to conceptualise and theoretically order the everyday assumptions, definitions and rules by which these patients constructed their health care action. The research involved 'around 200' Chicano patients (mostly women) in San Francisco and used both participant observation and open-ended interviews with the patients. These data were then analysed by the grounded theory method (Glaser and Strauss, 1967) to generate concepts, hypotheses and theories relating to the doctor-patient encounters. A series of papers was published covering access to health care (Hayes-Bautista, 1979), the classification and evaluation of medical practitioners (Hayes-Bautista, 1976c), modification of treatment and non-compliance (Hayes-Bautista, 1976b), and termination of the doctor-patient relationship (Hayes-Bautista, 1976a).

Hayes-Bautista (1976a) placed his work on the termination of the doctor-patient relationship within G. and M. McCall's (G. McCall, 1970; M. McCall, 1970) model of social relationships. 'Termination' was seen as a particular stage in the 'career' of the doctor-patient relationship. Hayes-Bautista rigorously applied the grounded theory method of Glaser and Strauss (1967) to determine the theoretical properties of termination as derived from patients' accounts of doctor-patient encounters. His findings are summarized as follows.

*Termination* (box 1.7) is defined as the end of a particular doctor-patient relationship. It may be initiated by either the patient or the medical practitioner or it may be the

result of 'overriding conditions', such as when the patient moves out of the area served by the practitioner. *Patient-initiated* termination comes about as a result of the patient evaluating the practitioner's medical care and concluding that it is inadequate. This inadequacy may be absolute or only come to light when the patient consults another practitioner and thereafter decides that her original practitioner is inadequate in comparison with the new practitioner. *Practitioner-initiated* termination is perceived by patients as being the result of their unwillingness to comply with the practitioner's advice, or due to the practitioner's self-recognized inability to handle an episode (e.g., termination consists of a referral to another physician with particular clinical expertise). Hayes-Bautista noted that when patients felt that the relationship was being terminated because they did not comply with medical advice, the patients perceived that the practitioner wanted either a permanent termination or a temporary one that would resume once the patient had learnt 'how to behave'.

**Box 1.7      Properties of termination of the relationship as experienced by the patient (Hayes-Bautista, 1976a):**

- *Desirability.* The patient may experience the termination as either sought or unsought. A sought termination is usually initiated by the patient whereas an unsought termination is doctor-initiated;
- *Duration.* Termination may be either temporary or permanent;
- *Closure.* In open-ended termination the patient now has no medical practitioner whereas in closed termination the patient has immediate recourse to another practitioner;
- *Anticipation.* The termination may be anticipated by the patient or be unanticipated.

Hayes-Bautista was also able to describe the various methods by which termination was accomplished by both practitioner and patient and these are summarized in box 1.8. In situations where one party wants termination, but the other party does not, the latter party may resort to *prolonging tactics*. Prolonging tactics were predominantly used by practitioners: the doctor could attempt to persuade the patient not to terminate the relationship by making claims on his medical expertise and by referring to his personal relationship with the patient. In contrast, the patient could only resort to prolonging the relationship by referring to her personal relationship with the doctor or by threatening confrontation if termination is carried out. Hayes-Bautista notes that there is a power differential in the relationship once a party has decided to terminate. The party initiating the termination simply has to refuse to do something: the patient simply does not attend; the doctor refuses to see the patient. In contrast, the party being terminated must attempt to change the other party's mind. This is likely to be difficult as the use of prolonging tactics may be counter-productive.

<p><b>Box 1.8</b>      <b>Methods by which termination of the relationship was accomplished by both practitioner and patient (Hayes-Bautista, 1976a):</b></p> <ul style="list-style-type: none"><li>• <i>Mutual withdrawal</i>, when both parties come to an agreement that the relationship has not worked out as either hoped and termination is the only way forward;</li><li>• <i>Confrontation</i>, when mutual withdrawal is attempted by one party but the other angrily refuses;</li><li>• <i>The 'fade-out'</i>, when patients, having decided to terminate the relationship, choose not to return to that particular practitioner;</li><li>• <i>The 'hand-off'</i>, when a practitioner refers a patient to another practitioner and does so for the specific purpose of terminating the relationship;</li><li>• <i>The 'put-off'</i>, when a practitioner, seemingly on purpose, refuses to accede to a patient's demands so that the patient loses patience with the practitioner and consults another doctor.</li></ul>
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Hayes-Bautista's work is the only published study that describes the process by which the doctor-patient relationship may be ended by patient and practitioner. Through a rigorous application of grounded theory (Glaser and Strauss, 1967) he is able to derive a model of termination that can be tested and refined in other health care settings. This model has yet to be applied to U.K. general practice. The title of the paper - 'termination of the patient-practitioner relationship: divorce, patient style' is also revealing as it suggests that the use of metaphors derived from marital relationships might usefully be applied to the doctor-patient relationship.

There are, however, three important caveats of Hayes-Bautista's (1976a) study. His account of termination is only based on the accounts of patients: practitioners' accounts of terminating the doctor-patient relationship are absent. He does not consider the status of the accounts he obtained from interviewing patients. These are retrospective accounts of termination of the relationship and, as Duck (1981) has noted, it is important to consider the functions such accounts serve in the interviewer-interviewee interaction and not to take the patients' accounts at 'face value'. Finally, he does not offer a detailed exploration of the insights termination could provide on the way in which power is generated and exercised by both parties in the doctor-patient relationship.

(c) Ending the doctor-patient relationship: lessons from the social psychology of personal relationships

G. and M. McCall's work (G. McCall, 1970; M. McCall, 1970) has also influenced social psychologists working in the field of personal relationships (Hinde, 1979, 1981; Duck, 1981, 1982). Duck (1981) provides a critical review of the social

psychological literature on the ending of personal relationships and makes the following important observations. First, in describing the process of ending a relationship it is important to get one's terminology right: the term 'breakdown' means different things to different researchers. Duck proposes that there is a distinction between 'breakdown' and 'dissolution': 'dissolution' or 'termination' refers to the permanent dismemberment of an existing relationship, whereas 'breakdown' refers to disorder in the relationship that may or may not lead to dissolution. Second, the literature almost entirely relates to marital relationships and it is unclear if general statements about ending social relationships can be generalised from the marital literature. Third, there is a lack of prospective research in this area.

As Duck notes:

*Research presently available for inspection focuses almost exclusively on one aspect: partners' retrospective analyses of the dissolution and of one another - after they know the fate of the relationship being described. Such work is likely to confuse the attribution of causality of the dissolution with the function or meaning that such an explanation has for the person (emphasis in original) (Duck, 1981: 22).*

Fourth, there is a need to explore the processes by which relationships are ended without imposing a prior theoretical model. Given that the ending of the doctor-patient relationship is largely uncharted territory it is important to be aware of the problems facing researchers working in related fields and all of Duck's observations are relevant to this thesis.

#### (d) Summary

Drawing on interpretive sociology, I argue that the ending of the doctor-patient relationship can be conceptualised as a stage in the career of a social relationship, and show how Hayes-Bautista (1976a) has used this approach to construct a model of the

termination of the doctor-patient relationship derived from Mexican-American patients' accounts of health care. I suggest the ending of the doctor-patient relationship, which I define as the process by which a patient becomes a 'removed' patient, needs further empirical study. Through a review of the social psychological literature on ending personal relationships I identify some of the difficulties that face researchers exploring this phenomenon.

## **1.6 Conclusions**

In this chapter I have reviewed the existing literature on the removal of patients from GPs' lists. The existing literature consists of detailed sets of guidance from professional bodies (GPC and RCGP) advising GPs as to how they 'ought' to act when faced with the possibility of removing a patient and a small amount of empirical research documenting the descriptive epidemiology of removal and a social policy perspective on removal. The guidance emphasises that removal is a rare event that should only be undertaken as a 'last resort' by GPs and should be a consequence of 'irretrievable' or 'irreparable' 'breakdown' of the doctor-patient relationship. Neither set of guidance offers a detailed definition of 'irretrievable breakdown'. The existing research literature has shown that patient removals occur relatively infrequently but there is a lack of rigorous qualitative research offering a 'rich' description of the removal process.

My review of the existing literature on removal was followed by considering removal in the context of a 'difficult' relationship between patient and GP. I presented

Stewart *et al*'s (1995) influential model of 'patient-centred medicine' and reviewed the evidence base for patient-centred medicine as it relates to removal, notably the requirement to negotiate a mutually acceptable solution to any difficulties and to maintain a 'therapeutic' doctor-patient relationship. I concluded that, in spite of a drive towards teaching GPs communication skills, there is little evidence that GPs share ideas and negotiate a mutually acceptable management plan in routine consultations. This raised the question as to whether GPs will do this when faced with a patient they perceive as 'difficult'. It was suggested that GPs may choose to use other strategies to deal with a 'difficult' patient other than attempting to resolve differences by 'finding common ground'. In addition, the notion of the 'therapeutic' doctor-patient relationship needs further empirical exploration. Patient-centred medicine has little specifically to say about what should happen when, in spite of training in counselling skills, a GP still views a patient with intense dislike and has difficulty maintaining any constructive or 'therapeutic' relationship with the patient.

In the final section of the literature review I showed how a sociological perspective could be brought to bear on the 'difficult' doctor-patient relationship. I suggested that 'patient-centred' medicine as presented in the general practice literature offered an inadequate conceptualisation of the 'difficult' doctor-patient relationship as it failed to adequately consider the power asymmetry between patient and doctor, the fact that doctors make moral judgements about patients in their day-to-day work and the nature of relationship 'breakdown' between doctor and patient.

In my review of power in the doctor-patient relationship I identified four key approaches to power: functionalist; conflict; Goffmanian; and Foucauldian. Taking

an interpretive position, I argued that future empirical research on the 'difficult' doctor-patient encounter in general practice needs to move beyond seeing such difficulties as attributable to communication 'failure' on the part of the doctor. It should look at the ways such difficulties arise out of the interaction between doctor and patient and relate them to the locally produced and necessary power differential between doctor and patient.

In my review of 'good' and 'bad' patients and doctors I showed that, in spite of claims to the contrary, doctors sometimes do typify patients into 'good' and 'bad' depending on whether or not they break the rules of the doctor-patient encounter. Patients come to be defined as 'good' or 'bad' as a result of the interaction between health care professionals and patients as opposed to their being something inherently 'wrong' with them in terms of type of illness or behaviour. I suggested that patients also typify doctors into 'good' and 'bad' doctors. I concluded that the rules of the doctor-patient encounter determine whether patient or doctor is viewed as 'good' or 'bad' by the other party.

Finally, I showed how the doctor-patient relationship could be conceptualized as a social relationship which has a history and a career that is constantly re-defined by each participant at each social encounter. In this model, the ending of the doctor-patient relationship can be explored by determining the rules governing termination of the relationship. I reviewed the work of Hayes-Bautista (1976a) and suggest that his description of the theoretical properties of termination of the doctor-patient relationship could be tested and refined in U.K. general practice. Removal offers a way to test his model as it represents a doctor-initiated ending of the relationship.

In the next chapter I begin the research process by presenting a summary of the methods used in this study. This is followed by a detailed description of the practicalities of the research process and a discussion of the theoretical position I adopt with regard to conduct and analysis of the interview data.

## **Chapter 2**

### **METHODS AND METHODOLOGY**

#### **2.1 Introduction**

In this chapter the focus is on the practicalities of the research process. I begin by summarising the methods used in the research. I then present a detailed description of the process of conducting the research, from planning the study to conducting the data analysis. This methods section is followed by a discussion of the important methodological issues raised by the study, notably how the interview data should be viewed and analysed.

The aim of the thesis is to explore the phenomenon of removal of patients from GPs' lists from the perspective of both GP and patient. It was therefore decided to conduct a qualitative study involving interviews with GPs and patients to access their retrospective accounts of the process of removal. The study was set in one English Health Authority (Leicestershire) and a descriptive epidemiological study of routinely collected health authority data was undertaken to inform the sampling strategy employed to recruit both GPs and patients into the study.

The GPs were recruited in one of two ways. 'Unpaired' GPs were sampled purposively from the list of GP principals held by the Health Authority in order that they represented as wide a spread as possible of GP and practice characteristics.

'Paired' GPs were recruited once the removed patient previously on their list had agreed to take part in the study. Twenty-five GPs were interviewed in 22 separate interviews. Eleven of the interviews were 'unpaired' and 11 were 'paired'. I interviewed the GPs and was viewed by the GPs as both a researcher and a fellow GP.

The patients had all been recently removed from a GP's list and were recruited following an initial approach by the Health Authority. Twenty-five interviews were conducted with 28 removed patients; the number of interviews is fewer than the number of patients because three of the interviews consisted of joint couple (household) interviews in which both partners had been removed. A non-medical Research Associate (Kate Windridge) interviewed the patients.

Semi-structured in-depth interviews were carried out with the study participants. The interviews were tape recorded and transcribed. I analysed each separate set of GP and patient interviews using the constant comparative method (Glaser, 1965). Systematic data analysis was assisted by the use of computer assisted qualitative data analysis software (NUD\*IST). The subset of interviews (11) where both GP and patient talk about the same removal event was treated as 'paired' data. These were a series of interviews in which the GP and the patient each gave their accounts of the same removal event. Analysis of the 'paired' data was carried out after the themes of the GP and patient interviews had been identified. This 'paired' analysis aimed to present each party's narrative about 'what happened' and to conduct a cross-case (GP-patient) comparison of the themes generated from each separate set of GP and patient interviews.

## 2.2 Methods

This section describes the process of conducting the research: how the epidemiological data was obtained and analysed, how participants were sampled, how access was negotiated, the form of the interviews and how the data were analysed. This description is based on entries in a reflective diary which I kept during the planning, recruitment, analysis and 'write up' stages of the PhD.

### 2.2.1 *Planning the study*

When the original research protocol for this study was drawn up in early 1998 the removal of patients from GPs' lists was a contentious issue and it has continued to be so throughout the conduct and writing up of the research (Dignan, 1998; Yamey, 1999). Removal has featured in the national press and in the weekly magazines GPs receive on a regular basis (*Pulse, GP and Doctor*). In addition, researchers have reported difficulties on conducting research on this area. For example, Buntwal *et al* (1999) tried to explore the issue of removal in an inner-city health authority in 1995/1996 but met with opposition from both the Local Medical Committee (LMC) and the health authority concerned.

I (TS) and my supervisors Mary Dixon-Woods (MDW) and Robert McKinley (RMcK) had two broad concerns when I set up the study. Firstly, there was a need to get all the key local stakeholders 'on board'. Secondly, there would be potential difficulties in recruitment of both patients and GPs into the study. These concerns were informed by our personal experience in previous research projects and a review

of the literature on strategies for negotiating access to primary care settings and subjects (Murphy *et al*, 1992).

I was concerned that the LMC might put barriers in the way of the study, as they had done in Birmingham with a qualitative study looking at why patients chose to change their GPs (Gandhi *et al*, 1997). In Gandhi *et al*'s study the LMC insisted that GPs should have the right to exclude any patient from being interviewed. I therefore wrote to the Leicestershire LMC as soon as funding for the project (which came from the Royal College of General Practitioners) and approval for the research from the Local Research Ethics Committee (LREC) (August 1998) had been obtained. This letter was written with the aim of securing LMC support for the aims and objectives of the study. I stressed the fact that the work was intended to be a rigorous piece of research, that I wished to put across both patients' and GPs' views on removal 'fairly and in a non-controversial manner' and that two members of the research team (myself and RMcK) were practising GPs and were 'aware of the pressures under which GPs work' and did not wish this research to be seen as 'yet another study criticising GPs.' We secured the co-operation of the LMC who were happy to allow us to state on our information sheet to GPs that they supported the project (*Appendix 2.1*). All members of the research team had a good working relationship with Leicestershire Health Authority: I had previously worked there as a registrar in public health medicine and MDW and RMcK had previously collaborated with the Data Services Manager - Colette Braidwood (CB) - on a project looking at the allocation of patients (unpublished). The final local stakeholder was the local Community Health Council (CHC) and we obtained the support of the chairperson of the CHC.

I and my supervisors believed that removed patients would be a difficult group to access. Macleod and Hopton (1998a) had obtained a 26% (58/221) response rate in their postal questionnaire survey of removed patients. We were concerned that a likely low response rate would be further reduced if a GP (myself) interviewed the patients in the study. We thought that patients would refuse to be interviewed by a GP as they would feel 'hurt' and 'angry' about recently being removed from a GP's list. We further felt that a GP interviewing patients would raise serious problems of ethics and theoretical sustainability. We therefore made a deliberate decision to seek external research funding for the project so that a non-medical Research Associate could be employed to interview the removed patients. As far as the recruitment of GPs was concerned, we thought that the fact that the research was being led by a GP and that a GP would be carrying out the interviews would facilitate access. Thus the combination of a non-medical researcher interviewing removed patients and a GP interviewing other GPs was felt to maximise recruitment of patients and GPs into the study, and was the most satisfactory solution to potential ethical and theoretical difficulties.

### *2.2.2 Descriptive epidemiology of removals from GPs' lists*

Routinely collected health authority data on removal covering the period 1<sup>st</sup> April 1998 to 31<sup>st</sup> March 1999 were obtained. This represented the calendar year prior to the start of the main study. Since April 1998 the data services department of Leicestershire Health Authority has recorded the following details on patients who have been removed from a GP's list but who have not changed address: name, address, age and sex of the patient; the registered GP; the date of removal and whether or not the patient had to be allocated to another GP's list. Reason for

removal was recorded only if the removal was an immediate removal for actual or threatened violence. Ethnicity could be ascribed to the removed patients on the basis of surname/forename analysis (Nicoll *et al*, 1986). One third of Leicestershire's population of approximately 930,000 lives in the city of Leicester, and 23.7% of the city's population can be classified as South Asian on the basis of the 1991 Census (22.3% Indian, 1% Pakistani and 0.4% Bangladeshi) (Balarajan and Soni Raleigh, 1992).

O'Reilly *et al*'s (1998a) definitions of removed patients were used. *Removal events* referred to the total number of removals; *removed patients* referred to the number of patients removed (repeatedly removed patients only counted once) and *removal decisions* referred to the decision by a GP to remove a patient and/or members of the same household (the removal on the same date of individuals who lived at the same address registered with the same GP practice was treated as one removal decision).

In addition, the information department of Leicestershire Health provided me with the following information about the 150 Leicestershire general practices: list size, number of GP principals and Townsend score. The Townsend score measures material deprivation (Townsend *et al*, 1988; Marsh *et al*, 2000). Practices with a Townsend score of less than or equal to zero were defined as 'affluent', those with a Townsend score greater than zero were defined as 'deprived' (Tobin and Packham, 1999). The removed patient's practice rather than registered GP is treated as the unit of analysis, as the GP who removed the patient may not be the 'registered GP' in a group practice.

Descriptive and simple summary statistics were calculated using *SPSS for Windows*, version 8.0.

### 2.2.3 *General Practitioners*

#### (a) Sampling strategy

The descriptive epidemiology of removal in Leicestershire which will be reported in chapter 3 was used to construct a quota sampling frame (*Appendix 1.1*) for the GPs. The GPs were sampled in one of two ways. ‘Unpaired’ GPs were sampled purposively from the list of GP principals held by Leicestershire Health Authority in order that they represented as wide a spread as possible of GP and practice characteristics (‘maximum variation sampling’) (Maykut and Morehouse, 1994). ‘Paired’ GPs were recruited once the removed patient previously on their list had agreed to take part in the study. Both sets of interviews ran concurrently.

#### (b) Negotiating access

Recruitment of GPs into the study took place between February 1999 and April 2000. The GPs were sent a letter informing them of the aims of the study (*Appendices 2.1* and *2.2*) and I telephoned them within two weeks of their receipt of the letter to determine whether or not they wished to take part in the study. At this telephone conversation both ‘unpaired’ and ‘paired’ GPs were briefed on the aims of the study, including the need to get a ‘balanced’ picture of removal by interviewing patients as well as GPs. The ‘paired’ GPs, however, if they agreed to take part at this point, were then specifically told that a non-medical researcher was interviewing removed patients, that I had no contact with the patients and that in the case of their practice we had interviewed a patient who had recently been removed. It was emphasised that

if the GP wanted to take part, both sets of interview were confidential, and that it was up to the GP as to whether he/she wanted to talk about this particular patient.

A total of 72 GPs were approached to take part in the study: 54 'unpaired' GPs and 18 'paired' GPs. A majority of GPs (53/72, 74%) agreed to take part, of which 25 participated. It was thought that both GPs and patients would be difficult to recruit and at the start of the study all GPs who had removed a patient from their list were approached with a view to contacting them again to arrange a 'paired' interview if the removed patient agreed to take part. After the first month of recruitment it became clear that it was patients, not GPs, who were proving difficult to access and I therefore decided to approach 'paired' GPs only if the patient they had removed had already been interviewed.

In sum, a total of 25 GPs were interviewed in 22 separate interviews (two 'group' interviews of 3 GPs and 2 GPs were carried out: both 'paired' interviews). Eleven of the interviews were 'unpaired' and 11 were 'paired'.

The response rate of 74% is high. Although data on response rates of GPs taking part in qualitative research is lacking, postal questionnaire surveys of GPs can have response rates as low as 30% (McAvoy and Kaner, 1996). I suggest that my 'insider' status as a GP helped me gain access to the GPs and I also offered them an hour's worth of Continuing Professional Development (PGEA). Of those GPs who did not wish to be interviewed, 'lack of time' was usually given as the reason, with the GPs stressing how busy they were with the NHS reforms. The GPs who did wish to be interviewed emphasised the need for their voices to be heard and strongly identified

with my prepared recruitment schedule statement that ‘some GPs feel that media representations of removal have been unfair to them’ (*Appendix 2.1*). Undoubtedly the fact that I was a GP encouraged GPs to see me as someone who would be sympathetic to their concerns and would be unlikely to ‘betray’ my own profession. This was evident from early telephone conversations even though I was at pains to point out that I wished to ‘present both sides of the story’ and that patients would also be interviewed. Several GPs explicitly checked that I was a practising GP before agreeing to take part. Five GPs were already known to me prior to the study and as the study progressed it became clear that word had got round the Leicester GP community that I was carrying out the study. Although the word ‘collusion’ is a little strong – perhaps ‘collegiality’ is better – there was definitely a sense of the GPs seeing me as someone who could be ‘trusted’ with potentially controversial information and this facilitated my access to GPs.

As far as the ‘paired’ interviews were concerned, it was a source of anxiety to me at the start of the study that the GPs would find the prospect of being interviewed about a patient they had removed as a ‘threat’ and that they would decline to take part. In fact, the majority of ‘paired’ GPs who refused to take part (8) did so at the beginning of my recruitment telephone call. Only two ‘paired’ GPs declined to take part once I informed them that a removed patient of theirs was to be interviewed. Nonetheless, several ‘paired’ GPs who agreed to be interviewed wanted reassurance that their comments would be treated in strict confidence and that, conversely, I should not treat the patient’s side of the story at ‘face value’.

### (c) Interviews

Both 'unpaired' and 'paired' GP interviews are considered together in this section as the content and form of the interviews did not appreciably differ between the two groups.

Semi-structured interviews were carried out with the GPs. These interviews consisted of a loose structure of open questions which defined the area to be explored and from which either myself or the GP could depart in order to pursue a topic in more detail. Patton (1990) defines such a list of questions as an interview guide.

The initial interview guide was developed from a review of the literature on removed patients and from discussions within the research team. Four broad areas were to be covered:

- A description of the GP's practice and practice population, including practice policy on removing patients;
- 'Difficult' patients: how they were defined and managed by the GP and/or practice;
- Relationship between patients who had been recently removed and the GP and/or practice;
- What events led to the removal of the patient and how was removal carried out.

The topic guide was emergent. It was not fixed from the outset but was reviewed after each GP interview and refinements were made as appropriate. When the first six interviews had been transcribed and analysed the guide was re-worked so as to focus

on the emerging categories of data. It was found necessary to develop two separate topic guides for the 'paired' and 'unpaired' interviews. The topic guide for the 'unpaired' interviews allowed the idea of the 'difficult' patient to be explored in more detail if the GP had had no personal experience of removing patients (*Appendix 3.1*). The topic guide for the 'paired' interviews allowed the nature of the relationship between the removed patient and the GP and/or practice and the events that led to removal to be explored in more detail (*Appendix 3.2*).

All but three of the 22 interviews were conducted at the GP's surgery, usually either after morning surgery or over lunchtime. The other interviews were conducted at the GP's home (2) or in a seminar room in the Department of General Practice, University of Leicester (1). The interviews lasted between 30 and 70 minutes.

#### (d) Data Analysis

I originally chose to carry out data analysis of the interviews manually, using a word processor programme (*Word 95*) to facilitate 'cutting and pasting' of the open codes (Burnard, 1998). I found this process very cumbersome and after I had coded two of the GP transcripts I decided to see if computer assisted qualitative data analysis software (CAQDAS) would aid analysis. I chose to use *NUD\*IST Version 3* (Non-numerical Unstructured Data \* Indexing Searching and Theorizing), a CAQDAS package that is widely used by qualitative researchers (Barry, 1998; Richards and Richards, 1998). I was impressed with the ease with which 'cutting and pasting' could be achieved using the software, the fact that the easy inspection of how units of text had been coded facilitated generation of categories and that it allowed me write analytic memos on the codes and categories. A criticism that has been levelled at

CAQDAS is that it distances researchers from their data and may be a substitute for rigour of analysis (Barry, 1998). I should stress, however, that I used NUD\*IST as an *aid* to analysis. All ‘thinking’ about the data was done on hard copies of the interviews, codes, categories and memos. Where NUD\*IST came into its own was that it allowed the easy re-grouping of open codes into themes and categories and had the ability to search for related words and phrases across categories which helped sensitise me to the relationships between different categories.

As I discuss in section 2.3.4 my methods of analysis drew on the grounded theory approach of Glaser and Strauss (1967), in particular, their method of constant comparison. The particular approach used here is based on the advice of my sociology co-supervisor (MDW) and two review articles on how to ‘do’ grounded theory in practice (Charmaz, 1995; Pidgeon and Henwood, 1996).

Although the constant comparison of codes and categories occurred throughout analysis, for ease of presentation data analysis can be broken down into four distinct stages: preparation of the transcript for analysis; open coding and generation of preliminary categories; definition of themes and categories and category integration: linking themes and categories. I also describe the timescale for each stage of the analysis which illustrates the labour-intensive nature of qualitative data analysis, even when aided with NUD\*IST software.

#### *Preparation of transcripts for analysis*

(March 1999 to August 2000)

Immediately after each GP interview I made notes on the conduct of the interview and what I considered to be the main items of discussion in my reflective diary. This information was referred to throughout the process of analysis.

One of the interviews consisted entirely of notes made immediately after the interview, as the GP refused to allow the interview to be tape-recorded. Another interview was only partially recorded as I forgot to turn the tape recorder on again after an interruption during the interview and the missing data were replaced with notes made immediately after the interview. The remaining interviews were transcribed by a departmental secretary, who was paid using funds from the research grant. I carefully checked the initial transcription against the recorded interview and made corrections and highlighted para-verbal cues (tone of voice, laughter, etc.) as appropriate. I also made further notes on the salient issues of the interview in my reflective diary. Hard copies of the interviews were made and they were also exported into NUD\*IST for analysis.

*Open coding and generation of preliminary categories*

(September to December 1999)

The first six GP transcripts were read and open codes applied to each in turn. A line-by-line analysis was undertaken and the text broken down into a multitude of codes which I felt reflected the meaning in each sentence/group of sentences. At this stage generation of codes proceeded sequentially, and no attempt was made to impose any prior framework on the data. The first six transcripts yielded 304 open codes in total.

These 304 codes were then read sequentially. As coding progressed groups of codes were gathered together into key descriptive (e.g., policy on removal) or theoretical (e.g., 'therapeutic' doctor-patient relationship) categories. The first GP transcript generated the highest number of codes and subsequent interviews contributed fewer new codes. At this stage the codes were constantly compared with each other, and memos relating to the codes and possible category/concept generation were written as appropriate.

A preliminary coding frame was then set up using the sequential list of open codes but which additionally highlighted the number of GPs who expressed a given code and links with other codes. As the codes were read NUD\*IST was used to identify the other codes which had been ascribed to the text and possible links between the codes explored. There was also a small amount of recoding of open codes as it became apparent that some codes were unclear and/or further clarification could be added. As the constant comparing of codes progressed, memos were written linking various codes into categories. Once the open codes had been read the process of categorisation continued with the grouping of linked codes into key categories and concepts, using the overall structure mentioned above. At this stage the preliminary themes and categories were given to MDW and she independently coded the first six transcripts using these themes and categories. I then met with MDW to discuss agreement on the open coding and initial categories. This resulted in several modifications to the categories as well as further elaborations of the specifications for the categories.

### *Definition of themes and categories*

(April to August 2000)

Once agreement had been reached between MDW and myself as to the broad categories emerging from the GP transcripts I then wrote a 3000 word summary of my findings to date which included detailed specifications for each category. These definitions were to be used to code the subsequent GP interviews – what Charmaz (1995: 40) terms ‘focused coding’ as distinct from ‘open’ or ‘line-by-line’ coding. This coding frame consisted of four themes each with a series of categories and subcategories, all of them with detailed specifications. The remaining GP interviews were then coded into this coding frame and, as coding progressed, the existing definitions of the categories were modified and new categories developed as appropriate. All the categories were the subject of analytic memos. Memo writing was crucial as it allowed me to explore definitions of categories, their relationships to other categories, emerging theoretical reflections and links to the relevant research literature (e.g., memo on ‘the properties of the doctor-patient relationship that stop it working’, *Appendix 4.2*). As coding of the GP transcripts progressed, ‘theoretical saturation’ was reached. Strauss and Corbin (1990: 188) define theoretical saturation as the point at which no new data emerges regarding a category, category development accounts for variation in the data and the relationships between categories are well established. In short, the point at which no new themes emerge from the data. Here, no new themes emerged after the 18<sup>th</sup> interview and later interviews served to confirm themes identified earlier in the analysis.

### *Category integration: linking themes and categories*

(August to November 2000)

After all the GP interviews had been coded the final thematic coding frame (*Appendix 4.1*), attendant categories and memos were assembled. The themes and memos were constantly compared and further analytic memos were written linking the categories to each other. This process was aided by drawing concept maps (Miles and Huberman, 1994) that illustrated important links between the categories (e.g., ‘What stops the doctor-patient relationship working?’ *Appendix 4.3*). At this stage explicit links were made between the findings of the research and previous theoretical concepts relating to the doctor-patient relationship. In addition, the themes and categories were re-read with two key questions in mind. First, what exactly were the narratives that the GPs used in talking about removal and what functions did such narratives perform? Second, what key metaphors were used by the GPs to ‘make sense of’ removal and how were they employed?

#### *2.2.4 Patients*

Kate Windridge (referred to as KW) conducted both patient recruitment and the patient interviews. She was between 40 and 50 years of age, of ‘white’ ethnicity and had previously worked with me on another sensitive topic: women’s accounts of services for genital chlamydial infection (Dixon-Woods *et al*, 2001). Her academic background was in psychology.

##### (a) Sampling strategy

The descriptive epidemiology of removal in Leicestershire to be reported in chapter 3 was used to construct a quota sampling frame (*Appendix 2.2*) for the patients. Inclusion criteria were all individuals/households who had been removed from a GP’s list without changing address in Leicestershire for the period 1<sup>st</sup> February 1999

to 28th February 2000. Exclusion criteria were immediate removal for violence, nursing/residential home removals and individual removals aged under 16. My original intention was to sample patients purposively so as to represent as wide a spread as possible of patient characteristics.

**(b) Negotiating access**

Recruitment of patients into the study took place between February 1999 and April 2000.

*Original recruitment strategy*

Ethical committee approval was obtained in August 1998 for an 'opt out' approach for recruitment. The names and addresses of patients who met the inclusion criteria were passed by Leicestershire Health Authority onto TS and KW and a letter informing these patients of the aims of the study was sent from the Department of General Practice and Primary Health Care, University of Leicester. The rationale was that this minimised the work of the Data Services Department, Leicestershire Health Authority and secured the participation of patients in the research. If the removed patients did not explicitly 'opt out' from taking part in the study then non-responders were to be followed up by a further letter inviting them to take part in order to maximise the response rate.

In March 1999, however, a removed patient complained to the Department of General Practice and Leicestershire Health Authority that his name had been disclosed to a third party (the University of Leicester) without his consent. Recruitment of patients was frozen for two months until the matter could be resolved.

Following discussion with the Chairman of the LREC, the Director of Public Health, and the Data Services Manager (CB) of Leicestershire Health Authority it was decided to move to an 'opt in' approach for recruitment managed by the party who held the database (Leicestershire Health Authority). Patients could only be approached to take part in the research by the research team if they had previously consented to release their names and addresses. It should be noted that during the seven months between original ethical committee approval for the study and the patient's complaint there was increasing national and local awareness of the implications of the *Data Protection Act 1988* (Act of Parliament, 1998) for access to patients' medical records and their use by any third parties. The key issue was that the University of Leicester constituted a 'third party' as far as data protection was concerned and the names and addresses of removed patients could not be disclosed to a third party without their explicit consent.

The study was able to recommence following the agreement of the Health Authority that it would undertake the initial phase of recruitment. I and my supervisors expected that an 'opt in' approach would lead to a low response rate and I renegotiated KW's research contract so that she extended the length of time she was employed to work on the project.

#### *Revised recruitment strategy*

Patients or households who met the study inclusion criteria were sent a letter from the Health Authority two weeks after their removal asking them if they wished to be sent information about the study (*Appendix 2.3*). If they consented, their names and addresses were passed onto me and they were then sent a letter signed by me

informing them about the study and asking them if they wished to participate (*Appendices 2.4 and 2.5*). Once the patient had returned the reply slip or left a message on the study answer-phone he/she was contacted by KW, usually by telephone, to arrange a date and time for the interview. At this telephone conversation the patients were informed about the overall aims of the study and that the removing GP was also to be approached to take part in the study. The patients were informed that the other member of the research team was a researcher who was also a practising GP. It was emphasised that the interviewer was not a medical doctor, did not have access to their medical records and had no contact with their previous or current GP.

The removed patients (RPs) proved a difficult group to access. Of the 393 eligible removal decisions only 60 (15%) consented to receive further information about the study. Of these 60 removal decisions 25 (42%) agreed to be interviewed: 18 were 'individual' removals and 7 were 'household' removals. Twenty-five interviews were conducted with 28 removed patients; the number of interviews is fewer than the number of patients because three of the interviews consisted of joint couple (household) interviews in which both partners had been removed.

Access may have been aided by the fact that the interviewer was non-medical. All except one of the patients had negative feelings towards the removing GP. Two patients went further and were openly critical of the fact that a GP was interviewing the removing GPs. They stated that a non-medical researcher should have interviewed both parties. These patients felt that the GP interviewer and GP

interviewee would collude together to present a version of the events surrounding removal that would portray the GPs in a favourable light.

The low response rate is consistent with postal questionnaire surveys of removed patients in Kent (Perry, 1995) and Lothian (Macleod and Hopton, 1998a). One consequence of the low response rate was that it was not necessary to quota sample the removed patients. Every patient/household who agreed to take part in the study was interviewed. Although I was not able to determine why non-responders did not wish to take part in the research I was able to determine why the interviewees had chosen to take part. The question as to why the patient had chosen to take part in the study was raised in the majority of the interviews (22) either spontaneously or as the result of a direct question by KW. An analysis of these responses reveals that the decision to take part was linked to the fact that the patients were either distressed or angry or both about removal. The patients wanted to show a third party that the GP had acted wrongly in removing them from his/her list.

### (c) The interviews

Semi-structured interviews were carried out with the patients. These interviews consisted of a loose structure of open questions which defined the area to be explored and from which either KW or the patient could depart in order to pursue a topic in more detail.

The initial interview guide was developed from a review of the literature on removed patients and from discussions within the research team. Four broad areas were to be covered:

- The relationship with general practitioner/practice before removal;

- How removal was conducted by the general practitioner/practice;
- How they went about finding another general practitioner and how they view their relationship with new GP/practice;
- ‘Good’ and ‘bad’ doctors: what do patients most value and/or dislike about GPs.

The topic guide (*Appendix 3.3*) was emergent. It was not fixed from the outset but was reviewed after each patient interview following discussion between KW and myself and refinements were made as appropriate. It was not possible to formally re-work the guide so as to focus on the emerging categories of data. The reason for this was that preliminary categorization of the first six patient interviews occurred after the majority of the interviews (22/25) had been completed.

Particular consideration was given to KW’s personal security as it was thought that some interviewees might have alcohol or drug problems and that a majority of interviews was likely to occur in patients’ homes in urban deprived areas. It was agreed that KW would carry a mobile phone and ring either myself or a member of the secretarial staff when she arrived at the patient’s house and again at the end of the interview.

All but two of the interviews were conducted in the patient’s own home, at a time convenient to the patient. The other two interviews were carried out in a seminar room in the Department of General Practice. The interviews lasted between 25 and 80 minutes.

Overall, a high level of emotional distress was displayed by the patients and in one case this necessitated extended discussion within the research team. I had been informally ‘warned’ by the Health Authority that the individual was a repeatedly removed patient who made numerous complaints and KW had identified these concerns in the initial telephone conversation with the patient. The high level of distress was manifested by the patient making a number of threats that he wished to ‘shoot’ unnamed GPs. The study team took the latter threat seriously, even though we felt it was an expression of distress rather than any serious intent, and the matter was discussed with the Local Research Ethics Committee. Following this, all subsequent interviews were recorded with a statement to the effect that while the interview data is confidential it may be disclosed to a third party if the interviewer feels that it is in the patient’s best interests to do so.

#### (d) Data Analysis

The same method of data analysis was used for both the patient and GP transcripts (section 2.3.4). The only difference related to the preparation of the transcripts for analysis.

#### *Preparation of transcripts for analysis*

(November 1999 to January 2001)

Immediately after each patient interview KW made notes on the conduct of the interview and what she considered to be the main items of discussion. These notes were similar in content to my own contemporaneous notes on the GP interviews and they were attached to the text of the interview in NUD\*IST (document memo) and referred to throughout the process of analysis.

All the interviews were tape recorded and were transcribed by a departmental secretary. KW checked the accuracy of the transcription before passing it onto me. I listened to the recording of KW's interview and made notes on the salient issues of the interview in my reflective diary as I did with the GP interviews. I also re-checked the corrected transcription against the recorded interview and made further corrections and highlighted para-verbal cues (tone of voice, crying, etc.) as appropriate. Hard copies of the interviews were made and electronic versions were exported into NUD\*IST for analysis.

*(Open coding and generation of preliminary categories*

(January to March 2000)

*Definition of themes and categories*

(December 2000 to February 2001)

Theoretical saturation was also reached with the patient interviews: no new themes emerged after the 14<sup>th</sup> interview and later interviews served to confirm themes identified earlier in the analysis. The final thematic coding frame is presented in

*Appendix 4.4.*

*Category integration: linking themes and categories*

(February to April 2001)

*2.2.5 The 'paired' data: general practitioners' and patients' accounts of the same removal event*

Analysis of the 'paired' data – GPs' and patients' accounts of the same removal event – was not carried out until after the themes of the GP and patient interviews had been determined.

I began the analysis by comparing the two sets of GP and patient themes and found the themes, identified in the separate analysis of the GP and patient interviews, that were being used by each party in relation to removal from a GP's list (chapter 6, table 6.1).

In their accounts of removal each narrator offered a story of removal that sometimes appeared disjointed and did not neatly fit into a temporally ordered version of removal. I organised each GP and patient 'paired' account so that each became a temporally ordered account or 'narrative' about removal with a 'beginning', 'middle' and an 'end'. The 'beginning' section constituted the description of the relationship that the parties had had with each other before removal. The 'middle' section constituted the events that were thought to lead up to removal and the 'end' section was the removal event itself and its aftermath. Using Mishler's (1995) terminology I thereby reconstructed the order of the told (an assumed sequence of 'actual' events) from the telling (an ordering of these events in their representation, as narrative).

Finally, I systematically compared each party's account of the removal process in relation to their use of the themes presented in table 6.1 (chapter 6). The accounts were dichotomised using the GPs' definition as to whether the removal constituted 'divorce' or was a case of the patient 'breaking the rules' of the doctor-patient encounter. This approach allowed me to determine which themes were being used by both parties, to describe how each party used a particular theme and to carry out a cross-case (GP – patient) comparison. The results were summarized in a matrix format (Miles and Huberman, 1994) (e.g., matrix relating to pair 9, *Appendix 4.5*) and analytic memos were written.

## **2.3 Methodological issues**

In this section I consider the important methodological issues raised by the research process. I begin by reviewing how the quality of the research may be ensured, paying particular attention to the key concept of reflexivity. This concept is illustrated by my reflections on how the interview data is the product of a particular interviewer-interviewer interaction: a GP and researcher interviewing other GPs and a non-medical researcher interviewing removed patients. I also summarise the theoretical position I have taken with regard to the interviews and the analysis and discuss some of the ethical issues relating to the presentation of the qualitative data.

### *2.3.1 Ensuring the quality of the research*

Murphy *et al* (1998) conducted a thorough review of the existing literature and proposed that the validity of qualitative research should be assessed according to five

criteria (box 2.1). Their proposals have been widely cited and form the basis of the guidance for authors submitting qualitative research papers to the *British Journal of General Practice* (British Journal of General Practice, 2002). I have paid attention to these criteria in the presentation of both the methods used and the results of the study.

Murphy *et al* identify reflexivity as crucial to rigorous qualitative research.

Reflexivity is defined as:

*A sensitivity to the ways in which the researcher's presence in the research setting has contributed to the data collected and how their own a priori assumptions have shaped the data analysis (Murphy et al, 1998: 188).*

In practical terms I paid attention to reflexivity by keeping a *reflective diary*. This covered my own constantly changing feelings, emotions, reflections and insights into the study and is summarised in box 2.2. It also considered the issues discussed in more detail in the sections that follow.

**Box 2.1**      **Criteria for ensuring the validity of qualitative research  
(Murphy *et al*, 1998):**

*Validity: The extent to which an account accurately represents the social phenomenon to which it refers (Hammersley, 1990: 57)*

- ***A clear exposition of the data collection method***
  - If one is to establish the credibility of the research findings then one must give an adequate account of the circumstances of their production. The researcher must therefore provide a detailed description of the process by which the data on which the analysis was based were collected.
- ***A clear exposition of the process of data analysis***
  - This will include the clarification of the concepts and categories used in the research and the demonstration that the conclusions are justified in relation to the data collected. Such assessment depends upon the extent to which the researchers have separated out the data and the analysis of the data, in presenting their conclusions. The trustworthiness of the researchers' analyses of their data is enhanced where researchers can demonstrate that they have considered alternative plausible explanations of their data.
- ***Evidence that reflexivity has been considered***
  - Qualitative researchers emphasise that it is not possible to separate the researcher from the researched. The analysis of research data should therefore involve a careful reflection of the ways in which the data have been shaped by the research process itself.
- ***Evidence of attention to negative cases***
  - Holistic bias has been identified as a major threat to the validity of qualitative research and is defined as the tendency to make the data look more patterned than it really is. The credibility of research reports is strengthened where researchers demonstrate that they have engaged in a conscientious search for data that are inconsistent with the emerging analysis. The careful search for such deviant or negative cases allows researchers to refine their analyses until they can incorporate all available data. Such cases should be reported and their relationship to the analysis discussed
- ***Evidence of 'fair dealing' in the analysis and reporting of data***
  - Many qualitative researchers are committed to the view that any phenomenon may be understood from a number of different perspectives. This commitment to multiple perspectives has major implications for the claims to truth of any research. The researcher must be wary of presenting the perspective of one group as if it defined the objective truth about the phenomena. Such 'fair dealing' should cover all the observed groups including the 'powerful' (e.g. GPs) and the 'powerless' (e.g. removed patients).

## **Box 2.2      Ensuring reflexivity: keeping a reflective diary**

The key elements of the diary were:

- ***My personal feelings towards the study***
  - The subject of patient removal elicited strong emotions in both parties being interviewed and I came across patients and/or GPs expressing views that I did not share (e.g. patients expressing racist views);
- ***My professional feelings to the study***
  - As a practising GP I interviewed other practising GPs. This meant that I could: gain access to GPs; have a common understanding of the issues involved; and quickly get to issues that were important. The chief problem was that I was very much part of the culture I was studying and found it difficult not to identify with the views expressed. It is likely that without self-reflection and discussion with my sociology co-supervisor (Mary Dixon-Woods) I would have been unable to detach myself sufficiently from the topic to be able to explore issues that I had previously regarded as 'common sense' (e.g., seeing removal as 'teaching patients a lesson'). A different problem confronted me when analysing patient transcripts. I noticed a tendency to impose a biopsychosocial framework (Dowrick *et al*, 1996), as I would with a 'real' patient, on patient transcripts. In other words, I sought an explanation of the patient's account in terms of some external model rather than being constructed from the accounts themselves;
- ***A reflection on how each interview 'went'***
  - The interview data is a product both of the respondent and the interviewer;
- ***My relationship with my co-researcher (research associate) who carried out the patient interviews (Kate Windridge: KW)***
  - It was important that I analysed patient transcripts with awareness of the contextual issues the co-researcher felt were salient;
- ***Reflections on the process of joint coding of the transcripts***
  - Joint data coding was carried out with my sociology co-supervisor to sensitise me to the way in which data should be coded and to question any 'taken for granted' assumptions in the coding process that were the result of my inexperience or, in the case of the GP interviews, my being a GP interviewing one's peers.

### 2.3.2 *The interviewer – interviewee interaction*

Until recently, the issue of how the researcher's presence had shaped the data collected was neglected in qualitative research published in medical journals (Hoddinott and Pill, 1997). Recent work has, however, considered issues relating to GPs and sociologists interviewing patients about heart disease (Richards and Emslie, 2000) and GPs interviewing other GPs about their management of low back pain and drug misuse (Chew-Graham, 1999; Chew-Graham *et al*, 2002). Both groups emphasise that the identity that the interviewee attributes to the interviewer is of crucial importance in forming the data that is collected from the interviewer – interviewee interaction. In this study a GP (who was also a researcher) interviewed other GPs and the removed patients were interviewed by a Research Associate (KW). I shall now deal with the conduct of each of these sets of interviews in turn and reflect on how the status of the researcher may have shaped the data collected.

#### (a) The GP interviews

As the GP interviews progressed I noted that sometimes the GP would talk in great detail about his or her personal feelings towards a removed patient, as if I were a fellow GP in the practice. At other times, however, it was clear that the GP saw me as a researcher trying to get to the bottom of why he/she had removed a particular patient. It was usual for the interview to move between these two 'modes' depending on the nature of the subject under discussion, although a small number of interviews were predominantly 'GP to GP' or 'researcher to GP' in form. As Brannen (1988) has noted, the power relationship between interviewer and interviewee in a semi-structured interview is complex and both parties are able to exert control.

*GP as colleague:*

I was viewed as a GP and therefore potentially as a colleague. Some GPs felt able to talk in great detail and with much feeling about the problems they had encountered with patients. This account was the sort of talk one GP would use when talking to another GP. The following frank statement of views about removal was made by a GP who was keen to establish at the beginning of the interview that the interview was confidential:

They [patients] do abuse you, they do make the most of you, take you for granted. There's very little respect for you, so I think I wouldn't take too big a deal for you to actually snap and just say "Oh sod it, just get off my list, I don't want to have to be bothered with you". (GP6)

The act of talking about a 'difficult' patient also led some GPs to express 'strong emotions' about the patient. Such emotions were primarily non-verbal and verbal displays of anger and irritation about a patient. At no time did any of the GPs, in contrast to the patient interviews, display emotional distress. Although I have had training in psychotherapy (as a member of a Balint group) and wondered if the interviews might be 'therapeutic' for the GPs – in the sense that an unburdening of deeply held emotions about a patient might help resolve the difficulties experienced with the patient ('catharsis') – I did not feel that the intensity of emotions felt during the interview equated to that experienced in a psychotherapeutic encounter.

I was also able to use my experience as a GP as a way into probing issues of interest:

TS: So, I hope I can reflect on my own experience as a GP here, that's you know it's perhaps sort of cases where I ... "oh my goodness that so and so again" and then they walk in and then you feel perhaps various feelings of anger or hopelessness or whatever, the concern may affect you giving them impartial care that they require.

GP: Yes, I mean this sort of hopeless heartsink types, well I think everybody has people like that and you just accept that, don't you, on the whole and just sort of live with it. (GP16)

Being a GP, however, also had problems. It was not simply that as a GP I shared the same 'world' as the interviewees and therefore found it difficult to recognise my 'taken-for-granted' assumptions of the situation (Britten *et al*, 1995) but that within the interview itself it was difficult to probe such assumptions precisely because, as a fellow GP, it broke conversational norms to 'ask the obvious' (Platt, 1981): it could present an image of being ignorant about the topic under study. In this extract that follows I felt 'uncomfortable' teasing out what I felt was 'obvious':

TS: I mean from what I'm saying then supposing you had a concern about a particular patient, would you try and therefore try and resolve it informally say by meeting with them or talking about it with them or?

GP: Yes we often do that.

TS: I'm not trying to state the obvious, it's just for the point of the interview I'm still trying to get a picture.

GP: No, no. Yes, we have complaints procedure.

TS: Right, right. So I guess, OK I think that's fine. (GP 20)

A further problem was that while GPs may have talked to me 'as one GP would talk to another'; the use of the term 'private' account (Cornwell, 1984) is misleading to describe this talk, as it implies that the GPs are sharing their 'true' feelings with a fellow GP (Rhodes, 1994; Radley and Billig, 1996). In fact, the GPs arguably tend to express views or emotions which might present themselves as acting as a 'good' GP - one who would draw approval from me, a fellow GP; it did not seem acceptable in the interview for the GPs to present themselves as 'bad' GPs to another GP. This point can be illustrated by the question as to whether or not GPs remove patients for

financial reasons. This is an important policy question as it features prominently in media discourses of removal (Yamey, 1999) and there is some research evidence to support this claim (Munro and Skinner, 1998). None of the GPs interviewed, however, stated that they had ever removed a patient on financial grounds. Indeed, the GPs were at pains to prove to the interviewer that such removals were seen as ethically unacceptable and a sign of 'bad' practice:

That would be desperately unethical, I mean, you can't do that, that's not allowed. (GP15)

Even if a GP admitted that a removed patient had also cost the GP practice money because of, say, excessive use of out-of-hours service, then it was the latter that was the stated reason for removal:

But don't think I would regard it purely on financial reasons to consider removing a patient. As I said there, it is negotiable and if this chap heard me when I was saying, if you continue to call the Out of Hours Service for paracetamol and repeat prescriptions. I may have considered it, but that is not financial only, it is for misuse [emphasis] of the service. (GP18)

In this case the GP had noted previously that the patient was ringing the 'out of hours' service twice a week to request paracetamol, at a cost to the GP of £15 a time. But in his account to me of his actions he stressed that the patient would be removed for a publicly acceptable reason - 'misuse' of the service. One GP went so far as to state while financial issues may have a bearing on a removal decision it was not publicly acceptable to state them as grounds for removal:

TS: Some people have suggested that doctors may be removing or may have removed patients for financial reasons and targets and that, is that something that you have got a view on?

GP: I think it does pressurise some doctors where they are trying to achieve a goal set by the government. If they're set a goal by the government to produce, erm, a percentage of immunisations or smears and they have a group of patients who are going to bar them for one reason or another, then there is inevitably going to be a temptation to say that we are better off without this patient for one reason or another. I think it's politically not acceptable to do that and this is the difficulty of politics. (GP17)

Thus the question as to whether or not GPs remove patients for financial reasons highlights the difficulty of accessing accounts of publicly 'unacceptable' behaviour by GPs, even when an 'insider' has conducted the interviews. As Strong (1979) has shown, the bureaucratic format of the consultation emphasises the ideal of service and it is not acceptable for doctors to be seen as 'money grabbing', even when talking to another GP. This causes a particular tension in general practice, given the fact that GPs are independent contractors who run their practices along the lines of small businesses. The implication of this is that we may never be able to determine if GPs remove patients for financial reasons, let alone quantify the phenomenon, by surveying a sample of GPs or by interviewing them 'in depth'.

*GP as researcher:*

As well as being seen as a GP and colleague, I was, by contrast also seen as a researcher accessing sensitive information (Lee and Renzetti, 1993; Lee, 1993). Some GPs saw the prospect of me interviewing them about patients they had removed as threatening and they wished to put on a 'best face' – they therefore offered what could be characterised as a 'public account': they told me what they thought the Department of Health or Royal College of General Practitioners might wish to hear (Cornwell, 1984). To do this they used a variety of strategies. One

notable strategy was controlling the length of the interview. In several instances I was made to feel that a 'very busy' GP had granted me a great favour by allowing me to interview him at his surgery over lunchtime, even if 'only for half an hour'. Indeed, as the interviews progressed I began to ask at the start of the interview 'how long have I got?' so that I could tailor the topic guide to the allotted time, although the GPs were given one hour's Postgraduate Educational Allowance (PGEA) as an incentive to taking part. Other strategies used by GPs included reading from prepared notes, not allowing the interview to be taped or bringing members of the practice staff into the interview to act as a 'witness' to corroborate the GP's version of events.

At times I felt that the GPs were trying to get me to collude with their accounts and in one case I was actually put on the spot and asked to agree that I would also have done likewise:

GP: Now you are a GP, doctor, would you do anything different?

TS: Would I do anything different?

GP: Yes.

TS: I think from what you have told me I think as a practice we would be in a very similar position because I think there would be the issue about how much we told and what could we honestly tell the relatives.

GP: Yes, that's what I thought. (GP22)

This extract clearly illustrates that I was expected to concur with the GP's version of events as he had portrayed his account of removal in such terms that I - a fellow GP - could not but agree that he (the GP) had acted with great patience and forbearance in dealing with a very difficult patient.

The fact that the interviews should be regarded as accounts given to serve certain specific functions was brought home to me in one interview when the GPs stressed that their practice had last removed a patient two years previously. According to the health authority data, however, the practice had made over 15 removal decisions in the previous calendar year. In this particular case I concluded that the GPs wished to present a publicly acceptable account of removal – one in which the removal of patients was seen to occur rarely. I should add that the confidentiality of the health authority data prevented me from openly challenging such accounts during the interview.

(b) The Patient interviews

The patient interviews consisted of long and detailed descriptions of the patient's illnesses and/or descriptions of the actions of the ex-GP and his/her practice with much use of reported speech. In addition, as previously noted, a high level of emotional distress was displayed by many of the patients.

A consistent feature of the interviews is that the patients stress that the GPs have behaved unreasonably. By 'telling the truth' to a third party, however, patients can share the distress and anger they feel about the injustice of removal with someone – they can attempt to 'right the wrong' of removal. The patients present themselves as 'witnesses' to what really happened, as the partner of a removed patient notes at the very end of an interview:

KW: Right, well that is everything I wanted to ask. Thank you all very much indeed and what we do ...

Partner: We were just speaking the truth, nothing else. (RP15)

The idea of a being a 'witness' is supported by the presentation of the letter of removal from the Health Authority to KW and the use of contemporaneous notes to 'prove' that an event had really happened. In two interviews the patients actually went so far as to ask if the interview could be used as evidence in a court of law against the GP. A common feature of the interviews was that partners or family present at the interview act in the interview to support the patient's version of events. Indeed, on a number of occasions KW was also put in a position where she could not but agree that the GP had behaved in a very unreasonable manner:

RP: If she'd [GP] have admitted she was wrong, I would have thought "well fair enough I will go and see another doctor, I won't see you anymore". Which is what I would have done, what I was going to do. Which again is what anybody would do wouldn't they?

KW: Yes, Yes.

RP: So I was just angry because she was using me for the reason, you know. (RP13)

The idea that patients seek approval from KW for their version of events leads on to an issue that I have already raised in relation to the GP interviews: 'public' versus 'private' accounts (Cornwell, 1984). As with the GP interviews, the patients tend to express views or emotions which might present themselves as acting as a 'good' patient or person - one who would draw approval from KW; it did not seem acceptable in the interview for the patients to present themselves as 'bad' patients to another person. Two examples merit discussion here: racism and aggression. Although the issue of racism was raised in three interviews in relation to a removed patient being 'white' and the removing GP being South Asian the patients took great

pains to prove during the interview that they were not racist, whatever the GP might say. This is how one woman put it:

RP: You know – this was a strange – this was a doctor took, well, Dr. X., he did come out, he come out the last time, and which I didn't like about it – he accused me of liking a white-faced doctor, not the colour of his face, now that's not right, because even at home [Scotland], my own doctor was from Malawi, and he, when I had my son in the house, he was at the confinement.

KW: Yeah.

RP: So not that I am racist or anything. (RP14)

The patient pre-empts any criticism that she is racist by using the strategy of 'credentialing' (Hewitt and Stokes, 1975). She shows that she 'got on' with a previous African GP. A further example of 'impression management' (Goffman, 1959) is the way in which no patient admits that he/she was violent or aggressive towards the GP. Note how this man describes a previous removal by a GP:

RP: Erm, I had been taken off the register before but I had, I did end up having an argument with the doctor [patient smiles] so that was the reason why I got taken off the register.

KW: Right, and did you. You know what happened then in that case?

RP: Erm, that erm he was being fine with me until he realised I had been in prison and then like he sort of, he turned funny once he realised I'd been in prison. It's like one ... [?] Do you know what I mean?

KW: So how did he find out you'd been in prison?

RP: It come out in a conversation.

KW: Right, yes. And then after that, what happened?

RP: We had a little argument [patient laughs]. (RP11)

The para-verbal cues suggest that the ‘argument’ may possibly have been more than a mere ‘exchange of views’.

This reflection on the ways in which the interview data has been shaped by the interviewer-interviewee interaction highlights the fact that the interviews should be regarded as accounts given to serve certain specific functions. Thus the GPs chose to regard me as a GP and potential colleague as well as a researcher accessing sensitive information. The patients present themselves to KW as credible witnesses: they seek to demonstrate that their version of ‘what happened’ is the correct one, irrespective of what their ex-GP might say.

### *2.3.2 The status of the interview data*

The above discussion of how the interview data have been shaped by the interviewer-interviewee interaction leads onto a more general consideration of methodological issues relating to the interview.

Interviews were conducted with GPs and patients to access their retrospective accounts of removal. A key issue is the stance that I take towards the status of these accounts given to me by the GPs and to KW by the removed patients. I have chosen to treat the interview data as the product of the interaction between the interviewee and interviewer, and am mindful that the claim that interview data offer unproblematic access to GPs’ and patients’ ‘experiences’ that could be verified for their ‘truth’ has been the subject of much sociological criticism (Cunningham-Burley, 1985; Dingwall, 1997; Silverman, 1998). At this stage, it seems appropriate to offer a summary of this position as I shall discuss the critique with reference to my

own findings in chapter 7. Such a summary is provided by Melia (1997) who reports that she undertook a study of the occupational socialization of student nurses which relied exclusively on informal interviews. She used this work to reflect on whether the interview data explained the student's social world and offered the following succinct observation:

*Informal interview data are yielded by a series of questions and general lines of enquiry embedded in a seemingly natural conversation with the interviewee. The data can be seen, then, as an account of the interviewee's opinions and views, arrived at as a result of the interaction with the researcher ... We can view the interview as a presentation of self by the interviewee with the data as a representation that has no further credibility. Or we can see the interview as a means of gaining insight into a world beyond the story that the interviewee tells, a means of getting a handle on a more complex set of ideas than the ones that the interviewee is ostensibly talking about (Melia, 1997: 34).*

I do not regard interviews as simply an exercise in 'impression management' (Goffman, 1959) nor as allowing unproblematic access to what respondents 'truly' feel or believe. Rather, I adopt a 'middle position' in which it is necessary to: a) attempt to 'make sense' of the accounts given of removal from the perspective of both GP and patient and to place these accounts within a more general theoretical framework of the rules governing the doctor-patient relationship; b) pay explicit attention to the functions that the narrative of removal serves in the interviewer-interviewee interaction. The chosen methods of data analysis allow me to achieve both these goals.

#### 2.3.4 Data analysis

In this section the principles underlying the chosen methods of analysis are summarised. It is important to note that I treat each dataset separately prior to my

analysis of the subset of interviews in which each party gives their account of the same removal event.

(a) GP and patient interviews treated as separate datasets

In my attempt to ‘make sense’ of the accounts given of removal from the perspective of both GP and patient and to use these accounts to explore and develop existing theory on the doctor-patient relationship I have chosen to use the *constant comparative method* of analysis as first outlined by Glaser in 1965:

*While coding an incident for a category, compare it with the previous incidents in the same and different groups coded in the same category ... This constant comparison of the incidents very soon starts to generate theoretical properties of the category. One starts thinking in terms of the full range or continua of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, the relation of the category to other categories, and other properties of the category (Glaser, 1965: 439).*

The key element here is the continual comparing and refining of codes and categories as data analysis proceeds. This well-known method of qualitative data analysis is an important part of the more general *grounded theory approach* developed by the American sociologists Glaser and Strauss in the 1960s. I have reviewed the original description of grounded theory (Glaser and Strauss, 1967) and more recent formulations (Strauss and Corbin, 1990; Charmaz, 1995) and summarise its key components in box 2.3.

**Box 2.3 Key components of the grounded theory approach:**

- Data collection and analysis should proceed iteratively;
- Ensure that analytic codes and categories are developed from the data, not from preconceived hypotheses;
- Develop theory grounded in the data to explain observed phenomena. Grounded theory should be inductively derived from the study of the phenomena it represents. It therefore requires the researcher to use the respondent/participant's own account of events and the context within which they occur;
- Use memo writing. Memos are defined as analytic notes to explain categories. Memo writing is seen as a crucial step between coding data and the final write up of the research;
- Use theoretical sampling to check and refine the emerging conceptual categories. Theoretical sampling is the selection of cases to test and develop theory as opposed to, for example, sampling for representativeness;
- The literature review should be delayed until after the main conceptual analysis of the data has been completed.

Although Glaser and Strauss's work has been extremely influential there are few researchers who use the grounded theory approach in its entirety. Two key problems with the grounded theory approach have been identified: one practical, the other theoretical. On a practical level it has been argued that the practicalities of qualitative fieldwork, such as the time lag between the tape recording of interviews and transcription, mean that it is extremely difficult to ensure that data collection and analysis occur iteratively and thereby allow theoretical sampling to occur (Bryman, 1988). This was the case in this study: the preliminary coding and categorization of the first six GP transcripts coincided with me having completed interviews with half of the GPs and preliminary coding and categorization of the first six patient

transcripts did not occur until the majority of the patient interviews had been completed. A further difficulty with the grounded theory approach in its 'pure' form is the proposal that the relevant literature should not be reviewed until the conceptual analysis is complete. In this study a draft literature review was undertaken at the beginning of the research which formed the basis of the topic guides for both the GP and patient interviews. Once the analysis was complete this review was comprehensively re-written to reflect the findings of the study. A more substantive criticism of grounded theory rests on its proposition that it is possible to generate theory *de novo* without reference to existing theory (Bulmer, 1979) and without a prior literature review. It is difficult to see how any researcher can put pre-existing theory to one side until the main conceptual analysis has been undertaken. A more useful approach would be to identify the origin of the theory used, be it inductively derived from the data or 'deductively' derived from other studies. This is the approach used here.

(b) GP and patient interviews treated as 'paired' accounts of the same removal event

The above discussion relates to the treatment of each separate dataset. Thus the GPs' accounts of removing patients and the patients' accounts of being removed are each broken down into a long list of open codes which are then re-assembled to form conceptual categories which illustrate and develop existing theory on the doctor-patient relationship. This is an important overall aim of the study but an unintended consequence is that individual GP's or patient's stories or narratives of removal may be fragmented into individual categories.

This study, however, has a third dataset: a series of interviews in which the GP and the patient each give their accounts of the same removal event. As pointed out in the previous section, I do not hold the position that the interview data provides an unproblematic account of ‘what really happened’ which would allow me to treat each dataset as a factual record and weigh up which was more or less likely to reflect ‘the truth’. Given that it is likely that both parties, when being interviewed, will be concerned with presenting their actions as reasonable and ‘correct’ one would expect that there would be little agreement between the paired accounts. I will therefore analyse the paired accounts so as to show what each party is trying to accomplish in the interview by giving their story or narrative of the removal process. This approach is consistent with current sociological research in fields where it is usual to analyse two parties’ versions of the same event. Thus Allsop and Mulcahy (Allsop, 1994; Mulcahy, 1996; Allsop and Mulcahy, 1998) note that, in sociolegal studies of complaint making in the NHS, the focus has moved from seeing complaints and their responses as competing realities to be adjudicated upon, towards an approach which accepts lay and professional accounts as equally valid discourses to be analysed and explained. A similar approach has been used in research looking at both parties’ accounts of divorce mediation (Cobb, 1994).

I therefore adopt the theoretical position that both parties’ accounts of removal should be treated as narratives that are constructed in the research interview. Such narratives have a variety of functions (Hyden, 1997; Bury, 2001). They offer a window on the subjective ‘experience’ of removal as perceived by both GP and patient. But they also present the self-image that the GP and patient wish to convey to the interviewer. As Riessman (1990: 1197) notes ‘narratives are always edited

versions of reality, not objective or impartial descriptions of it, and interviewees always make choices about what to divulge’.

Moving onto the methods used to analyse the ‘paired’ data I have chosen not to carry out a formal narrative analysis as advocated by researchers such as Riessman (1990, 1993). The rationale for this is that such an approach would be a substantial undertaking which would constitute a study in itself. Instead, I present the narratives of removal in such a way as to facilitate cross-case (GP-patient) comparison of themes generated from an analysis of each separate set of patient and GP interviews.

### *2.3.5 Ethical issues relating to the presentation of qualitative data*

This thesis attempts to interpret the phenomenon of removal in terms of the meanings ascribed by GPs and patients. Crucial to this interpretive approach is a commitment to view reported events and values from the perspective of those being interviewed (Bryman, 1988). One important way this is achieved in qualitative research is to present extracts from the interview data as the participant’s own words can often illustrate the meaning of a particular theme or category better than a paraphrase of events reported by the researcher. In this thesis such extracts have already been used to illustrate the relationship between interviewer and interviewee in this chapter and will illustrate the findings of the study in chapters 4, 5 and 6. The use of extracts from interview data, however, raises three important ethical issues which have been highlighted elsewhere in the qualitative research literature (May, 1991a; Lee, 1993; Britten *et al*, 1995) and which merit consideration here: the protection of participants’ confidentiality and anonymity; the grounds for choosing a particular extract for inclusion; and the issue of whether or not the participant’s own

interpretation of events is preserved in what is often a short extract from a much longer body of speech.

Medical (Jones *et al*, 1995; General Medical Council, 2001b) and social research ethics (British Sociological Association, 1994) place great stress on the need to preserve the confidentiality and anonymity of participants in research studies. My study was approved by the Local Research Ethics Committee and both the patient and GP information leaflets (*Appendix 2*) emphasised that the interview data would 'remain strictly confidential'. The use of extracts from the interviews, however, potentially breaches confidentiality and anonymity as the research subjects are likely to recognise themselves in any verbatim quotations presented in this thesis or any subsequent reports or research papers (Jones *et al*, 1995). In this study this difficulty applies to both the separate GP and patient accounts (chapters 4 and 5) and the 'paired' interviews (chapter 6). Indeed, it is a particular problem in relation to the 'paired' interviews as the chosen method of presentation of the 'paired' data is to report three detailed case studies that allow a detailed description of the process of removal from the perspective of both patient and GP.

I have protected participants' confidentiality and anonymity in this chapter and in the separate GP and patient accounts (chapters 4 and 5) by limiting the amount of demographic identifier data presented with the extract (i.e., I do not give the participant's age, sex, location or ethnicity unless it is required contextual information) and by using fictitious names for patients and GPs. In a number of cases I have altered the gender/location/illness of the participant and/or individual referred to by the participant when I felt that participants/individuals referred to were likely to

recognise themselves in the extract. In the case of the ‘paired’ data it is likely that participants and individuals referred to in the narrative will identify themselves unless the accounts are disguised. I have therefore disguised the narratives of removal presented in chapter 6 by altering key details of the stories (e.g., the gender, location and nature of the illness described may have been changed) but at the same time I have endeavoured to maintain the ‘sense’ of the stories.

As far as the grounds for choosing one particular extract rather than another to illustrate a particular theme or category presented in chapters 4 and 5 are concerned I have deliberately chosen extracts that I feel best reflect the emergent theme or category. I have avoided the use of extracts that offer an extreme perspective and thereby appear to court controversy unless they make an important contribution to the development of the category under consideration.

Lastly, I have tried to present each participant’s point of view in sufficient detail so as to preserve the participant’s intended meaning and, whenever possible, have offered contextual information in relation to the extract. To this end I have only changed the wording of the extracts presented in chapters 4 and 5 when I felt that the confidentiality and anonymity of the participant and/or individual referred to by the participant was under threat. As noted in section 2.3.1 and highlighted in my letters to the study participants (*Appendix 2*), I aimed to be even-handed in my presentation of each party’s account of the removal process and have tried to ensure that equal weight is given to the perspectives of the GPs and the patients.

## 2.4 Conclusions

This chapter has described the practicalities of the research process. The emphasis was on presenting the methods of the study in such a way as to ensure the quality of the research (Murphy *et al*, 1998). I therefore provided a detailed account of how the interview data was produced; how the themes and categories were developed from the data; and reflected on the ways in which the data were shaped by the research process itself. I also considered the ethical difficulties faced by the presentation of qualitative data. The need to protect the confidentiality and anonymity of participants and the ways this can be achieved were discussed.

I began my detailed account of the methods by noting that removal was a controversial topic at the start of the project and continued to be so during the conduct and write up of the research. There was therefore good reason to be concerned about gaining access to both GPs and patients at the start of the study. I argued that the decision to have two separate interviewers was necessary to facilitate access to both the GPs and the patients. Thus a GP (myself) recruited and interviewed other GPs and a non-medical Research Associate (KW) recruited and interviewed patients.

A crucial aspect of the description of how the interview data was produced was the demonstration that the interviews served a variety of functions. On the one hand, they offered access to the subjective experience of 'removal' as described by both GP and patient. On the other, they could be seen as presenting the self-image that the GP and patient wished to convey to the interviewer. Thus each party gave an account of

removal that presented him/herself in a favourable light, as a 'good' GP or patient. This point was illustrated by the fact that none of the GPs chose to reveal to me that they frequently removed patients from their list or that they removed patients on financial grounds. Similarly, none of the patients chose to reveal to KW that they held 'racist' views or had been violent towards the GPs. Analysis of both the separate GP and patient interviews and the 'paired' interviews therefore needs to pay attention to both 'what' and 'why': 'what' is it that the GPs and patients are saying (their subjective 'experience' of removal) and 'why' do they choose to give this particular version of events (the functions that their account serves in the interviewer-interviewee interaction). In this respect, the ways in which the data has been shaped by the research process itself is crucial. In the GP interviews I showed that the GPs chose to regard me as a GP and potential colleague as well as a researcher accessing sensitive information. In the patient interviews the patients presented themselves to KW as 'witnesses to the truth', they sought to demonstrate that their version of 'what happened' is the correct one, irrespective of what their ex-GP might say.

The next chapter presents the results of the descriptive epidemiology of removal which were used to inform the sampling strategies described in sections 2.2.3 and 2.2.4 of this chapter.

## Chapter 3

# DESCRIPTIVE EPIDEMIOLOGY OF REMOVALS FROM GENERAL PRACTITIONERS' LISTS

### 3.1 Introduction

In this chapter I present the descriptive epidemiology of removals from GPs' lists in Leicestershire for the calendar year prior to the start of the main study.<sup>1</sup> The work uses routinely collected health authority data and I use the same methodology as that reported in other studies discussed in chapter 1 (O'Reilly *et al*, 1998a; Munro and Skinner, 1998).

The rationale for this work was to construct a quota sampling frame for GPs and patients to be included in the main study (*Appendices 1.1 and 1.2*) that would allow the sample to be representative of the population of removed patients and general practices in Leicestershire. I am therefore cautious about using this data to speculate on possible reasons for removal or why certain groups of patients appear to be removed more frequently than others. As I have discussed in chapter 1, routinely collected health authority does not allow the reasons for removal to be ascertained and does not offer insight into the process of removal.

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<sup>1</sup> The use of the term 'descriptive epidemiology' should not be seen as medicalising the social phenomenon of 'removal'. It is merely an accepted way of summarising quantitative data on removal.

## 3.2 Results

The results refer to the period 1<sup>st</sup> April 1998 to 31<sup>st</sup> March 1999.

### 3.2.1 Patients

There were a total of 812 removal events (repeatedly removed patients were counted each time they were removed). There were a total of 783 removed patients. Of these 51% (401/783) were household removals, 39% (306/783) were individual removals and 10% (76/783) were residential or nursing home removals. A quarter of these patients (26%, 206/783) were assigned ('allocated') to another GP's list. A minority of removed patients (20/785, 2.5%) were repeatedly removed from a GP's list (range of frequency of removal: 2-4, mean 2.5). Only a minority of removal events were immediate removals for violence (35/683, 5%).

The age distribution of removed patients is shown in tables 3.1 and 3.2. It differed depending on whether they were removed as part of a household or individually. Patients aged under 20 years of age constituted 45% (180/401) of all household removals whereas patients aged 20 to 50 constituted 63% (193/306) of all individual removals. More male than female patients were removed (53% versus 47%,  $\chi^2 = 5.64$ , 1df,  $p = 0.017$ ). Over three quarters (79%, 618/783) of removed patients lived in the city of Leicester. The proportion of removed patients in Leicester who were South Asians (37%, 229/618) differed significantly from the proportion in the population (37% versus 24%,  $\chi = 57.6$ , 1df,  $P < 0.0001$ ).

**Table 3.1. Age distribution of removed patients who were household removals (n = 400)**

Age range	Number (%) of removed patients	
0 - 9	120	30
10 - 19	58	14
20 - 29	72	18
30 - 39	74	19
40 - 49	36	9
50 - 59	13	3
60 - 69	19	5
70 - 79	8	2
80+	0	0

**Table 3.2. Age distribution of removed patients who were individual removals (n = 302)**

Age range	Number (%) of removed patients	
0 - 9	8	2
10 - 19	14	5
20 - 29	69	23
30 - 39	73	24
40 - 49	48	16
50 - 59	33	11
60 - 69	29	10
70 - 79	21	7
80+	7	2

### 3.2.2 General Practices

There were 453 removal decisions by Leicestershire general practices. Of these 72% (324/453) were individual removals, 27% (124/453) were household removals and 1% (4/453) were residential or nursing home removals.

A majority (68%, 105/154) of Leicestershire practices had made at least one removal decision (range: 0-56; mean 2.9; standard deviation 5.55). The upper quartile of Leicestershire practices made 4 or more removal decisions and I termed these 'high' removers; the remaining practices had made 3 or less removal decisions and were termed 'low' removers.

Practices were dichotomised, using Townsend scores, into serving 'affluent' and 'deprived' areas. Practices in deprived areas made a significantly higher number of removal decisions than those in affluent areas (mean deprived removal decisions 5.1 versus mean affluent removal decisions 1.1,  $Z$  6.11,  $p < 0.0001$ , Mann Whitney  $U$ -test).

### **3.4 Discussion**

The interpretation of routinely collected health authority data on removals is a difficult matter. The reason for removal is not recorded except for 'immediate' removal for violence. The need to differentiate between removed patients and removal decisions so as to adjust for the confounding effect of household removals makes it difficult to decide which comparative population denominator data should be used (e.g., data relating to household or to individuals). Ethnicity poses two particular problems. First, the label 'South Asian' as ascribed by name/forename analysis groups diverse populations together, e.g. Muslims, Sikhs and Hindus and individuals who originated from East Africa as well as the Indian subcontinent. Second, Leicester's 'South Asian' population is not evenly registered with GPs

throughout the city but is clustered around a small number (12) of general practices (Hsu *et al*, 1999).

Nonetheless, the limited conclusions that can be drawn from the data are consistent with other published studies (O'Reilly *et al*, 1998a; Munro and Skinner, 1998). The removal rate of 2.9 per GP practice per year confirms that it is uncommon for a patient to be removed from a GP's list, although it is noteworthy that a sizeable number of people – nearly 800 – are affected. It is also true that many patients who are removed appear to be successful in re-registering with another GP voluntarily but over a quarter (26%) of removed patients required assignment ('allocation') to another GP's list by the health authority. Individual removals account for the majority (72%) of removal decisions and the age distribution of the data suggests that household removals are often adults with young children.

Although I differentiated general practices into 'high' and 'low' removing practices on the basis of numbers of removal decisions over the study period it is unclear whether this indicates a real difference between the practices in terms of removal behaviour: four or more removal decisions per practice is still an uncommon event. Nonetheless, practices in deprived areas do seem to have higher rates of removal than those in affluent areas. This is consistent with the finding in Northern Ireland that removal rates were most closely associated with family poverty (O'Reilly *et al*, 1998a). The question of ethnicity and removal rates has not hitherto been explored. The apparent excess of removals of South Asian patients noted here is possibly due to confounding variables such as clustering of registration with a small number of general practices, different age/sex distribution in the population and deprivation. In

the absence of a multivariate analysis to adjust for these variables it is premature to conclude that South Asian patients are more likely to be removed from a GP's list in Leicestershire.

### **3.5 Conclusions**

The purpose of carrying out an analysis of the descriptive epidemiology of removals in Leicestershire was to describe the characteristics of removed patients and their general practices so as to inform the quota sampling strategy for the qualitative interviews. In this respect the data suggest that it will be important to ensure that patients are recruited from deprived urban areas and from Leicester's sizeable South Asian population. As far as the GPs are concerned it will be important to recruit single-handed and group practice GPs who work in urban deprived areas, including those who qualified in medicine in the Indian subcontinent (Taylor and Esmail, 1999).

In the next chapter I present the first of the three main results chapters: the GPs' accounts of removing patients from their lists. I have chosen to present the GPs' accounts before the patients' accounts on chronological grounds as the GPs' accounts were analysed first.

## Chapter 4

### GENERAL PRACTITIONERS'

### ACCOUNTS OF REMOVING PATIENTS FROM THEIR LISTS

#### 4.1 Introduction

In this chapter I present an analysis of the retrospective accounts of removal given to me by 25 GPs in 22 interviews. I treat these retrospective accounts as narratives that are jointly constructed by the GPs and myself to perform a variety of functions. As I have previously argued, two important functions are the respondent's own need to present a particular image of self (Riessman, 1990) by presenting a coherent and reasonable version of events, together with my own desire to present the events as an orderly story. As Mishler (1995) puts it:

*It is clear that we do not find stories; we make stories. We retell our respondents' accounts through our analytic redescriptions. We too are storytellers and through our concepts and methods ... we construct the story and its meaning. In this sense the story is always co-authored, either directly in the process of an interviewer eliciting an account or indirectly through our re-presenting and thus transforming others' texts and discourses (Mishler, 1995: 117-118).*

I will therefore attend to both 'what' the GPs are saying and 'why' they are saying it. It should be stressed, however, that suggestions that the GPs' (and patients') accounts of removal are constructed is not the same as saying that the accounts are 'fabricated.' Although we cannot compare the GPs' (and patients') retrospective accounts against direct observation of the events under scrutiny or the contemporaneous medical record (except in terms of number of removal decisions

made per practice in the previous calendar year) I will argue that my analysis of GPs' accounts of removal offers a number of important insights into a poorly understood phenomenon. These insights have significant implications for GPs, patients and policy makers.

## **4.2 The Participants**

Twenty-two interviews were conducted with 25 GPs. The number of interviews is fewer than the number of GPs because two of the interviews were 'group' interviews (consisting of 2 and 3 GPs respectively). The removing GP had requested that all the GPs in the practice be interviewed together.

The characteristics of the GPs are shown in table 4.1 and the characteristics of their general practices in table 4.2. The purposive sampling strategy (*Appendix 1.1*) ensured that the sample of GPs were representative of the population of removed GPs in Leicestershire in terms of key demographic variables drawn from the descriptive epidemiology of removal reported in chapter 3.

As discussed in chapter 2, I refer to each extract by GP number only to protect the confidentiality and anonymity of the participant. In some cases, when I felt that the participants referred to were likely to recognise themselves in the extract, I have altered the gender or location of the GP and/or the patient referred to by the GP.

**Table 4.1** *Key characteristics of purposive sample of general practices*  
(n = 22)

<i>Characteristic</i>	<i>No of practices</i>
<b>Practice Type</b>	
Group	16
Single-Handed	6
Postgraduate training practice	5
<b>Practice Area</b>	
Deprived (Townsend score > 0)	12
Affluent (Townsend score ≤ 0)	10
<b>Location</b>	
<b>City of Leicester</b>	
Deprived	10
Affluent	2
<b>County (Leicestershire)</b>	
Urban	6
Semi-rural	2
Rural	2
<b>Number of removal decisions made</b>	
'High' removing practice (≥ 4 removal decisions per year)	8
'Low' removing practice (≤ 3 removal decisions per year)	14

**Table 4.2** *Key characteristics of purposive sample of general practitioners*  
(n=25)

<i>Characteristic</i>	<i>No of general practitioners</i>
<b>Sex</b>	
Male	18
Female	7
<b>Age</b>	
less than 34	3
35 – 55	18
greater than 55	4
<b>Place of primary medical qualification</b>	
U.K.	18
Indian subcontinent (South Asia)	7
<b>Hours worked</b>	
Full time	18
Part Time	7

### 4.3 Themes

I identify four themes which help explain the phenomenon of removal from the perspective of the GPs. In 'removal as tip of the iceberg' I show that the formal removal of a patient from a GP's list, as described in official guidance on removal, may be the visible 'tip' of a much larger volume of patient 'removals' due to 'informal' termination of the doctor-patient relationship by either practitioner or patient. I also show that when formal removal is used, the practice policies that govern its implementation differ from those recommended in official guidance. The process by which a patient is formally removed from a GP's list is explored in detail in 'removal as divorce', removal as breaking the rules', and 'removal as sanction'. In these three themes the GPs describe removal as a necessary termination of the doctor-patient relationship when the boundary rule of 'affective neutrality' between GP and patient has been breached ('divorce') or in response to a 'difficult' patient who 'breaks the rules' of conduct of the doctor-patient encounter ('breaking the rules' and 'sanction').

#### 4.3.1 *Removal as 'tip of the iceberg'*

Three categories of termination of the doctor-patient relationship were identified from the GPs' accounts: patients may 'vote with their feet' and remove themselves or they may be the subject of 'informal' or 'formal' removal by the GP.

##### (a) Patients 'vote with their feet'

When patients 'vote with their feet' they may remove themselves from the GP's list. The GPs portrayed such patients as experiencing difficulties with a particular GP and

that the patients themselves decided to either see another GP in the same practice or leave the practice and re-register elsewhere. Thus patients ‘voting with their feet’ can be seen as a patient-initiated termination of the doctor-patient relationship. It occurs without the GP explicitly advising the patient to leave the practice, although GPs may implicitly encourage it or fail to discourage it as suggested here:

But, the end result is, if they think they are not getting what they want, they do take their own decisions, so I’ll let them have their own decision rather than initiating [it] myself. (GP10)

(b) ‘Informal’ Removal

I have coined this term ‘informal removal’ to describe the situation where the GP directly proposes to the patient that he or she would be better served by re-registering with another doctor. It can be seen as a doctor-initiated termination of the doctor-patient relationship. In this extract the GP uses this strategy with a family who were at ‘loggerheads’ with the GP over a wide range of issues:

We wrote them a letter explaining that we thought it was better if they found another practice who were more accommodating to their views, because we didn’t feel we could work with them professionally ... and they in fact went off and found somebody else, so we didn’t actually throw them off the list. We didn’t actually formally tell the Health Authority to remove them from our list. But they did actually accept that the professional relationship had broken down and went elsewhere. (GP4)

‘Informal’ removal can also be used as a prelude to ‘formal’ removal if, after a defined period of time, the patient had not left the practice ‘voluntarily’:

GP: Well we try now, if we feel that's come, we ask the patients to go and find another doctor, rather than remove them we say “look, you don't seem to be very happy with what we are doing, because we've set this up and you are doing that, and we are only prepared to do this.

Therefore if you're unhappy you are very free to go and find another GP". And I think that is the better thing to do, although it invariably takes a lot longer ...

TS: You mean it takes a lot longer in what sense?

GP: Well they still kind of, it takes a lot longer to go and find another doctor and move, whereas if you actually remove somebody you've got your seven days and they've gone. (GP14)

This particular GP felt 'informal removal' was the preferred method of 'removing' a patient, as she had found that a 'formal' removal made patients angry about the way they had been treated and that this anger often led to a formal complaint being made against the GP.

It is also interesting to note that one GP, at least, found my suggestion that GPs may use 'informal removal' (an issue raised with the GPs in later interviews) was a strategy he might use in the future:

TS: As I said at this stage I am just testing out some of the other points that have been made in other interviews as well, just to see ...

GP: It's not something that we've said "look we have a policy at a practice meeting we will say we want this patient to leave, so we will throw them off".

TS: Right.

GP: But as a stage one we will have them in and say "look we think things are broken down, would you move, dot dot dot, because if you don't we will throw you off". Erm and that's an idea which I might take on board. (GP17)

#### (d) Formal removal

Formal removal occurs when the GP writes to the Health Authority requesting removal of a patient. In all cases of formal removal, the GPs stated that they had

discussed the decision to remove with other GPs in the practice (if applicable). In their accounts of how the decision to remove was made, the GP often actively sought to show that his/her decision was 'sanctioned' by describing a process where confirmation from other GPs/staff that the 'difficulty' the GP experienced was the fault of the patient, not of the GP, was offered:

The two of us who had been most recently involved in looking after him [removed patient] had both agreed. Well, three actually because a third doctor had been involved as well in this process. (GP1)

Two types of practice policy on removal were identified. In the first type of practice policy the GPs (7) have no written policy on removal. Removal is considered when a perceived problem with a patient leads to the doctors discussing the future of the patient in the practice among themselves:

It's just a case of saying, "look this patient is doing this" and if we can't work it out then you would ask the other partners "would it be acceptable to remove this patient?" and with their agreement, yes we would. (GP14)

In the second type of practice policy the GPs (8) note that decisions to remove are minuted at practice meetings and the GPs and practice staff know what procedure should be followed. Policy may be written down to the extent that it is available to GPs and staff, although not available to patients:

I think it's written down within minutes of a previous meeting about removals, but it's all much certainly, it's sort of a known agreement that we all stick to. (GP11)

Only one GP stated that their practice had an explicit written policy available for consultation by patients as well as staff:

We have got a very explicit policy, which we committed it to paper about three years ago. And it's available for inspection by the patients. We state in our practice leaflet that there is a policy on removal of patients from the list.  
(GP1)

Practice policy on removal is thus usually informally agreed between the GPs within a practice and may also be formalised into the minutes of partnership meetings. Staff may be made aware of the policy but only one GP reported that patients had access to the practice's policy on removal.

A second important issue regarding formal removal is whether or not the GPs inform patients of their reason for removal. GPs are not obliged under their terms of service to give patients a reason for being removed (Department of Health, 1989). As far as the GPs' stated reasons for removing a patient were concerned, these fell into three broad categories: violence and/or aggression (20 GPs); 'breakdown' in the doctor-patient relationship (20 GPs) and 'inappropriate' service use (13 GPs). My sample was split between those GPs who would inform the patient of the reasons for removal (12) and those who would not (8). Of those GPs who would give a reason for removal to the patient, the patient was either told of the decision verbally (6) or was written a letter setting out the reasons for removal (6). A letter to the patient was viewed as a 'public' document. Often the letter would simply state that there had been a 'breakdown' in the doctor-patient relationship. In one instance, a practice used the fact that the patient had moved out of the practice area as a convenient excuse for removing the patient. The letter to the patient stated that she had been removed

because she how lived outside the practice area – ‘out of area’ is a publicly acceptable reason for removal - but in fact the GP told me that the patient was removed because none of the GPs wished to continue to provide care to a very ‘difficult’ patient. Those GPs who made it a point of policy not to tell a patient why they had been removed did so on the grounds that patients already ‘knew’ why they were being removed or that telling a patient would lead to further difficulties with the patient.

#### 4.3.2 *Removal as ‘divorce’*

The first way that GPs accounted for the phenomenon of removal was to use the metaphor of ‘removal as divorce’. As one GP put it:

I think it’s an indication that the relationship is effectively over, you know, it’s time for a divorce sort of thing. (GP3)

The narrative of removal as ‘divorce’ had four components. First, the GPs presented themselves as having a long-term relationship with their patients that could not easily be ended. Second, the GPs established grounds for divorce on the basis of ‘irretrievable breakdown’ in the doctor-patient relationship. Third, the GPs showed that they had acted reasonably and consistently: removal was presented as a ‘last resort’ and a ‘final act’ when all practicable attempts to ‘fix’ the doctor-patient relationship had failed. Fourth, removal was presented as allowing this ‘breakdown’ to be appropriately managed and both parties are seen as benefiting - the GP has ended a dysfunctional and stressful relationship; the patient finds a new GP ‘they can get on with’. I shall expand on each of these components in the sections that follow.

(a) The 'long-term' relationship

The first component of the narrative of removal as 'divorce' was that most GPs saw themselves as having a long-term relationship with their patients. This was a particular feature of single-handed GPs' talk about patients but was found in interviews with GPs in group practices as well. In contrast with their hospital colleagues, it was seen as more difficult for GPs to terminate a relationship with a patient:

- (i) You know, they say don't they the difference between hospital doctors and GPs is that GPs' have their patients for life where the hospital doctors just see them say "hello" and after a while say "goodbye". Then in fact they can say goodbye as soon as they like. Whereas GPs don't have that privilege unless events overtake them, or a sort of positive attitude to leave or remove goes on. (GP3)
  
- (ii) We don't have the luxury that perhaps teachers have in the same situation of knowing full well that that person will not be in their class next year. You know, they're theoretically for twenty or thirty years, particularly in a practice like ours where we get a very low turnover. You know, patients have been here for sixty years, they were "here with Dr X. and then", you know, they can quote the life-story of the practice back further that I can trace it. (GP4)

In order to deal with the rigours of such a relationship, GPs needed to be able to 'take the rough with the smooth' – a GP was potentially 'saddled' with 'difficult' patients for a considerable period of time. The ability to 'take the rough with the smooth' allowed GPs to be able to provide care for patients even if the patient aroused negative emotions in the GP – a 'heartsink' patient (O'Dowd, 1988) – and to use the long-term relationship in a 'therapeutic' manner:

They ['heartsinks'] are difficult, obviously, but I think that's part of the job. You know, you can't have "Mr Smiley" comes in every day, you can't have, you know, people that have got a perfect physical illness. I think as time goes by we begin to understand these patients more and try to deal with their anxieties, their depressions, all the other illnesses that are associated with them I think, they are the patients I would probably be most opposed to ever being removed, because I think in some ways they actually need the relationship with the doctors they've got here, and I think that because we find them difficult, it isn't a reason to remove anybody from the list. (GP13)

(b) Establishing the 'grounds for divorce'

The second component of the narrative of removal as 'divorce' involved establishing the 'grounds for divorce'. In certain situations the long-term relationship could break down and this could lead to a patient being removed, as this GP noted:

When it is very clear the relationship with a patient has broken down - I know that sounds trite, but when it's very clear that as a doctor you have [are of] no use to the patient, I then would very seriously consider removing the patient. (GP3)

Many GPs used the phrase 'breakdown in the doctor-patient relationship' as if it were self-explanatory and one GP went so far as to cite the published guidance on removal word-for-word: 'the doctor-patient relationship has irretrievably broken down' (General Practitioners Committee of the British Medical Association, 1999). An analysis of the narratives GPs told of removing patients, however, revealed that the phrase 'breakdown' was interpreted in two different ways. First, that the patient aroused such strong dislike in the GP that the GP had difficulty providing care for the patient and/or felt emotionally drained from repeated encounters: 'enough was enough'. Alternatively, that the patient persisted with 'unreasonable' behaviour in spite of attempts by the GP to address the issue: 'failed negotiation'.

*'Enough was enough'*

In situations where the GP had been experiencing difficulties with a patient over a considerable period of time, a decision was made that 'enough was enough' and the patient was removed. This GP's choice of words demonstrates a strong sense of exhaustion and dislike:

And that was a patient who really was driving me distracted. I was beginning to sort of lose it because the patient was just so difficult to handle. It wasn't that they had no faith in me, it was just that I was beginning to lose faith in myself really, and I just really felt I had to get rid of him, sorry to get rid of him is unfriendly, I mean remove him. (GP3)

Although in such accounts there is often a display of dislike of the patient by the GP, 'dislike' *per se* is not a reason for removal. The GPs felt it was acceptable to dislike a patient *provided* that such feelings did not affect the care the GPs felt they could offer the patient and/or the GP felt able to deal with such negative feelings. Several GPs expressed concern that they might miss an important diagnosis in such a patient in their haste to terminate the consultation as quickly as possible. As this GP put it, such a patient may well be the first to complain if the GP made a mistake:

And I think we were just a bit worn out with him really ... one of the other partners who had a concern about him felt that the difficulty with patients like that was that one of these days they would have something significantly wrong, and we might miss it, and he would be the first to have you for breakfast. (GP21)

The GPs' emotional involvement with patients was therefore conditional on the doctor's need to remain objective and the maintenance of a 'therapeutic' relationship.

*'Failed negotiation'*

In contrast to the GP having strong negative feelings towards a patient, 'relationship breakdown' was also seen to occur when a patient persistently 'abused' the service by making, for example, frequent use of the out-of-hours service or home visits:

Repeated misuse of usually out-of-hours or emergency appointments, or failure to keep appointments so just not respecting the needs of other patients and doctors to deliver care. (GP1)

The key issue here was 'negotiation'. The GPs saw patients as 'reasonable' or rational individuals with whom it was possible to negotiate a solution acceptable to both parties. Several GPs (7) explicitly drew on the rhetoric of 'patient-centred medicine' with its emphasis on the need to reach a 'shared understanding' of the problem brought by the patient (Stewart *et al*, 1995; Mead and Bower, 2000):

Well, I think an ideal relationship would be where both parties felt able to express their views about what was happening. I mean, in the case of a doctor/patient relationship it was possible to reach a shared understanding of the nature of the problem and to negotiate appropriate solution for it, whether it was physical or a psychological illness. (GP1)

GPs, however, encountered patients with whom they tried to negotiate an 'acceptable' (doctor-defined) use of the service but who 'chose' to 'ignore' the advice the doctor had given even when the difficulties were *repeatedly* brought to the patient's attention. The GPs found this situation problematic and evidence of such 'failed negotiation' was seen as justifiable grounds for removal. As this female GP put it:

GP: I think, where you foresee there is some kind of problem, you try and approach it by putting it to the patient, explaining, and then trying to give them guidelines, something that they agree to. Yes?

TS: Yes.

GP: That they will change what they are doing and that we will offer this service if they do that, yeah. So you try and negotiate. And if it's negotiable then things can carry on, but then if the negotiated agreement just keeps breaking down, and that would be my definition of doctor-patient relationship breakdown. (GP14)

Note how the GP is also presenting herself as acting 'reasonably' – the GP makes several attempts to address the problem with the patient but the patient continues to persist with his/her 'unreasonable' demand.

(c) Removal as a 'final act'

The third component of the narrative of removal as 'divorce' presented removal as a rarely invoked 'final act'. All the GPs (including GPs from the eight practices which had been identified from the Health Authority data as 'high' removers) sought to present themselves as rarely removing patients:

We see it very much as a last resort really. We find there is very few situations in which you'd actually have to resort to removing somebody from here. (GP5)

In addition to being a 'rare' event, the GPs also saw the decision to remove as a 'final act.' The 'breakdown' between the GP and the patient was portrayed as 'irretrievable' and there was therefore no scope for the patient to be re-accepted back onto the GP's list, even if the patient requested it:

Half an hour later he [removed patient] rang the Practice Manager asking the Practice Manager to reinstate him. The Practice Manager, obviously the decision was not hers, said she would go back and ask me again. She came back and asked me, and I said “my opinion stood, but I would be willing to have another meeting with the other partners to see if they would reconsider”, which we did do the next day, and again even more so - there was a more unanimous decision, and the decision was upheld, and that’s really the story. (GP13)

A further reading of this extract is how ‘reasonable’ the removing GP is: he even went back to the partnership to double-check their decision to remove when the patient queried it.

Two GPs gave instances of subsequently accepting back onto their lists patients they had previously removed. This appears to run counter to the idea of removal as a ‘final act’. In each case, however, acceptance back onto the list was *conditional* on the patient agreeing to comply with medical advice and to use the service responsibly. One of these ‘negative’ cases is a ‘paired’ case and is presented as Case Study 3 in chapter 6.

(d) The benefits of ‘divorce’

The final aspect of the narrative of removal as ‘divorce’ is that it allows patient removal to be seen as an appropriate way to manage a ‘relationship breakdown’. The GPs are seen as having ended a dysfunctional and stressful relationship, whereas the patient finds a new GP ‘they can get on with’. As this GP puts it, it’s ‘horses for courses’:

I am of the opinion that some people do need new practices. You know, they do need a new doctor. You know, that can be making of the doctor/patient relationship. But ... I’m not just saying I’m wonderful. What I mean is that

even the patients of mine who've cleared off, you know, I'm sure it is probably a big success for the next doctor they went to after me. I think it works, you know, it's horses for courses. (GP3)

The phrase 'horses for courses' is defined by the *Oxford English Dictionary* (Simpson and Weiner, 1989) as 'the matching of tasks and talents' and implies that the source of the difficulty could lie with either the GP or the patient. Half of the GPs (12) drew on this metaphor to argue that removal – initiated by the GP - allowed a 'difficult' relationship to be terminated and the patient could start afresh with a new GP. Supporting evidence for the success of this approach was offered by GPs' accounts of dealing with patients who had been previously removed by another GP and had joined their list voluntarily or who were allocated to their list. Most (19) GPs saw such patients as generally being 'no trouble' and one reason put forward for this was that the removal had resolved a 'personality clash' between the patient and the GP:

But, we've not had any experience of any patients that have been allocated that have actually been troublesome in any way, and I suspect it's because largely it has become a personal thing with their own GP. (GP6)

#### 4.3.3 *Removal as 'breaking the rules' of the doctor-patient relationship*

The second important way that GPs accounted for the phenomenon of removal was to use the metaphor of 'breaking the rules'. The narrative of removal as 'breaking the rules' had two components. First, the GPs showed that removed patients were 'difficult' or 'bad' patients. Second, these 'difficult' patients were shown to bring removal upon themselves by committing an act or acts that violated the formal or informal rules of conduct governing the doctor-patient relationship in general practice and thereby 'triggered' their general practice's policy on removing patients.

**(a) The 'difficult' patient**

The first component of the narrative of removal as 'breaking the rules' presented removed patients as 'difficult' or 'bad' patients. Most GPs saw removed patients as being 'difficult' patients. The 'difficulty' experienced by the GP was seen as originating from one of three sources: the patient; the doctor; or the manner in which the general practice was organised.

*Patient is 'the problem'*

GPs often saw the patient as 'the problem'. One type of commonly described 'difficult' patient exhibited a range of behaviours that were seen as problematic by the GPs. Such behaviour included (i) frequent service use and 'doctor hopping', (ii) putting in formal complaints, and (iii) manipulative behaviour so that patient 'gets their own way':

- (i) **Frequent service use and 'doctor hopping'**  
And you'll see the same face you know, two or three times a week often, and they have this awful habit of as well as seeing one GP who says "No you don't need antibiotics, it's a virus" and then just making an appointment the very next day, or later that afternoon for a different GP in the same practice. (GP6)
- (ii) **Putting in a formal complaint**  
And she went home and that generated, you know, a visit from the husband who came stalking in and was very very angry and said he was going to report me to the GMC or BMA or somewhere for accusing them for being of too poor to afford private treatment. (GP3)
- (iii) **Manipulative behaviour**  
About quarter to twelve he phoned the surgery to say that he was having chest pain, and that he was short of breath he couldn't possibly get to the surgery, and so he had no transport. So I left the surgery, I went to see him, and in actual fact what he was describing was a pain

in his shoulder that he consulted Dr. X. about two days previously.  
His wife was present at the house with her car. (GP9)

Note how GP9 portrays the patient as manipulative on the grounds that the patient says he has 'chest' pain (to get a home visit) when in fact he has a pain in his shoulder (not justifying a home visit) and, in any case, his wife could have brought him to the surgery with her car.

Another type of 'difficult' patient was seen by GPs as having certain types of illnesses. Such illnesses included (i) somatisation, (ii) substance abuse (drug and alcohol dependence), (iii) personality disorder and (iv) mental illness:

- (i) Somatisation  
Yes, it's a very common problem really. Because the parties again, the failure on the patient's part accept that you know, it could really be an early mental illness, or because you know, somatisation of the symptoms is culturally very very prominent. (GP2)
- (ii) Substance abuse  
A chap came in first thing in the morning, an alcoholic chap wanting to be seen by the doctor straight away ... I had to force him to go out in the waiting room and wait until I had finished writing the notes and was ready for him to come in. So just, you know, a badly behaved drunk basically. (GP6)
- (iii) Personality disorders  
Then clearly they have psychological problems which are irremediable because you know, they fit into a personality disorder category which, of course, we can't treat, and the psychiatrists won't touch with a barge-pole. (GP4)
- (iv) Mental illness  
Well, usually it would again be patients with mental illness. So it might be patients with psychotic disorder or anxiety neurosis who obviously because of their illness find it very difficult to, it is difficult to reach that true level of understanding for them of what their illness is about, and what can be done for it. (GP1)

*GP is 'the problem'*

Another way of portraying a patient as 'difficult' was to see the GP as 'the problem'.

The term 'heartsink' patient refers to the GP labelling a patient as 'difficult' because of the strong negative emotions that are aroused in the GP. (O'Dowd, 1988) Some GPs recognised that they themselves might be 'the problem', that they may have negative feelings towards patients:

I don't like her and I don't like the way she treated me and the things she said. She was just very very rude and, you know, she boiled me to the point that I was almost just being rude back to her, and you know, I wouldn't want to stoop so low, but she really maddened me. (GP6)

*Practice organisation is 'the problem'*

Lastly, some GPs identified certain features of practice organisation that could lead to a patient becoming 'exasperated' and therefore becoming a 'difficult' patient. This could include difficulty in gaining access to GPs or not being able to see the same doctor each time:

The most common grumble that you hear from patients is "Oh I couldn't get to see my doctor for three weeks. You have to book to be ill". You know, that's already set them up to be upset by the time they come and see the doctor. (GP4)

Overall, the GPs' accounts tend to locate the difficulties encountered within the patient's own behaviour and illness rather than seeing it as a result of the interaction between GP/practice and the patient.

**(b) Breaking the rules of conduct: a ‘trigger event’**

The second component of the narrative of removal as ‘breaking the rules’ presented ‘difficult’ patients committing a ‘trigger event’ that led to removal from a GP’s list. Although many removed patients could be characterised as being ‘difficult’ patients, being ‘difficult’ on its own was not deemed to be a sufficient cause for removal, and only a small number of ‘difficult’ patients was removed. All of the GPs stated that there was a ‘trigger event’ by which a patient previously identified as being ‘difficult’ became a removed patient. Five of the GPs stated that it was also possible for a patient to be removed following a ‘trigger event’ without there being any prior difficulty with the patient. The following types of ‘trigger events’ were identified (box 4.1).

<p><b>Box 4.1</b>      <b>‘Trigger events’ that lead to removal</b></p> <ul style="list-style-type: none"><li>• violence and aggression</li><li>• rudeness and losing one’s temper</li><li>• open criticism of the doctor</li><li>• manipulation</li><li>• lying</li><li>• making a formal complaint</li></ul>
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These ‘trigger events’ represented a breach of the formal and informal ‘taken for granted’ rules of conduct governing the doctor-patient relationship in general practice and are considered in detail in the following section.

### *Violence and/or aggression*

Violence and/or aggression has already been identified as an important criterion used by the GPs for removing a patient from their lists:

I think anybody who is physically violent towards any of us, including our staff, we would have to think very hard about removing them, and we would almost certainly do that, because I don't think we can tolerate violence within the practice. (GP4)

The phrase 'violence and aggression' had a variety of meanings. At one end of the spectrum it could mean actual physical violence or verbal threat of bodily harm and/or damage to the surgery premises. Reports of actual violence were rare:

I think the only one patient I removed, I think that was very early on, was er he was very aggressive actually, virtually nearly got hold of one of my staff and was really about to grab her neck. So that was the next one to go. That was a long time ago. (GP18)

It was more common for GPs or other members of the practice staff to fear that they were about to be attacked and/or the premises damaged. As one GP put it about a patient who was a drug (amphetamine) addict:

He was asked if he could go to the main surgery and declined again, leaned over the counter and put the receptionist in the state of some considerable fear. He's not physically abusive, but threatened to damage the property. (GP15)

Actual or intended violence made GPs fear for their safety. Given that such behaviour constitutes a breach of formal rules of behaviour and can lead to legal

sanctions, it is not surprising that the GPs saw removal for violence as unproblematic.

### *Rudeness and losing one's temper*

On the other hand, 'violence and aggression' could also be used to indicate behaviour that was deemed impolite or discourteous. Such behaviour included patients being rude to staff and losing their temper, and could also be a 'trigger event'. Note how this GP describes the patient's behaviour as being 'aggressive' when what is actually described is the patient being rude about the GP:

We chunked them off the list because they were rude and aggressive on the telephone ... the husband slagged me off once, and I just said "I'm sorry, I don't take that language" and he did it again, so I actually contacted him and said "If you do that again, you will be off the list" and he did it again of course, so he was off. (GP11)

The belief that patients shouldn't lose their temper with GPs can be further illustrated by an account of a patient who'd been removed from his previous GP's list because of a disagreement about the correct choice of asthma therapy:

I think he'd lost his temper or something with the doctor over the inhaler issue and he was removed, which I think is reasonably OK. To start losing your temper in front of doctors because you [pause] I mean, you just can't. (GP5)

### *Open criticism of the doctor*

It was also impolite to be openly critical of the care the doctor had provided, to tell the doctor to his or her face that he/she is 'useless' or 'incompetent':

She also stated specifically she thought that we were not competent to treat her and contrasted our treatment of her very unfavourably compared to that of her partner who was not registered with the practice. (GP1)

In the case of the patient discussed by this GP the patient had also been ‘verbally aggressive’ in her demands, thereby breaching more than one rule of behaviour.

The concept of ‘respect’ was an organising theme that linked the different types of impolite behaviour. The need for patients to respect the doctor means that they should be polite in their dealings with the doctor. Thus ‘respect’ is violated when the patient is verbally aggressive (rude or abusive) or openly critical of the doctor’s actions.

### *Manipulation*

The use of the doctor by the patient to achieve his/her own ends rather than ‘wanting to get better’ was also seen as a ‘trigger event.’ Perceived manipulation is problematic because it suggests to the doctor that he/she is being co-opted into maintaining the patient’s illness rather than co-operating with a patient who ‘wants to get better’ and doctors assume that patients will want to get better. In this extract the patient is ‘manipulative’ as he requests a ‘sick note’ simply to have some time off work:

The chap came in, wanting a sick note, with no objective signs or symptoms of illness, but just felt a bit off and felt a bit pressured and wanted to get on with some work at home I think. And when the doctor refused to give him, well he just said “well, I’ll go and see one of the other doctors then”. (GP11)

In addition, a further ‘difficult’ behaviour is shown – the patient is not prepared to accept the GP’s opinion and is prepared to ‘doctor hop’ until he get what he wants.

### *Lying*

Lying could also act as a 'trigger' to removal and was a source of considerable difficulty with patients. It was seen as a particular problem with alcoholic patients and drug addicts:

TS: I guess drug addicts, though, they are a problem again for the reason that you've outlined ...

GP: Well, because they are not honest.

TS: Not honest.

GP: I mean, you want to believe them and you want to help them, and then you find they are selling their methadone so they can, so [pause]

TS: You just don't know [whether they're telling the truth or not]?

GP: No. I don't like that. I really, I don't like have to think cunning all the time, yeah? (GP14)

Lying was seen as being particularly problematic because it resulted in a breach of 'trust' in the doctor-patient relationship. 'Lying' meant that the patient's statements cannot be taken at 'face value' and so the doctor lacked confidence in how the patient would act in future.

### *Making a formal complaint*

A further 'trigger event' was the patient making a formal complaint about the doctor. GPs described perceiving a formal complaint as a 'threat'. In the extract that follows I had initially equated 'threat' with physical or verbal abuse, but it is clear the GP is referring to a patient putting in a complaint:

- GP: I don't really like being threatened, and the heavier the threat the more I'm inclined to think about removing the patient, but, you know, I don't sort of immediately jump to do such a thing even if I'm threatened in some way or another. When I say threatened, I don't mean physically, because I don't think ...
- TS: Right. And that would be what, that would basically be verbal abuse would it?
- GP: No. No, I'm not bothered about verbal abuse. I'm talking about - "I'm going to report you, I'm going to this, I'm going to do that". Those kind of veiled threats. I mean they do make you consider whether or not it's worth retaining the patient.
- TS: I mean, it [removal] would depend on the level of that ...
- GP: It would very much depend on the level of the threat, yes and how enthusiastically it was being proffered. (GP3)

In a job concerned with managing therapeutic uncertainty (Lupton, 1996) a formal complaint also meant that the doctor would have the additional uncertainty as to how the patient would behave in future. As this GP put it with regard to a patient who had made previously made a serious allegation against a former GP in the practice:

I think the only patient who ... cause me a little bit of heartache, are patients that have made complaints against other members of the practice, and there is one that's been quite a serious patient, and the doctor now has retired, who I do know quite well, and he's made quite a serious allegation against him. I find them difficult, because at the back of my mind a) I feel I'm being slightly disloyal to him [the GP], and b) there's always a worry that he'll make a complaint against me. Thankfully we seem to get on quite well, and the relationship is a good one, but I think they are possibly the most difficult other group of people that I see. (GP13)

The GP clearly had difficulty 'trusting' the patient. The GPs thus found formal complaints a threat to both their emotional well-being and their professional identity.

Although 'trigger events' might lead to removal, they could be mitigated if the patient was suffering from an acute mental illness which meant that the patient was not seen as responsible for his or her actions. This could apply even in cases of violence:

GPa: The only time I nearly got stabbed was years ago, but that was a schizophrenic patient really and we were just in the process of committing him, that he then pulled a knife and nearly stabbed me. But that particular rule didn't apply then, you know, immediate removal really. I don't think he would have qualified because he went into hospital and he ...

GPb: We didn't remove him, he was schizophrenic. (GP2)

#### 4.3.4 *Removal as 'sanction'*

I have suggested that the GPs saw removed patients who have joined their list as generally being 'no trouble' and that one way of explaining this was the use of the metaphor of 'divorce' as showing that removal had resolved a relationship difficulty between the patient and the ex-GP. Another metaphor that is important in explaining removal is that of 'removal as sanction'.

Removal was seen as equivalent to a legal sanction: a penalty for disobeying the rules of the doctor-patient encounter. It was viewed by the GPs as a way of disciplining patients whose behaviour was problematic. Sometimes the GPs openly used punitive language when referring to removal such as the phrases to 'throw off' (8 GPs) or 'chuck off' (4 GPs) a patient from the list.

The sanction was sometimes seen to enforce obedience to the rules of the doctor-patient relationship. It was noted to lead to an 'improvement' in the patient's subsequent behaviour. Half of the GPs (13) saw the removal process as 'educative' for patients. As this GP noted:

The vast majority in my experience of patients who have been thrown off a practice list and then go to another doctor learn very quickly that it is to their advantage to treat their surgery appropriately. Not undemandingly, but appropriately. (GP17)

Some GPs felt that the (a) 'shock' and (b) 'stigma' of being removed from a GP's list would in itself make patients realise that they had better change their behaviour for the better:

- (a) There again, it can be quite a shock and quite a revelation to someone to be removed, because I think on the whole most of them do not understand the way general practitioner's contracts work, and do not understand that we have the right to remove them. (GP9)
- (b) Somehow when then they change doctors things tend to get better. Maybe they then realise "am I going to go round from doctor to doctor from now onwards". It does stigmatise the patient, but I suppose it does solve the problem also. Quite a lot of [the] time. (GP10)

The GPs, however, also gave instances of where removal 'failed' to make any difference to the patient's behaviour and the patient ended up being removed from the new GP's list:

And it was very difficult for me to cope with him with his repeat prescription in spite of the pharmacist taking on board, giving him the medication that he used to call you out for trivial things all the time, no matter what advice you would give. And so I had to ask the Health Authority to re-allocate him to another practice. (GP10)

Such allocated patients were likely to be put on 'probation' and be told that they would only be kept on the new GP's list if their behaviour with the practice met certain standards. As this GP noted:

The allocations are all seen. We've got to have them anyway, but at least they're seen, and some sort of ground rules are drawn up, which again usually involve addressing the issue. You know, "why were you taken off that list?" And again you often get the comment "I don't know. I don't think there's anything I said, doctor". When you get the notes through it's quite clear, and very often it's been documented, and you then ... or a doctor will then address that with the patient the next time. [patient] "Oh, well yes, I suppose so, yes, yeah, well he didn't like the way I ... well, you know it wasn't my fault". [GP] "Well, it's quite clear. That is the reason". And ... you would reflect it [back] so that the patient, we hope, knows, that we know, and we know, that that they know we know, and say "and that doesn't happen here either. So, end of story. Is that acceptable?" [patient] "Well, yeah, yeah, I'll try me best doctor". [GP] "Right, okay. And you will be kept under review". (GP11)

Indeed, a 'recidivist' class of allocated patients was identified who were repeatedly removed from GPs' lists. These were the 'three monthlies', so called because they were kept on a GP's list for three months before being removed and being re-allocated elsewhere:

So they're just going on the three-monthly. I mean, if they're just on their three-monthly, you know, with us and they go elsewhere, then I guess you've just got to grin and bear it. (GP6)

The 'three monthlies' were seen as rare but extremely 'difficult to handle' patients who were seen as often having a mix of substance abuse and personality problems. A number of GPs described in great detail the difficulties such 'nightmare' patients presented. This description of a couple who made 'unbelievable' demands on the service is typical:

It's a husband and wife, or cohabiting couple, who moved here from the south-west and after they'd been here some time the notes followed them, and in the notes it was quite obvious that this is not new behaviour, and in the first three months they were registered with us, and in the first three months they had something like 120 trips to the hospital A&E department between them. (GP11)

Under a GP's terms of service there is no specific obligation on the GP to keep allocated patients on their books for three months (Department of Health, 1992; Ainsworth, 2001). In Leicestershire the 'three month rule' referred to the frequency with which the allocation panel met to consider requests for removal of allocated patients (Colette Braidwood, personal communication) and this has therefore become usual practice.

#### **4.4 Discussion**

In this section I shall discuss the findings of the accounts GPs give of removal and will follow this by an analysis of the functions such accounts may serve. I shall consider the wider theoretical and policy implications of these findings in chapter 7.

I have suggested that formal removal is but the 'tip of the iceberg' as far as termination of the doctor-patient relationship is concerned. The 'tip of the iceberg' metaphor is useful as 'formal' removal is both publicly visible - recorded by some Health Authorities and the subject of scrutiny by the Health Ombudsman (Select Committee on Public Administration, 1999) - and a relatively uncommon event. Underneath the surface, however, there may lie a much bigger volume of patient

movements due to 'informal' removal. It is possible that some of these patients may view themselves as having been 'removed' even though they would not officially have been removed. Although this area needs further empirical study it seems reasonable to hypothesise that with formal removals being the subject of increasing public scrutiny, one will see an increasing tendency for GPs to use 'informal' removal as a way of initiating termination of the doctor-patient relationship. Certainly one of the study GPs felt it was an approach that he might use in the future. As far as 'formal' removals are concerned, official guidance on removal (General Practitioners Committee of the British Medical Association, 1999; Royal College of General Practitioners, 1997) recommends that GPs should follow an orderly process governed by clear formal procedures. I have shown that, in practice, the GP's decision to remove a patient often relies on the patient breaking tacit, 'taken for granted', rules of the doctor-patient relationship. How that breach of the 'rules' is dealt with by the general practice constitutes the practice's 'unofficial' 'removal policy'. It is also important that some GPs report that they do not inform patients of the reasons for their removal and, even when they do, the patients receive short statements to the effect that the 'doctor-patient relationship has broken down' or that they have moved 'outside the practice area'. I shall discuss the observed differences between 'official' and 'unofficial' policy on removal in chapter 7.

Moving onto the themes that deal with the removal process, in 'removal as divorce' the GPs recognised that providing long-term care to patients was an emotionally demanding job. Occasionally they met patients who engendered such a degree of dislike that the GPs no longer felt able to provide care for the patient. For such patients, formal removal was seen as 'divorce': an uncommon but necessary step to

resolve a situation that caused the GP considerable emotional stress. The term 'affective neutrality' has its origin in Parsons' (1951) formulation of the doctor-patient relationship with the need for doctors to be objective and emotionally detached in their dealings with patients. In removal as 'divorce' there is loss of 'affective neutrality' and the GP is no longer able to accomplish the tasks of the doctor-patient encounter as his/her emotions 'get in the way'. This can be conceptualised as a breach of an important boundary rule (M. McCall, 1970) ('affective neutrality') of the doctor-patient relationship. This need to maintain professional boundaries has been identified as a feature of nurse-patient (May, 1991b) and GP-patient (May *et al*, 1996) relationships.

In removal as 'breaking the rules' GPs reported that they experienced difficulties with patients who 'break the rules' of conduct (Denzin, 1970) of the doctor-patient relationship. Such patients are 'difficult' patients who exhibit 'bad' behaviour such as aggression, rudeness, lying and persistently 'unreasonable' requests for services. These findings are in accordance with McKeganey's (1988) work on opiate-abusing patients where the perception of such patients as 'bad' – being manipulative, lying, poorly motivated and aggressive – is a judgement based partly on the actions of the patients themselves and partly on the doctors' tacit informal rules as to how patients 'ought' to behave.

Removal as 'sanction' echoes Jeffrey's (1979) work on patients in hospital accident and emergency departments where he argued that 'breaking the rules' of the doctor-patient encounter led to 'punishment' being meted out on the patient by the casualty staff. The metaphor of removal as 'sanction' has four key elements. First, it is

appropriate to discipline patients who 'break the rules' by removal. Removal may be seen as equivalent to a legal sanction: a penalty for disobeying the rules of the doctor-patient encounter. Second, the GP is the arbiter of what constitutes 'rule breaking' meriting the imposition of the sanction. Third, removal is of necessity a 'shock' to patients that makes them realise that their behaviour is unacceptable. Fourth, GPs justify their 'right' to be able to remove patients on the grounds that the penalty sometimes 'works', as removed patients who join another GP's list are often perceived to be 'no trouble' by the new GP. They may have learnt that their behaviour 'doesn't pay'. When the sanction doesn't work, the patient is labelled a 'three monthly' and becomes the subject of repeated removals from a GP's list.

I shall now turn my attention to the functions served by the narratives of removal as 'divorce', removal as 'breaking the rules', and removal as 'sanction'.

The narrative of 'removal as divorce' can be viewed as a 'strategic device' (Hyden, 1997): it is used to achieve certain effects in the social interaction. The desired effect is that the GPs justify their own actions and construct a publicly acceptable account of removing patients from their lists. To understand why the narrative serves this function, it is necessary to elaborate in more detail what is meant by 'divorce'. In English divorce law it is necessary to establish that the marriage has 'broken down irretrievably'. The most common grounds for divorce in England and Wales is that the 'respondent has behaved in such a way that the petitioner cannot reasonably be expected to live with the respondent' (Hayes and Williams, 1999). The published guidance on removal (Royal College of General Practitioners, 1997; General Practitioners Committee of the British Medical Association, 1999) mirrors the legal

terminology of 'divorce' by emphasising that there is a need to establish that the doctor-patient relationship has 'irretrievably broken down' before removing a patient:

*In the vast majority of cases the sole criterion should be irretrievable breakdown of the doctor-patient relationship ... If all else fails the GMSC [General Medical Services Committee of the British Medical Association] believes that it is not in the best interests of either patient or doctor for an unsatisfactory relationship to continue and it will be necessary to remove the patient from the list (General Practitioners Committee of the British Medical Association, 1999).*

The metaphor of 'removal as divorce' is therefore officially sanctioned and offers the possibility of constructing a publicly acceptable account of removal. Persistently unreasonable behaviour on the part of the patient/respondent ('failed negotiation') or the GP feeling that he/she can't cope with a patient any longer ('enough is enough') is seen as grounds for divorce by the GP/petitioner on the basis of irretrievable breakdown in the doctor-patient relationship. Removal is a 'last resort' and a 'final act' when all reasonable attempts to 'fix' the doctor-patient relationship have failed. Removal is presented as allowing this 'breakdown' to be appropriately managed and both parties are seen as benefiting - the GP has ended a dysfunctional and stressful relationship; the patient lives, perhaps happily ever after, with a new GP.

There are, however, problems with the 'divorce' metaphor. Even if one accepts that removal can be seen as analogous to 'divorce', then empirical work on the nature of divorce shows that divorce is in fact a stressful and messy process, particularly for the respondent (Hart, 1976). First, any attempt to terminate the marriage with the minimum bitterness, distress and humiliation is undermined when either party seeks to show that the other has behaved 'unreasonably'. Divorce petitions often contain a long list of incidents going back many years in support of the allegation of

'unreasonable behaviour' in order that they may add up to sufficient grounds for divorce. Not surprisingly, such a petition is seen as threatening by the other party and may be vigorously contested (Hayes and Williams, 1999). Second, the marital relationship has been viewed by sociologists, like the doctor-patient relationship, in terms of functional, conflict and interpretive approaches (Askham, 1984). Research from an interpretive perspective has shown that there is an important difference between the party who initiates divorce and the potentially unwilling partner (Hart, 1976). For the party who initiates divorce (petitioner) the marriage may well be seen as having 'irretrievably broken down' and may represent a release from an oppressive relationship. The petitioner knows what he/she wants and is therefore able to plan the transition from being married to being separated. In contrast, the respondent may be unwilling to accept that the marriage has ended and may still hope for a reconciliation. The respondent may therefore find the transition from being married to being separated much more stressful and distressing as the transition from being married to being separated lacks structure.

In any case, there are substantive differences between divorce law and a GP's terms of service. A patient may be removed immediately and without any prior notice and the patient has no access to reconciliation or any means of redress (Department of Health, 1989; Department of Health, 1992). It also seems difficult to see the sociological conception of the doctor-patient relationship, with its power asymmetry of necessity in favour of the doctor (Maseide, 1991), as being equivalent to a marital relationship.

In sum, empirical work on divorce and a consideration of GPs' terms of service would suggest that patient's accounts of removal are likely to show that removal is associated with a considerable degree of distress and that the relationship may not be seen as having 'irretrievably' broken down. At this stage it seems reasonable to conclude that 'removal as divorce' may not best explain the process of removal from the perspective of both GP *and* patient.

In characterising removal as the result of 'breaking the rules' of the doctor-patient relationship, I have shown how GPs talk about removal can be organised around the metaphor of 'breaking the rules' of conduct. The GPs presented a narrative of removal in which the patient was shown to be a 'difficult' or 'bad' patient who brought removal upon him/herself by committing an act that violated the formal (e.g., physical violence) or informal (e.g., rudeness) rules governing the doctor-patient relationship in general practice. The 'violation' was brought to the attention of the other GPs in the practice and their confirmation that the 'violation' was unacceptable was sought. If all the GPs were in agreement then the patient was removed. I suggest that this narrative, like that of removal as 'divorce', can also be viewed as a 'strategic device' (Hyden, 1997) to achieve certain effects in the social interaction. It can be seen as a 'moral tale' or 'atrocious story' (Dingwall, 1977; Baruch, 1981). Dingwall (1977) argued that such stories commonly occur in client/professional relationships and that one could expect professionals to tell such stories about their clients as well as *vice-versa*. He offered this useful definition of the term:

*The use of the term "atrocious" should not be allowed to mislead us into thinking that some disaster must necessarily lie at the heart of the story. The choice of a dramatic term reflects the dramatic nature of the account by which a straightforward complaint or slight is transformed into a moral tale inviting all right-thinking persons (the audience) to testify to the worth of the*

*teller as against the failings of the other characters in the story (Dingwall, 1977: 394).*

Dingwall argued that such stories had two functions. First, at group level (professional or lay), they may be used to bind a group together through the exchange of common problems and the mutual affirmation that such problems are difficult to deal with. Second, they can be used by an individual to show that he/she behaves in a rational and reasonable manner. Further empirical support for the importance of 'atrocious stories' comes from Baruch's (1981) study of parents' stories of encounters with health professionals. Baruch's methodological position was to treat the respondents' 'atrocious stories' as situated accounts constructed to display the competence of the respondent as an interviewee. He also avoided imposing any external social or psychological framework to explain the respondent's behaviour. Baruch concluded that atrocious stories were constructed as displays of adequate parenthood. He also used his data to derive a model of how all such atrocious stories were constructed so as to achieve moral adequacy.

The narrative of 'breaking the rules' fits Baruch's model. First of all, the GPs categorise removed patients as 'difficult' patients – patients who are viewed as 'inappropriate' users of the service, or who have certain types of illness that lead to difficulties in their interaction with doctors. These illnesses and behaviours are consistent with the published literature on the 'bad' patient as discussed in chapter 1 (Stimson, 1976; Kelly and May, 1982; McKeganey, 1988). Such patients by definition fall short of the standards of behaviour expected of the 'average' patient. In addition, removed patients are also shown as acting in such a way as to violate certain key properties of professional-client relationships, notably 'respect' and trust'.

'Respect' is violated when the patient is verbally aggressive (rude or abusive) or openly critical of the doctor's actions. Such impolite behaviour can be seen as violating the ceremonial informal 'etiquette' rules of social interaction in general (Goffman, 1967a) and the medical encounter in particular, and results in a breach of the 'appeal to gentility' (Strong, 1979). 'Trust' can be defined as:

*Confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principles. (Giddens, 1990: 34)*

'Lying' is a breach of trust in that a lying patient's statements cannot be taken at 'face value' and so the doctor has no confidence as to how the patient would act in future. The violation of these key properties of 'respect' and 'trust' is presented by GPs as justification for the removal of a patient. The GPs seek to validate their actions in three ways. First, they show how the patient's behaviour is at variance with the GP's own conception of the rules governing the medical encounter. Second, the GPs seek sanction for their proposed actions from the other GPs in the practice and receive affirmation from the other GPs that they are acting reasonably. Third, in offering their account to the interviewer, also a practising GP, the GPs look for further support for the fact that they have acted reasonably, particularly if they seek explicit confirmation from the interviewer that he would have done the same thing in the same circumstances. Removal as 'breaking the rules' can therefore be seen as a 'moral tale'. The telling of such a tale allows the GPs reassert both individual security and professional identity by showing that they have behaved reasonably and that other GPs when faced with the same problem would deal with it in the same way.

In addition, this 'moral tale' offers insight into the behaviour of GPs towards removed patients. The act of showing how the patient's behaviour is at variance with the GP's own conception of the rules governing the medical encounter raises two important points about how GPs view patients who 'break the rules'. First, the GPs tend to locate the difficulties encountered within the patient's own behaviour and illness rather than seeing it as the result of the interaction between the GP/practice and the patient. This finding is in accordance with other published work (Rogers *et al*, 1999b). One consequence is that it may be difficult to get GPs to 'think' about how their own behaviour and/or practice organisation may have contributed to the 'difficulty' experienced with the patient. Second, it is notable that the rules governing the doctor-patient relationship in general practice appear to be largely unwritten and accessible only to GPs and practice staff. One important implication of this is that patients may not know what these 'rules' are until *after* they have broken them.

The narrative of removal as 'sanction', in contrast to removal as 'divorce', does not feature in official guidance on removal. It offers insight into how some GPs view their relationships with removed patients. The doctor-patient relationship is presented in paternalistic (Szasz and Hollender, 1956), not participatory, terms: the image is that of a parent (or schoolteacher) disciplining an unruly child (or pupil). A further aspect of removal as 'sanction' is that it reinforces the idea that GPs tend to locate the difficulties encountered with patients within the patient's own behaviour and illness rather than seeing it as the result of the interaction between the GP/practice and the patient. It offers support for the argument, made in relation to removal as 'breaking the rules,' that it may be difficult to get GPs to think about how their own

behaviour and/or practice organisation may have contributed to the ‘difficulty’ experienced with the patient.

#### **4.5 Conclusions**

In this chapter I have presented the themes that emerged from an analysis of the GPs talking about their ‘experiences’ of removing patients from their lists with a fellow GP and researcher. I have paid attention to both ‘what’ the GPs were saying and ‘why’ they were saying it. I identified that the GPs accounted for their ‘experience’ of removing patients using three key narratives: removal as removal as ‘divorce’. Removal as ‘breaking the rules’, and removal as ‘sanction’. Each of these three narratives constituted a form of strategic interaction in which the GP presented him/herself as acting as any ‘good’ GP would when faced with a ‘bad’ patient who ‘breaks the rules’ of conduct of the doctor-patient encounter (narratives of ‘breaking the rules’ and ‘sanction’) or when the boundary rule of ‘affective neutrality’ between GP and patient has been breached (removal as ‘divorce’).

In the next chapter I turn my attention to the narratives that the patients use to ‘make sense’ of being removed from a GP’s list.

## **Chapter 5**

# **PATIENTS' ACCOUNTS OF BEING REMOVED FROM A GENERAL PRACTITIONER'S LIST**

### **5.1 Introduction**

In this chapter I present an analysis of the retrospective accounts of removal given to the Research Associate employed on the study (Kate Windridge - KW) by 28 removed patients in 25 interviews. As with the GP interviews, I treat these retrospective accounts as narratives that are jointly constructed by the patients and KW to perform a variety of functions. As I have previously argued, two important functions are the respondent's own need to present a particular image of self (Riessman, 1990) by presenting a coherent and reasonable version of events, together with KW's and my own desire to present the events as an orderly story. I will therefore attend to both 'what' the patients are saying and 'why' they are saying it. I will argue that my analysis of patients' accounts of being removed from a GP's list offers a number of important insights into a poorly understood phenomenon that have significant implications for GPs, patients and policy makers.

## **5.2 The Participants**

Twenty-five interviews were conducted with 28 removed patients. The number of interviews is fewer than the number of patients because three of the interviews consisted of joint couple interviews in which both partners had been removed. A third party was present in five of the interviews - either the current partner or close relative of the removed patient.

The characteristics of the patients are shown in table 5.1. The sample of patients was representative of the population of removed patients in Leicestershire in terms of key demographic variables drawn from the descriptive epidemiology of removal reported in chapter 3.

As discussed in chapter 2, I refer to each extract by removed patient (RP) number only, to protect the confidentiality and anonymity of the participant. In some cases, when I felt that the participants referred to were likely to recognise themselves in the extract, I have altered the gender, location and illness of the patient and/or the gender and location of the GP referred to by the patient.

**Table 5.1** *Key characteristics of sample of removed patients (n = 28)*

<b>Characteristic</b>	<b>No of patients</b>
<b>Sex</b>	
Male	13
Female	15
<b>Age</b>	
16 – 24 years	3
25 – 39	11
40 – 64	9
65+	5
<b>Location</b>	
<i>*City of Leicester</i>	
Deprived	16
Affluent	2
<i>County (Leicestershire)</i>	
Urban	6
Semi-rural	3
Rural	1
<b>Ethnicity</b>	
South Asian (name/surname)	10
Other	18
<b>Employment status</b>	
Employed	3
Unemployed	17
Student	1
Retired	5

17 removals were individual removals; 8 were household removals.

\*The Townsend score for the general practice the patient was registered with is used as a proxy measure of whether the area is deprived (Townsend score > 0) or affluent (Townsend score ≤ 0) (Majeed, 1999).

### 5.3 Themes

I identify three themes which help explain the phenomenon of removal from the perspective of patients who have recently been removed from a GP's list. In 'the good patient' I show that removed patients present themselves as 'good' patients. Being a 'good' patient means being 'ill' and acting in accordance with the rules of the patient-doctor relationship. In 'bad GPs and good GPs' I show that patients also see the GPs as subject to the lay rules governing the patient-doctor relationship and categorise GPs into 'good' and 'bad' GPs. The removing GP is presented as a 'bad' GP – he/she has broken the rules of the patient-doctor relationship. Lastly, in 'removal as a threatening event', the patients present themselves as victims of an unjustified act - the patients found removal very distressing and felt stigmatised.

#### 5.3.1 *The 'good' patient*

The removed patients present themselves as 'good' patients. Being a 'good' patient means being 'ill' and therefore needing medical care and acting in accordance with the formal and informal rules of the patient-doctor relationship. Their removal from a GP's list is seen as unjustified. In contrast, other patients who do merit removal from a GP's list are shown as acting in such a way as to breach the unwritten rules of the patient-doctor relationship: they are 'bad' patients.

##### (a) Patient is 'ill'

One commonly used strategy is for the patient to present themselves as 'ill' and therefore in need of medical care. Only two interviews could not be coded into this category. In cases where the patient presents him/herself as 'ill' the question 'what is

your health like in general at the moment?’ is followed by the patient using a range of narrative strategies to assert the authenticity of their medical problems. This can be illustrated by this woman’s talk about her illnesses:

KW: Yes, and what is your health like generally at the moment?

RP: Not very good.

KW: Isn’t it?

RP: No. [long pause while interviewee struggles with tears]

KW: You’ve had some trouble with it for a while?

RP: Oh yes, yes, a long time. I’ve got, well I had a stroke. That’s when all the problems seemed to start. I mean, I had bowel trouble and that before that, but I had a stroke and then, [pause] that was February ‘96, and then I think it was in the April that I was started suffering from depression, and of course I’ve had lots of anti-depressants and nothing seems to do me any good ... Of course I’ve suffered from depression terrible, I’ve got arthritis, I’ve got bladder problems. Oh, of course I’m on lots, lots of medication, lots, and of course I did have to visit the doctor very very often ... week after week that I had to go ... and each time I went, I’d got a water infection, or it was me bowels or something, and I was always [emphasis] given medication, always, I must stress that, antibiotics, painkillers, things like that. (RP3)

Thus the patient has had a range of medical conditions for a considerable period of time, needed to see her GP frequently as she was ‘ill’ and each time she saw the GP the GP confirmed her belief that she was ‘ill’ by prescribing her medication. From this patient’s point of view, her frequent attendance was entirely appropriate given the severity of her illness.

Further strategies that could be used to demonstrate to the interviewer that the patient was ‘ill’ (11 RPs) included use of dramatic language and accompanying non-verbal

expressions of distress and pain. This man's account relates to the pain suffered following an attack of gout:

RP: So I'm at home, oahh [expression of pain], and it's, it's, my toe's really driving me mad and it feels really swollen and I don't know what it is, and the pain, it was bearable, but getting unbearable, so I started taking some painkillers [advised by the GP] ... and I thought "no I'm not a wimp to pain, I'll just carry on" ... and it got to about one o'clock that morning and I just couldn't take it any more, I was crying, I wanted to rip my foot off just to get rid of the pain, and I had to phone the emergency doctor. I couldn't stand it no more. (RP5)

Note how the patient also presents himself as being 'stoical' when it comes to pain and that he follows medical advice about treating the problem with painkillers. Another strategy was to actually show KW physical evidence of illness such as showing her an operation scar (RP8) and spreading out the contents of a plastic bag filled with all the medication prescribed by the GP (RP4).

In household removals with young children (5 RPs), the parents (usually the mother) present themselves as 'good' parents by showing how they have cared for and acted on behalf of their children's illnesses in their encounters with the GP. The children are presented as 'ill' using the same narrative strategies as outlined for RP3 above.

(b) Patient acts in accordance with the rules of the patient-doctor relationship

The second way that the patients present themselves as 'good' patients is to show that they act in accordance with the formal or informal rules of their relationship with the doctor. This is a strategy used by all the patients. Other patients who merit removal by the GP, however, are viewed as 'bad' and can be shown to have breached some of

these rules. An analysis of the patients' accounts of the 'rules' reveals five core categories. Three of these categories are used by patients in both their 'good' and 'bad' formulations (box 5.1).

<b>Box 5.1</b>	
<b>'Good' patients:</b>	<b>'Bad' patients:</b>
<ul style="list-style-type: none"><li>• Try to cope with illness and follow medical advice</li></ul>	
<ul style="list-style-type: none"><li>• Use the service 'appropriately'</li></ul>	<ul style="list-style-type: none"><li>• Use the service 'inappropriately'</li></ul>
<ul style="list-style-type: none"><li>• Are uncomplaining</li></ul>	<ul style="list-style-type: none"><li>• Are complaining</li></ul>
<ul style="list-style-type: none"><li>• Are polite with the GP when voicing any concern</li></ul>	<ul style="list-style-type: none"><li>• Are rude with the GP</li></ul>
<ul style="list-style-type: none"><li>• Value a 'long-term' relationship with the GP</li></ul>	

*Patients try to cope with illness and follow medical advice*

The patients present themselves as being stoical individuals who cope with their illnesses as best they can by self-care and only see the GP when absolutely necessary. When they do see a doctor, they follow the advice given by the doctor. Thus one man will not see a doctor with a 'cold', only takes medication for diabetes because he has been advised to by the doctor, and is keen to 'look after' his own health:

RP: And I don't go to doctor unnecessarily.

KW: No, no.

RP: It's not my habit. If I have a cold or a 'flu I will never go to a doctor. I do not want antibiotics, and I don't like medication personally. It's only when I have to take it, I take it. And because of my diabetes I have to take these sugar-lowering tablets ... You take it in your stride, you know, and a doctor can't do everything can he?

KW: No.

RP: It's our mental state also is important. Yes.

KW: Yes, that's right.

RP: Yes, because, I think also, I try to take as many walks as possible, because it's good for you ...

KW: Yes, yes.

RP: And we have to also cure ourselves.

KW: We do. (RP21)

*Patients use the service 'appropriately' / 'inappropriately'*

The patients also show themselves to be 'appropriate' users of general practitioner services. They do this by presenting themselves as not wasting the GP's time or abusing the service and use two types of narrative strategy to accomplish this. First, they specifically state that they use the service infrequently and rarely request home visits, if at all. This can be a denial of frequent service use in direct response to a question from KW about service use, as used here:

KW: How often would that be [seeing the GP], once a week, once a month?

RP: No I never seen him once a week, I used to see him fairly regularly though about once a month.

KW: Yes, and did he ever have to come to the house to visit you or anything like that or ...

RP: He has been to the house once.

KW: Yes, so that wasn't a frequent thing then.

RP: No, no. (RP10)

Alternatively, in the stories that they told about encounters with the GP the patients stressed that they managed to attend the surgery with their complaint or that it was the first time they had ever called the GP out to their house. As this woman who has already been noted to have multiple medical problems put it:

RP: Believe me, I've gone down there [GP surgery] when it's been an absolute struggle to get down.

KW: I can imagine.

RP: I've felt dreadful, but I've gone down. I've gone down when I ... I, could hardly walk. (RP3)

A second strategy used is for the patient to state that they do consult frequently with the GP and need home visits *but* that this is justified on the basis of the patient's illness. Thus this woman justifies her frequent attendance on the basis that she had changed her medication and needed a medical certificate:

KW: Yes, so how often did you go there [to the surgery]?

RP: Erm.

KW: Being poorly you must have needed to go ...

RP: I went quite a few times because I was trying a different sort of medication and also I needed a medical certificate to sort of tell the DSS office, you know. (RP25)

'Other' patients - who could legitimately be removed from GPs' lists - are characterised by the removed patients as 'bad': as 'inappropriate' users of services. These patients are portrayed as 'hypochondriacs' (a term used by three RPs) who have neither a genuine 'illness' nor attend the surgery appropriately. Here the inappropriateness of such behaviour is highlighted by being directly contrasted with the infrequent service use shown by the interviewee:

I think if you abuse the service, if you are a hypochondriac, and you're sitting there from morning till night every day, day in and day out, then I can understand it [being removed from a GP's list]. If you are a genuine person with problems, then you know, I don't know. Because previous to me going on this doctor's list, I've never visited a doctor in eleven years apart from a blood pressure check. (RP5)

#### *Patients are uncomplaining / complaining*

The patients show themselves to be uncomplaining about the care received from the GP and/or practice. They use two types of narrative strategy to accomplish this. First, they give accounts of their actions that show that they don't complain even if unhappy about the care received. This woman is unhappy that a doctor in the practice ('bad' doctor) misdiagnosed her diabetes and has decided not to consult that doctor again, but she doesn't complain about the misdiagnosis, even to a GP she feels is 'good' doctor:

RP: Anyway I went as an emergency and I went to see this doctor and erm he obviously didn't know what it was and he just gave me these tablets for like this tiredness I was having. Well obviously that didn't sort it out because it was diabetes I got. Anyway I went back to see my own doctor because I was still feeling very poorly and erm I had a blood test. He spotted it straight away, well what he thought it was obviously he didn't confirm it until I'd had my blood test results back. I had a blood test which normally takes up to ten days. Well within days Doctor X. was ringing me, saying "it's dangerously high", he said "get on these tablets straight away", which I did ... But that is the only reason why I personally would rather go and see another doctor. Although I didn't complain about it, I never even said anything about it, even to Doctor X., that was just me.

KW: Yes but that was because they didn't sort of diagnose what was wrong?

RP: But surely I mean anybody would feel like that. But as I said I never once complained 'bout it. Not to anybody, only like the family.  
(RP13)

Alternatively, the patient may state that they did put a formal complaint in about the GP and/or practice *but* that this complaint was justified. Thus this man felt that it was only correct that he should complain about the unacceptable standard of care (elsewhere in the interview he shows how his particular complaint was legitimated by a deputising service GP):

You've [GP practice] got to just accept that you've hurt me, to stay on a doctor's list. That's the way I feel. If I hadn't had shouted about it, or I hadn't have done anything about it, then I'd have still had a doctor, but surely that is my right to choose, and I shouldn't be - I shouldn't be treated that way because I chose to go that way, because I chose to say "excuse me, stop, you're not going to do this to anybody else, you know". (RP5)

'Bad' patients, whom the GP has every right to remove from his/her list, are portrayed as being patients who would openly question a doctor's judgement and

who would threaten legal action against the GP in circumstances when such action is unjustified. As this woman put it:

Let's take a simple case, let's say somebody wants antibiotics all the time - and I know from [being] a nurse antibiotics all the time isn't good for someone - and that GP every time that person comes in they have an argument about having some antibiotics, and they might even threaten them [GP] with a law suit or something like that I think they have the right to remove that person. (RP24)

Note how the patient uses her status as a nurse to strengthen her claim that it is wrong to want antibiotics 'all the time'.

*Patients are polite with the GP when voicing any concerns / are rude or violent*

It is important that the patients show themselves to be polite to the GP and/or practice staff when they voice any concerns that they may have. Again, two types of narrative strategy are used to accomplish this. First, in their accounts of any disagreement with the GP the patients present themselves as behaving in a polite manner. This man presents himself as politely asking his GP why the practice does not have an Asian receptionist. The polite behaviour of the patient is contrasted with the 'rude' behaviour of the doctor:

So I says to him [GP] with great respect - we don't just call him "doctor", we just call him "doctor [Name]". I never called him doctor any time that he was my GP, I kept on calling him "Dr [name]". I was calling him by this. I said "Dr. [name] why are you saying this? He says "you ought to go to change doctor" and he said "He [father] can't get on with my receptionist" and I said "why is that?" ... So I said can I suggest to you something doctor, it's just the exact words I say, "Why don't you have an Asian receptionist?" And he went mad, you see, he just lost his bottle ... But I said "it's just a mere suggestion", I said [in polite tone]. "It would be nice if we had an Asian receptionist as well." (RP6)

A second strategy is for the patient to admit that he/she 'lost his temper' but that this was justified because the GP or another member of practice had first of all lost his/her temper. There was provocation by the GP, the patient was simply reacting to the former's 'bad' behaviour. Thus in this account of the last consultation with the ex-GP these two women (removed patient and female partner) are keen to show provocation:

RP: And so I was sitting there crying and then he [GP] got up and opened the door and I hadn't even said what I had been there for and he said "All right, I have got other patients now".

Partner: [GP] "I would like you to leave now."

RP: And because I was crying, she starts crying and ...

Partner: He was pointing his finger in my face.

RP: Yeah, and she [partner] said "She's got other things to say to you. She's losing it, she's suicidal".

Partner: I said "Look at her, she needs help", because she was standing there sobbing.

RP: I was crying, she was crying.

Partner: He [GP] was pointing his finger in my face.

RP: And he [GP] said "Just listen". And she goes to him "You listen here you". Like that, crying her eyes out. I mean it wasn't threatening or anything it was just like...

Partner: [GP] "Just listen", you know.

RP: We looked like a couple of [inaudible] let alone anything else and then. So he just stood at the door, holding it open and I just said to her "come on, you know, it's pointless" ... a couple of days later he had struck me off. (RP2)

Note how the GP fails to listen to the patient's concerns and shows rudeness by standing up and opening the door while she was crying and pointing his finger in her face. In contrast the patient is keen to point out that her partner's behaviour wasn't threatening.

'Bad' patients, on the other hand, merited removal if they were rude or violent towards the GP and/or staff. This woman clearly views such behaviour as justified grounds for removal:

KW: Do you think that GPs should be allowed to remove patients from their list under any circumstances?

RP: Oh, there could be circumstances, oh yes. I mean, you get some people who ... their behaviour is disgraceful, and you can't expect a doctor to subject himself to being knocked about and spoken to in a disgusting manner, so oh, no. Good gracious me. (RP8)

*Patients value a 'long-term' relationship with the GP*

The last informal 'unwritten' rule that patients invoke is seen as specific to general practice. The patients are keen to show that they both have and value a 'long-term' relationship with a particular GP and/or practice. They do this in two ways. First, they place stress on the fact that they have been registered with the removing practice for a considerable period of time - a fact that demonstrates loyalty to that particular GP or practice and that they have hitherto 'got on' with the practice. This patient and his partner are at pains to show how this loyalty was simply brushed aside by the removing practice:

- KW: You didn't feel that it was that you weren't getting on with him [GP] or anything like that?
- Partner: No he was ... I mean I think you've been with him 20 years.
- RP: It's a long while. It is a long time, I think, 1975 something I've been with him since so, it is a long while and er until the last couple of years I rarely visited them.
- Partner: It was extremely abrupt wasn't it, bang, letter [of removal], gone. (RP12)

Alternatively the patients demonstrate that they have developed a personal relationship with the ex-GP over a long period of time - one in which the doctor 'knows' the patient as a person. As this woman put it:

He was my only doctor I'd had since I'd left home. You know, and it's a long time to have a GP and he knew me. You know he used to call me by my first name and everything you know, have a laugh and a joke and this all happens over these two, it's all happened till them stars [circumstances surrounding removal]. (RP19)

### 5.3.2 *'Bad' general practitioners and 'good' general practitioners*

In the previous section I have shown that patients seek to present themselves as 'good' patients. The patients also discredit the behaviour and actions of the removing GP. This is accomplished by dichotomising GPs into 'bad' GPs and 'good' GPs. The removing GP is presented as a 'bad' GP – he/she has broken the rules of the patient-doctor relationship. In contrast, other GPs, notably the 'new' GP with whom the patient is now registered, are presented as 'good' GPs – they act in accordance with the same rules. In their accounts of removal the patients use the 'good' / 'bad' GP

dichotomy strategically. Often the ‘bad’ actions of the removing GP are directly compared with the ‘good’ actions of the new GP practice.

The removing GP and/or practice staff are presented as being ‘bad’. In contrast, other GPs are presented as being ‘good’. The most common category of GPs who were described as ‘good’ were GPs in the new general practice, the practice the patient has joined since being removed (18 RPs). Other categories included a previous GP practice to the removing practice or another GP in the removing practice who was not involved in the removal decision. Only one interview cannot be coded into this theme. In this interview the patient is accepted back onto the GP’s list. It is the behaviour of a relative of the patient and not the GP which is seen as ‘bad’ by the patient and which is believed to be the cause of the decision to remove. The patient has always viewed the GP as being a ‘good’ GP.

An analysis of the patients’ accounts of the ‘rules’ revealed five core categories. I shall present these in their ‘bad’ and ‘good’ formulations (box 5.2).

<b>Box 5.2</b>	
<b>‘Bad’ GPs:</b>	<b>‘Good’ GPs:</b>
• Are rude	• Are polite
• Lie	• Are honest
• Are impersonal	• Value personal care
• Are uncaring	• Are caring
• Are incompetent	• Are competent

(a) GPs behave in a rude manner towards the patient / are polite

Rudeness could take the form of either non-verbal or verbal behaviour. Non-verbal manifestations of rudeness included the GP and/or staff having a brusque, abrupt or condescending manner. The GP might also be shown to openly lose patience with the patient. In this account given by the son of a removed patient the loud knocking on the door and shouting combine to present the GP as being very rude:

Well, once, my mum was ill, and was sleeping upstairs, and my mum called him, [GP] yeah, and he came and he was knocking on the door really loudly, and my mum was upstairs, innit, sleeping, and she came downstairs and then, you know, he started shouting and things and saying “I ain’t got no time, you should have opened the door quickly” and everything, and then he didn’t examine my mum properly, and then he said, “you know, it was just a waste of time, you should have come to the surgery and everything”. Proper shouting at her. (RP4)

Another way the GP might be rude is to falsely accuse the patient of socially unacceptable acts. Such acts include accusing the patient of racism or of lying to the GP. In this extract the patient states that the GP openly accuses her of lying and implies that she is a ‘drug pusher’, selling her prescription medication for profit. Her ‘alibi’ is that she was in hospital at the time of the alleged ‘offence’ and still has her ‘uncashed’ prescription to prove it:

He [GP] told me “I’d had my repeat prescription” and when I looked, the letter, my prescription - I’ve still got it, still got my prescription, [GP] says that I had prescription, I had been prescribed these tablets, and honestly I hadn’t because I was still in hospital. This is where [pause] he was shouting at me in the surgery over this and it was in black and white from my doctor’s notes from the hospital. I said “look, look at me notes then”. I says “you can see I was still in hospital on the eighteenth of May. I went in on the twelfth, I was still in on the Wednesday.” This is when I was supposed to have gone and got some tablets and I never had em. I never had em at all duck, never

had em and he turned round to me and said “what you doing then, are you selling em for drugs”. I said “what, heart drugs, heart tablets?” You know, it was unbelievable what he was actually saying to me. He was saying “so you’re trying to tell me then this computer’s lying and you’re not lying”. I says “yes, I’m telling you that you’re lying. I was in hospital. How could I have” ... because I’ve got the prescription in me pocket, I’ve kept that after, I already holded [sic] onto that. (RP19)

In contrast, the new GP and practice staff are portrayed as acting in a polite and friendly manner. This woman highlights the difference between the ‘good’ and the ‘bad’ by a direct comparison:

It’s like the difference to the surgery I’m at now is unbelievable. They are so polite, they are, they will do anything for you. They’d will put themselves out, they would get off their backsides, they will look into something for you. Whereas this place [removing GP’s surgery] they just didn’t care. (RP13)

(b) GP lies to the patient / is honest

Another interactional ‘rule’ which ‘bad’ GPs break is the requirement to ‘tell the truth’. ‘Bad’ GPs are shown to lie to the removed patient. Three patients refer to their last consultation with the GP and note that the GP offered them a further appointment or referral to a specialist and this never happened: the patient was removed from the list in the meantime. This extract is typical:

And then he [removing GP] told me to go and see him again within two weeks, but in that time he struck me off ... that’s the worst thing he ever did, because the least I would have expected of him was, he’d see me again in that two weeks and then said “now look, your behaviour problem is not what I’d expect” or “I can’t handle it” or whatever and told me to my face. But he wrote that [sick note] and then he said come and see me within two weeks and then he struck me off his list, you know. (RP10)

Not only does the GP lie to this man, he is also portrayed as acting in a cowardly manner – the removal is underhand as opposed to telling someone ‘to their face’ what the problem is. In this particular case it is not the removal *per se* that is treated as ‘bad’ rather the fact that the patient was told an ‘untruth’. This man would see a ‘good’ GP as being honest and up-front with the patient about the difficulties he was experiencing, even if it led to removal:

KW: What do you think that your doctor should have done instead of striking you off, in an ideal world?

RP: Well I think he ought to of like told me ... He ought to have turned around and said “look erm I appreciate your point of view but I can't cope with this kind of behaviour.” (RP10)

(c) GPs are uncaring / caring

An important core category is that the ‘bad’ GP is ‘uncaring’ in relation to his or her encounters with patients. In this context ‘uncaring’ encompasses two subcategories: GP ‘can’t be bothered’ and GP is not altruistic.

The GPs are portrayed as time-servers who ‘can’t be bothered’ to deal with patients properly. One key attribute is that the GPs don’t listen to patients or acknowledge their concerns. Some patients stated that such repeated behaviour on the part of the GP left them feeling that talking to a doctor was like ‘talking to a brick wall:’

I should have been able to go into that doctors, surgery that day and say “This is what has happened to me” ... But no, he gets up before I can even say that, and don’t even, you know, want to listen or want to do anything like that ... I mean, it really is brick wall after brick wall, that’s how it feels to me. (RP2)

Instead, the patient is 'fobbed off' – a phrase used by three patients to describe their dealings with the removing GP - with something less than he/she was expecting. The 'fob off' could be a short consultation in which there was inadequate time to discuss the problem at hand terminated either by the GP writing a prescription or by the GP stating that he/she had other patients to see. As this man put it:

You know, they [GPs] were giving me them [drugs] like they were just free sweeties ... You know, there you go, there you go. "Yeah, no problem, how long have you been here", oh hold on he has been here three minutes I had better write him one [prescription] out quick now. (RP1)

Another commonly used 'fob off' was the refusal by the GP or practice to do a home visit. In this extract the partner of the removed patient uses the strategy of citing that others are also unhappy about the care that the removing practice provides:

Partner: Yes, definitely they don't like to do call outs round here to anybody. There is an elderly woman that's quite an invalid and the X. [removing] practice have been extremely rude and totally upset her because she had to call them out due to water retention problems and she really was quite quite ill. But he [removing GP], she said that he was quite threatening in his manner and the fact that it was like gold dust, you have called me out the ultimate sin. They don't like it at all do they?

RP: No it's most peculiar, most peculiar. (RP12)

'Bad' GPs are portrayed as putting their own interests first before those of their patients: they are not altruistic. This is achieved by the patients presenting the GPs as being 'only in it for the money.' Being very busy and having no time to see or talk to patients is presented negatively as showing that the GPs simply see medicine as a

'business' in which the aim is to make as much money as possible. In this extract the GP is not only presented as money grabbing, he even goes so far as to openly discuss money with his patients:

Male: He is so much money-orientated, money minded, you know, he wants to make money. He's into making money rather than treating the patients. He's always saying and discussing money with the other patients, and everything.

Female: Every time we go in there he doesn't want to listen to our health, all he wants to ask is my husband "how is business? how much money have you made? You must have made twenty-five thousand by now," and things like that, you know. (RP6)

A further strategy is to present the GPs as charging large sums of money for medical reports felt by the patients to be both perfunctory and unhelpful. Given that some patients view themselves as being 'expensive' either in terms of drug therapy (5 RPs) or requesting home visits (4 RPs) then it is not surprising that patients draw on media discourses surrounding the removal of 'expensive' patients to account for why they have been removed from their GP's list:

It [removal] opens up a can of worms in that a doctor can then say he's got an expensive patient, that's using a lot of his funding and he'll say, "I don't want them" with no reason. So therefore, I would suspect there are a lot of patients who are taking up a lot of funding because they are ill, who are being struck off purely for that reason. (RP7)

In contrast, 'good' GPs take time to listen to their patients and explain why they have chosen a particular course of action; they do not resort to 'fob offs' to terminate a consultation. They are also shown as putting the interests of the patient first. Thus

this woman says of her former GP, whom she only left because she had to move out of the practice area:

RP: But the doctor that we were under in [council estate in Leicester]

KW: She was lovely ...

RP: It was [name of surgery] can't remember her name but she was a lovely doctor, she would listen to M. [partner] because she knew she was running late she would listen to M. because she knew what M. was going through. She's had letters from the hospital she'd sit listen to M. and she would sit listening to me even though she was pregnant, [I was] going through stress because [of] the break-in. She would sit and listen to make sure the baby was alright. She was a great doctor and I wish we hadn't have moved, it was only because of the break-ins and the council ... I mean she even said to M. one day when we were in the surgery "if you ever need me" she says "phone and tell them that you need to speak to me", "if I've got a surgery" she said "tell them" she said "and I will be on the phone to you" she said "you need moving" she said "I will I will try my hardest to help you out." (RP15)

Note how this woman uses the pregnancy of the GP and the fact that the GP was 'running late' to emphasise the 'caring' nature of the GP.

(d) GPs are impersonal in their dealings with the patient / know the patient as a person

The removing GP and other members of the primary health care team are often portrayed as being impersonal in their dealings with the patient. The metaphor of the 'production line' was used by two patients. This captures the idea of standardised mechanised treatment being given out to patients whose identity as a 'person' has been lost. This man directly contrasts the impersonal care of the removing practice with the more personal care provided by another former practice:

RP: I am not on my own about that practice, you know what I mean. There's a lot of people who feel that they, it is a production line. You are in, you are out, with the least as you can get, and as least help as you can get. They have made more money, you are all right, you know what I mean.

KW: And it wasn't like that where you were before, so you had no problems?

RP: No way, they used to sit there, you used to sit down tell them your problems and basically they would turn round and say, talk to you in a more, how shall I say it, in a fashion of not trying to tell you that you are going nuts but trying to explain that you are not thinking right. (RP1)

In constructing their accounts of 'good' GPs as 'knowing you as a person' patients use their experiences of the care provided by their new GP. Thus this woman sees her new GP as a 'friend':

RP: They don't act like doctors, you know, they act like friends, they actually sit and listen to you. They don't just ask you about your illness, they say you know "what you been up to" and they're really nice, because they know my mum really well. (RP25)

Alternatively patients draw on their experiences of the 'personal' GP they had when they were younger – such GPs are presented as having long since retired or else have left general practice because they are no longer able to provide personal care on the National Health Service. Indeed, this woman presents the benefits of personal care as she perceives them and offers a stark contrast between the personal care she used to receive and the impersonal care she got from the removing GP:

- KW: What do people look for in a really good doctor. What would you say a really good doctor is like?
- RP: A doctor that treats you like a person and not a number.
- KW: Yes.
- RP: A doctor that really cares. A doctor that listens to you. A doctor that's got time. A doctor that explains what the problem is. A doctor that explains what he is gonna do for you, a doctor that really cares and says "you know any more problems come and see me" like my original doctor did ...
- KW: And do you think it made you feel better?
- RP: Yes.
- KW: Physically as well, I mean as well as liking it, do you think it helps you to be more healthy?
- RP: Yes, because I felt that he was there for me. My doctor was there for me, somebody who actually cared for me, somebody that knew me. Yes it did, it helped a lot and that you know as he said in so many words to me, "you know things have changed here. Things are changing, so I'm glad to be retiring." Because that's what I said to him, "will you miss it?" and he said "no". Now a doctor that's been in it all them years, things are changing and you're just a number.  
(RP13)

(e) GPs are incompetent / competent

The patients draw on their own experiences of health care given by the GP, or the stories of other patients to portray the removing GP as incompetent – he/she is unable to properly diagnose and/or treat patients. This may relate to the events that led up to removal or be a separate incident used as to strengthen the case against the removing GP. In this woman's story the GP's unwillingness to look into her symptoms and his cursory treatment of her with medication is shown to lead to her admission to hospital with a complication of gall stones:

I never [emphasis] had to call him out and with my illness anyway he kept saying there was nothing really, just kept fobbing me off, fobbing me off with these damn tablets. I kept having to take these tablets and everything were just getting worse and worse. Then I just got admitted [to hospital], admitted last June. I had to have an operation very quickly because I'd got a [gall] stone that had blocked ... he always fobbed me off with tablets to stop me being sick. Nothing, he weren't looking deep into anything what was actually the matter with me. (RP19)

She further enhances her status as a 'good' GP by stressing that she never requested a home visit for this problem.

A further strategy employed by patients is to directly contrast the incompetence of the removing GP with the competence of the new GP:

There was one particular instance ... I've had a bad infection for ages and as soon as we signed up here I went down here, I seen the [new] doctor, I seen the nurse she gave me swabs and everything, checked me out, the doctor checked me out, gave me um a set of antibiotics that didn't work. Next week I went he'd sorted it out straight away with a cream. Now them [previous practice], they'd been messing around for ages and mucking about and you know I'd had, oh, cream after cream and "oh it's a lost cause" that was the answer. (RP22)

The thoroughness of the new practice is contrasted with the perfunctory care received by the removing practice.

### *5.3.3 Removal as a threatening event*

The act of being removed from a GP's list is very threatening for the patients. The patients present themselves as victims of an unjustified act which leads them to

suffer emotional distress. Removal is also presented as a threat to a person's identity as a 'patient' – it is seen as stigmatising.

**(a) Removal as 'victimhood'**

The act of removal is seen by patients as a flagrant abuse of power by 'bad' GPs. The extent of this abuse is shown by GPs being able to remove patients and their families from their lists without warning, without the need to justify their actions and without the patient having any right of appeal or redress. The patients present themselves as innocent victims.

The GPs are seen to remove patients without warning. It should be noted that all but one of the patients state that removal was totally unexpected. The only (partial) exception is a man who expected that he would receive a written warning for missing several appointments without cancelling. The first the patients knew about removal generally was when they received the formal letter of removal from the Health Authority (no reason for removal is given in this letter). Only in a minority of cases (4) did patients receive an additional letter from the GP setting out the 'grounds' for removal. The fact that the letter of removal arrived without any prior warning is seen as the source of much emotional distress for patients. The dominant emotion is often one of shock and disbelief (shown by 14 RPs) or anger and righteous indignation (shown by 15 RPs).

This account given by a woman who was removed over a Bank Holiday is typical of the 'shock' felt by patients:

- RP: And then I got ... [crying]
- KW: Shall I turn it off?
- RP: Yes. [Tape turned off for a few minutes]
- KW: We can do it in just little bits if that's easier for you ...
- RP: And of course, I didn't feel any better, and on, it was Christmas Eve, which was absolutely dreadful, that I got the letter ...
- KW: I can imagine. Oh no.
- RP: Christmas Eve, and I mean I was still feeling ill. I was in bed, and my husband came up and he says and he said "You've had a letter from the doctor". (RP3)

Note how the dramatic nature of this tale is enhanced by the use of reported speech, the setting of a bank holiday, the husband coming up the stairs with the 'letter from the doctor', the patient hearing the news 'ill in bed' and KW's expression of sympathy.

The fact that GPs can remove patients without the need to justify their actions is seen as open to abuse. Thus this removed patient and her partner use the metaphor of 'playing God' to emphasise that GPs can behave as if all-powerful, without any regard to their obligations to patients:

- RP: They [GPs] shouldn't be able to, you know, get rid of them [patients] just because they feel like it. Just because it's, you know, they can't be bothered.
- Partner: They seem to be playing Gods, the doctors, and, you know, seems to sort of go to their heads that I can do whatever I want, I can choose to help you or I can, you know, toss you aside. (RP2)

Household removals, in particular, are seen as victimizing, as the fact that ‘innocent parties’ – such as children - have been removed heightens the sense of injustice:

KW: And has it affected the rest of your family the way that this has been going on or the way you’ve been removed. Have they been removed?

RP: Yes, oh yes, the whole family, the whole family. That made me angry, because I thought “well if you’ve got something against me, then that is fine, but not to victimise the children as well”. They’ve done nothing, they’ve not abused the service. (RP5)

In contrast to the shock and distress shown by the ‘ill’ woman who was removed over a Bank Holiday weekend (RP3) the predominant emotion displayed by RP5 towards the removal of his entire family is that of anger and righteous indignation.

The final abuse of power shown by the GPs is the fact that patients are given no right of appeal or redress. Several patients express their anger at finding as part of the removal process that they have no right to query a GP’s decision to remove or right of reinstatement onto that same GP’s list. The comment of this woman whose family were all removed by their ex-GP is typical:

RP: I rang up to see what I could do about it [removal]. The surgery, I rang the Health Authority whatever it was and they were asking me about it and they said “oh I wouldn’t go to that doctors then”.

KW: Did they?

RP: Yes. “Oh no, the doctors can just get rid of you, they don’t need a reason”. So I was very annoyed at the fact, because they have picked on the wrong person here because I wouldn’t let it drop ... You know at the end of the day, I [emphasis] knew what was right and he [GP] obviously didn’t. That’s what so annoying about it, I’d done nothing wrong. I am even still annoyed about it now and if I could do something about it I would do. Because they shouldn’t be allowed to

get away with that and treat patients like that. Patients have a right.  
(RP13)

A further reason why such patients felt 'powerless' was that they felt that their version of events would be less likely to be believed by any third party than the doctor's version of events – the odds were seen as stacked in the GP's favour.

The patients stress that, in cases where removal is justified, then GPs should be brought to account for their actions. As the partner of this removed patient notes:

I think that certain accountability procedures should be put in place as well. These people [GPs] wander around like tin pot gods, can do what ever they like, and I think there should be justification to the patient and to the authorities why this person is really [emphasis] being removed. (RP12)

Note how this removed patient also uses the 'playing God' metaphor, with its implication of doctors being all-powerful. A range of ways that GPs should be brought to account for their actions are presented, notably that the GP should give patients an explanation as to why they are to be removed (7 RPs) and that they should discuss their intention to remove the patient with the patient beforehand (6 RPs).

#### (b) Removal as stigmatising

The second main effect of removal is that it is stigmatising (Goffman, 1968).

Removal 'spoils' the identity of the removed person as their right to be a 'patient' has been compromised. They can only become a 'patient' again by re-registering with

another GP. The use of the phrase ‘struck off’ to refer to removal (used by 6 RPs) emphasises the stigmatising effect of removal.

Removed patients report both *felt* and *enacted* stigma (Scambler and Hopkins, 1986).

Enacted stigma is defined as actual instances of discrimination against people who have been removed on the grounds of their perceived unacceptability or inferiority.

Felt stigma is defined as both the fear of enacted stigma and a feeling of shame associated with being a person who has been removed.

The dominant form of stigma exhibited by the patients was felt stigma (21 RPs).

Patients showed a fear of enacted stigma – a fear that they might be treated differently by their new GP or other health care professional. One of the main concerns was that removed patients’ notes had been marked so that they would receive different treatment from the new GP, as the partner of a patient noted:

But we would very much like to know how our notes have been marked because if they have clearly been marked, so we don’t actually know what our new GP is gonna make of whatever we don’t know that he is going to read. So we can’t get on with the new GP because we don’t know what’s been put down. (RP12)

The impact of a ‘black mark’ against one’s name is highlighted when one GP was portrayed as actually threatening to make life difficult for the patient in future by labelling him as ‘threatening and abusive’:

KW: The other thing I was interested in is that you said that he said that he’d make it hard for you to get registered with another GP. How, I mean, did he say any more about that?

RP: He's just basically trying to imply because he'd write on my record. He said er he's making out that my record will follow me everywhere, so when it got to the other doctor where I was trying to enrol with, he'd said that I'd been threatening and abusive and he said he'd put loads on it and saying so I wouldn't be able to get enrolled with no others. (RP23)

One way that the patients tried to reduce the risk of enacted stigma was to try to 'pass as normal'. In their accounts of re-registering with a new GP the patients did not tell the new GP they had been removed, they simply said that they wished to change doctors. In this account of removal it is important for the removed patient not to 'lose face':

KW: And how did you find your new doctors?

RP: The new doctor well I chose the surgery here, X. Clinic. It is not a private clinic, I think it's the main clinic, it has various doctors and staff there. Er, I went in there and I said we want to register with a doctor. There were no questions asked as to whether we had been removed from another doctor or were just ... the only question I was asked was "are you new in the local area?" I said "well we live, er, it is locally but we have changed our doctors". And I filled in the forms and everything and signed the forms and everything for the family and myself handed them to the receptionist. She said "you are registered now" and they took our name and address. (RP18)

The patients also felt a strong sense of shame about being removed. Removal could be viewed as making patients 'unworthy' of NHS treatment. The term 'alienated' was used by a couple whose whole family had been removed:

Male: I've told my friends even it's come out, and we feel alienated.

KW: Alienated from your friends or?

- Male: No, from the doctor.
- KW: From the doctor.
- Female: From the National Health, like you know. I mean, unsuitable for National Health for free treatment or whatever. (RP6)

Enacted stigma appeared to be less common. The majority of the patients (15) were able to voluntarily register with another GP, six required allocation and four were without a GP at the time of the interview. The allocated patients expressed concern that they would only be kept on their new doctor's list temporarily and one allocated patient gives a vivid description of what it's like to be on a 'thirteen week merry go round' (a phrase coined by another removed patient – RP12):

- RP: When we left Doctor [?] and went to Dr S., you know, L. Rd., and three months treat my family there, you know, after S. go to ... remember, you know, S. to ...
- Relative: Dr M. I think.
- RP: Dr M., you know, D. Road you know, three month there, after took me out of doctor and then I go to er Dr M. Some doctor – I don't know name, I don't know Dr name you know, D.  
[pauses]
- Relative: I think it was C. Street.
- KW: So how many doctors have you had since your mother came out of hospital?
- RP: Dr P., P. to Dr Z., Dr Z. to Dr M., L. Rd, L. Rd to Dr V., and Dr V. to Dr N.
- KW: So you couldn't stay with any of these doctors?
- Relative: No, not like permanently, no. (RP16)

This patient is in great distress during the interview. Elsewhere the relative asks whether or not GPs have ever been removed from a GP's list because, if they had, they would find the experience very unpleasant. Both patient and relative emphasise that being repeatedly removed means that the GPs never have his correct medical notes and that this adversely affects the care he receives.

#### **5.4 Discussion**

In this section I shall discuss the findings of the accounts patients give of removal and follow this by an analysis of the functions such accounts serve. I shall consider the wider theoretical and policy implications of these findings in chapter 7.

The patients present themselves as 'good' patients. Being a 'good' patient means being 'ill' and therefore needing medical care and acting in accordance with the rules of the patient-doctor relationship. The patients therefore see removal as unjustified as according to their accounts of their actions they require regular medical care and/or have done nothing 'wrong'. In contrast, patients who merit removal from a GP's list are shown as acting in such a way as to breach the rules of the patient-doctor relationship: they are 'bad' patients. While there is an extensive sociological literature on 'good' and 'bad' patients, as summarised in chapter 2, it is important to stress that this literature focuses on *health care professionals* categorising patients into 'good' and 'bad' patients depending on whether they conform or break the professionals' definition of the rules governing the encounter. Here, the terms 'good' and 'bad' are derived from *patients'* accounts of their encounters with doctors. Thus

patients themselves categorise other patients into 'good' or 'bad' patients depending on whether they conform or break lay definitions of the rules governing the encounter.

There are two important consequences of removed patients being 'good' patients. The act of removal suddenly and abruptly terminates access to a GP of patients who view themselves as 'ill' and thus regard themselves as requiring regular medical care. It is therefore not surprising that such patients found removal very distressing and described a high level of anxiety in relation to whether or not they could find another GP before they required a further consultation or prescription. In addition, patients are seen to evaluate their relationship with their doctor in terms of a sophisticated set of 'rules of engagement'. Patients see themselves as acting in accordance with these rules. The rules themselves are either formal (e.g., physical violence towards a GP is proscribed) or informal (e.g., one should not complain about a GP). Patients and GPs may not have consciously articulated informal rules, they may be tacit or implicit: it may take a 'breach' of the rule by either party before each party works out consciously 'what went wrong' and 'who was responsible' (Howitt *et al*, 1989). In addition, patients may hold a different definition of such rules than GPs and practice staff. A good example is the fact that patients saw their own service use as 'appropriate'. Such findings are consistent with published research into patients' accounts of service use (Roberts, 1992; Rogers *et al*, 1999b) and emphasise the fact that patients' and GPs' perceptions of service use are likely to differ considerably. As Roberts (1992) has shown in her ethnographic study of minor illness presenting at a children's A&E department, what may be seen as 'inappropriate' service use by the A&E staff may be seen as the 'appropriate' behaviour of a 'good parent'. An

important conclusion is that 're-education' in the form of health care professionals simply telling parents (or removed patients) that their service use is 'inappropriate' is unlikely to change future patterns of consulting behaviour.

The patients also saw the GPs as subject to the lay rules defining the patient-doctor relationship and typify GPs into 'good' and 'bad' GPs. The removing GP is presented as a 'bad' GP – he/she has broken the rules of the patient-doctor relationship. In contrast, other GPs, notably the 'new' GP with whom the patient is now registered, are presented as 'good' GPs – they act in accordance with the same rules. The findings reported here add to the limited empirical research on patients' typifications of doctors discussed in chapter 2. A consequence of the 'good' / 'bad' GP narrative is that the act of removal leads to the ex-GP being portrayed very negatively. Irrespective of whether or not the GP was 'really' bad, such a negative portrayal may come to the attention of the new GP and/or practice, local patient advocacy groups and the local or national media. This is likely to account for current media discourses surrounding removal of patients on financial grounds (Rogers *et al*, 1999a) as a key feature of being a 'bad' GP is being 'only in it for the money'.

Patients' accounts suggest that the act of being removed from a GP's list is very threatening for the patients. The patients present themselves as victims of an unjustified act which leads them to suffer emotional distress. Removal is also presented as a threat to a person's identity as a 'patient' – it is seen as stigmatising.

In the narrative of removal as 'victimhood' (Holstein and Miller, 2001) the act of removal is presented as an abuse of power by 'bad' GPs with the patients

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experiencing much suffering as ‘innocent’ victims. The use of the metaphor ‘playing God’ highlights the notion that the GPs are seen as exercising power without being accountable for their actions. Specifically, the GPs victimize patients. They remove patients and their families from their lists without any warning, without seeing fit to justify their actions to the patient and without the patient having any right of appeal or redress. These actions were perceived as being very threatening to the emotional well-being of patients who described a range of negative emotions, chiefly shock, distress and anger. Furthermore, the patients felt ‘powerless’ to put in a formal complaint about being removed as they believed that the word of a ‘professional’ person would carry greater weight than that of a lay person and they were also worried that such a complaint would make it more difficult for them to find another GP in the future. The ‘unreasonableness’ of the GPs’ actions is given added force by the patients making a reasoned case that the GPs should have the right to remove patients under certain circumstances, that GPs should discuss their intention to remove with the patient beforehand and that GPs should provide patients an explanation as to why they are being removed. Such proposals are in agreement with the guidance on removals issued by the Royal College of General Practitioners (1997). The latter guidance, however, has no force in law as a GP’s terms and conditions of service (Department of Health, 1989) simply states that a GP ‘may have any person removed from his list’ and assumes equivalence between a GP removing a particular patient and a patient choosing to leave a particular general practice – neither party is obliged to give a reason to the other. A GP’s terms of service thus fails to recognise the power imbalance in the relationship between practitioner and patient. I shall return to this particular point and the more general issue of power and the doctor-patient relationship in chapter 7.

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Evidence of the negative psychological, social and health consequences of removal is provided by the narrative of removal as 'stigmatising'. I would argue that removal 'spoils' the identity of the removed person (Goffman, 1968) as their right to be a 'patient' has been compromised. He or she can only become a 'patient' again by re-registering with another GP. The use of the phrase 'struck off' by patients is revealing as it is analogous to the use of the same phrase in the media to describe doctors who have been removed from the medical register by their regulatory body (General Medical Council) and who no longer have the right to practise their profession (Abbasi, 1998).

Scambler, in his interview-based study of patients with epilepsy, developed a useful analytic distinction between felt and enacted stigma (Scambler and Hopkins, 1986) which has been validated by other researchers (Jacoby, 1994). Applying Scambler's concepts to my work, I found that the dominant form of stigma was felt stigma. Patients feared that their notes were marked, labelling them as 'difficult' individuals, and that they might be treated differently by their new GP. They also felt a strong sense of shame about being removed. In contrast, enacted stigma was less common as the majority of patients were able to voluntarily register with another GP, arguably because they attempted to 'pass as normal' and therefore simply told the new practice that they wished to change doctors. Nonetheless, a minority of patients required allocation or were currently without a doctor. The allocated patients were concerned that the 'stigma' of being allocated meant that they might only be kept onto the new GP's list temporarily. If the stigma experienced by removed patients is comparable to that experienced by patients with epilepsy (Baker *et al*, 2000; Ellis *et al*, 2000) then

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one would expect such patients to exhibit psychological morbidity, chiefly anxiety and depression and low self-esteem.

Moving onto the functions that these narrative accounts serve, I would argue that the narrative of removal as a threatening event demonstrates that removal causes a high level of emotional distress and threatens a person's identity as a 'patient'. In giving their retrospective accounts of the events that lead up to removal to KW the patients seek to reassert their identity as a 'patient'. The narratives of the 'good' patient and 'bad' GPs and 'good' GPs should therefore be viewed as a 'strategic device' (Hyden, 1997) to achieve this effect in the interviewer/interviewee interaction. They can be seen as constituting a 'moral tale' or 'atrocious story' (Dingwall, 1977; Baruch, 1981). I have already noted, in chapter 4, how, in his study of parents' stories of encounters with health professionals, Baruch (1981) treated the respondents' atrocious stories as situated accounts constructed to display the competence of the respondent as an interviewee. Baruch concluded that 'moral tales' were constructed as displays of adequate parenthood. He also used his data to derive a model of how all such atrocious stories were constructed so as to achieve moral adequacy. In the next section I show how the narratives of the 'good' patient and 'bad' GPs and 'good' GPs fit Baruch's model.

The removed patients show that they have acted reasonably and competently as *patients* by demonstrating the authenticity of their medical problems and by conforming to the rules of the patient-doctor relationship. The patients 'prove' the authenticity of their problems by recounting to KW the details of their various medical problems and, where appropriate, showing physical evidence of illness or the

medication currently prescribed by the GP. In showing that they conform to the rules of the patient-doctor relationship, the patients present a lay model of the relationship which has striking similarities with health care professionals' definitions of 'good' patients (Roth, 1972; Jeffrey, 1979; Kelly and May, 1982; Roberts, 1992). As Jeffrey's (1979) has shown, such 'good' patients act in accordance with Parson's (1951) formulation of the sick role. The patients thus try to cope with illness and follow medical advice, use the service 'appropriately' and are uncomplaining. They also observe the substantive (formal) and ceremonial (informal) rules of social interaction (Goffman, 1967a; Denzin, 1970), being neither violent nor rude. The patients also observe the 'appeal to gentility' (Strong, 1979), taking pains to show how polite they were with the doctor should they feel that they had to disagree with his/her suggested course of action. Interestingly, they also draw on the notion of a 'good' patient that is specific to general practice – they are keen to demonstrate that they value a long-term relationship with their GP. The patients enhance their status as 'good' patients by demonstrating that patients who do break the rules of the patient-doctor relationship – those who are rude and/or violent, use the service 'inappropriately' and pursue unjustified complaints – deserve to be removed by GPs.

In contrast, the removing GPs are portrayed as falling short of the standards expected of a 'good' GP. Such 'bad' GPs are portrayed as clinically incompetent, being unable to properly diagnose and/or treat patients, and are uncaring, being 'only in it for the money' – both attributes which violate Parson's (1951) definition of the responsibilities of a doctor. They also breach the rules of social interaction as 'bad' GPs 'lie' to patients and violate the 'appeal to gentility' (Strong, 1979): the patients show how GPs directly confront patients and (falsely) accuse them of socially

unacceptable acts. 'Bad' GPs were also portrayed as being impersonal in their dealings with patients. As in other studies (Calnan, 1988; Coyle, 1999), the metaphor of the 'production line' was used to capture the idea of standardised treatment being meted out to patients who are treated as 'objects' rather than as 'people'. The patients further enhance their status as 'good' patients by showing that they are able to evaluate 'good' medical care and that when this is provided by a 'good' GP, the patient has a satisfactory relationship with that GP, in contrast to the removing GP. A 'good' GP is the obverse of a bad GP, being polite, honest, caring, knows the patient as a 'person' and is competent at diagnosis and treatment.

The patients therefore use the narratives of the 'good' patient and the 'bad' GP and 'good' GP to accomplish valid patienthood. The telling of their tales of removal allows the patients to assert individual security and their identity as a 'patient' by showing that they have behaved according to the lay rules of the patient-doctor relationship even though the removing GP 'breaks the rules'.

Empirical support for using such an 'accounts' approach to the removal process is provided by Allsop's (1994; Allsop and Mulcahy, 1998) analysis of written complaints made by patients against GPs in one English Health Authority and Mulcahy's (1996) in-depth interview study of consultants' responses to complaints. Allsop (1994) demonstrates that the complainants took pains to establish their moral worth by establishing their 'good' character, concern for other patients and the fact that the doctors had consistently fallen short of the standards expected of them. Mulcahy's (1996) paper is also very relevant as it provided me with theoretical insight into what the patients were 'doing' with their accounts of removal. She argues

that complaints are very threatening for doctors as they are a threat to both the doctor's emotional well-being and a threat to their professional identity – as I have noted in chapter 4. The way that doctors deal with this threat in giving their retrospective accounts of complaints is to reassert their role in the doctor-patient relationship and to present the complainant as a passive patient. Instead of seeing complaints as a legitimate expression of grievance, they were portrayed as symptoms of either the disease process or 'problem personalities' of the complainant. By conceptualising removal as a complaint against a patient by a doctor I was able to 'make sense' of the patients' accounts of removal. The threat that removal poses to a person's identity as a 'patient' is dealt with by the patients making a claim to valid patienthood in giving their retrospective accounts of the process of removal.

## **5.5 Conclusions**

In this chapter I have presented the themes that emerged from an analysis of the patients talking about their 'experiences' of being removed from a GP's list to a non-medical researcher. I have paid attention to both 'what' the patients were saying and 'why' they were saying it. I proposed that the patients accounted for their 'experience' of being removed using three key narratives: the 'good' patient, 'bad' GPs and 'good' GPs and removal as a threatening event. The narrative of removal as a threatening event demonstrated that removal caused a high level of emotional distress and threatened a person's identity as a 'patient'. The patients used the narratives of the 'good' patient and the 'bad' GP and 'good' GP in a strategic manner to accomplish valid patienthood. The patients asserted their identity as a 'patient' by

showing that they had behaved according to the lay rules of conduct of the patient-doctor relationship even though the removing GP 'broke' the rules.

In the next chapter I turn my attention to the 'paired' accounts of removal given by GP and patient in relation to the same removal event and conduct a cross-case (GP-patient) comparison of how each party uses the rules of the doctor-patient encounter.

## Chapter 6

### THE 'PAIRED' DATA:

# GENERAL PRACTITIONERS' AND PATIENTS' ACCOUNTS OF THE SAME REMOVAL EVENT

## 6.1 Introduction

In this chapter I build on my analysis of the GPs' (chapter 4) and patients' (chapter 5) accounts of removal by exploring the subset of 'paired' interviews in which both the GP and the patient give their retrospective account of 'what happened'. There are two aims of this analysis.

First, by presenting a small number of case studies of removal in detail I am able to tell each party's story about 'what happened'. This narrative approach to the interviews complements the previous analysis in which individual interviews were broken down into units of meaning and re-assembled to form conceptual categories (in keeping with the constant comparative method). I should stress that in telling these stories I do not attempt to sift out the 'truth' about what happened from each party's account. What I regard as important is how and why each party presents its particular version of events. As Riessman (1989) notes:

*It is a sociological axiom that the way people define a situation is reality for them, however 'incorrect' that may be from another's point of view (Riessman, 1989: 749).*

The second aim is to conduct a cross-case (GP-patient) comparison of the themes generated from an analysis of each separate set of GP and patient interviews (table 6.1). It is clear from the GP and patient themes that each party invokes similar rules of conduct of the doctor-patient encounter to typify the other party as ‘good’ or ‘bad’. What is unknown, however, is whether each party draws on the same rules of conduct to explain ‘what happened’ in relation to the same removal event. A cross-case comparison allows one to test this hypothesis.

**Table 6.1** *Themes used in the ‘paired’ data analysis generated from analysis of the separate GPs’ and patients’ accounts, reported in chapters 4 and 5*

<b>GP themes</b>	<b>Patient themes</b>
<p><i>‘Breaking the rules of the doctor-patient relationship’ – the ‘difficult’ or ‘bad’ patient:</i></p> <ul style="list-style-type: none"> <li>• ‘difficult’ behaviour</li> <li>• ‘difficult’ illnesses</li> </ul>	<p><i>‘Breaking the rules of the patient-doctor relationship’ - the ‘bad’ GP is:</i></p> <ul style="list-style-type: none"> <li>• rude</li> <li>• a liar</li> <li>• uncaring</li> <li>• impersonal</li> <li>• incompetent</li> </ul>
<p><i>‘Breaking the rules’ – the ‘trigger’ event:</i></p> <ul style="list-style-type: none"> <li>• violence and aggression</li> <li>• rudeness and losing one’s temper</li> <li>• open criticism of the doctor</li> <li>• making a formal complaint</li> <li>• manipulation</li> <li>• lying</li> </ul>	<p><i>The ‘good’ patient – ‘I abide by the rules of the patient-doctor relationship’:</i></p> <ul style="list-style-type: none"> <li>• I try to cope with illness and follow medical advice</li> <li>• I use the service ‘appropriately’</li> <li>• I am uncomplaining</li> <li>• I am polite with the GP when voicing concerns</li> <li>• I value the ‘long term’ relationship</li> </ul>
<p><i>Removal as ‘divorce’:</i></p> <ul style="list-style-type: none"> <li>• the long-term relationship</li> <li>• establishing grounds for divorce</li> <li>• a ‘last resort’ or ‘final act’</li> <li>• the benefits of divorce</li> </ul>	<p><i>The ‘good’ Patient – ‘I am ill and therefore need medical care’</i></p>

As it is not practicable to present the results of all the paired interviews I have chosen to use a case study approach to identify and illustrate how a particular conceptual category or theme is used by each GP and patient. Such an approach has been used in the published qualitative research literature (Stake, 1998) and I draw on one such paper (Salmon and May, 1995) to help structure my presentation of the findings.

I begin by summarising each party's account of removal, writing it in the third-person as if I were the narrator. I then take a particular theme (e.g. 'breaking the rules of conduct') and illustrate its use by using, commenting on and comparing extracts from each party's interview. Three case studies are presented: two illustrate different key conceptual categories and the third is a 'negative' case which I use to explore and modify the findings from the other two cases.

As discussed in chapter 2, it is likely that participants and individuals referred to in the narratives will identify themselves unless steps are taken to disguise the accounts. Protecting confidentiality and anonymity of participants should take precedence over telling the story verbatim but efforts should be made to keep the story as 'faithful' as possible to the original (British Sociological Association, 1994). I have therefore disguised the narratives of removal by altering key details of the stories: the gender, location and nature of the illness described of the participants have been changed, in differing ways, in each of the three case studies. At the same time I have endeavoured to ensure that the changes keep the overall 'sense' of the narratives intact. Where this has not been possible I have not used extracts from the transcripts and have resorted to paraphrasing the participants' accounts.

## **6.2 The Paired Interviews**

Eleven of the study interviews were 'paired'. The 'paired' interviews could be divided into two groups. The majority of 'paired' interviews (8) were when the patient had been already been interviewed and the GP had specifically agreed to be interviewed by myself about this particular named patient. In three interviews, however, the GP was not interviewed specifically about a named patient. In these interviews the GP had been selected as an 'unpaired' GP according to the quota sampling frame and I was unaware at the time of the interview that a patient removed by this GP would subsequently be interviewed as part of the study. Once the patient was recruited into the study by KW it then became apparent to me that I had already interviewed the patient's GP about his/her removal.

In the three case studies presented here the patient knew, as did all the interviewed patients, that the removing GP would be approached to be interviewed. In addition, the GP knew that the patient had been interviewed and specifically agreed to be interviewed about this particular patient.

In the interviews in which both parties report the same set of events which led to removal in terms of time, place and person (10 of the 11 'pairs') each party alleges that the other has broken the rules of conduct. In six of the pairs the GP sees a 'trigger event' as the sole or main reason why the patient should be removed. One of these 'pairs' has been chosen to be Case Study 1. In four of the pairs the GP sees 'grounds for divorce' as the sole or main reason why the patient should be removed and in one of the pairs it is an important contributory factor. One of these 'pairs' has

been chosen to be Case Study 2. In one 'paired' interview, presented as Case Study 3, the initial decision to remove by the GP is followed by a re-acceptance back onto the list of the same GP. This can be viewed as a 'negative' case because it is inconsistent with the emergent category that removal is viewed as a 'final act' by GPs with no possibility that the patient will be re-accepted back onto the GP's list.

### **6.3 Case Study 1: breaking the rules of conduct**

I have already shown from an analysis of the separate data-sets how both GP and patient typify the other party as 'good' or 'bad' depending on whether they conform to or break the unwritten rules of conduct which govern the doctor-patient relationship (table 6.2). For the GPs, removal often occurs when a patient previously identified as having a 'difficult' illness or behaviour breaks a key rule of conduct. This is what I term a 'trigger event'.

The following case study is representative of those pairs where a 'trigger event' is identified by the GP. I shall show how each party draws on the same rules of conduct in relation to specific events. I shall also explore the question as to whether any attempt was made by either party to repair the breach in the relationship that resulted from breaking these rules.

I begin by summarising each party's account of the removal event and follow this by a discussion of how each party alleges that the other breaks the rules of conduct and whether any attempt was made by either party to repair this alleged breach of the

rules. I conclude by summarising the findings in the other GP-patient 'pairs' where a 'trigger event' is identified by the GP.

**Table 6.2** *The rules of conduct of the doctor-patient relationship, identified in chapters 4 and 5*

<b>'Good' patients</b>	<b>'Bad' Patients</b>	<b>'Good' GPs</b>	<b>'Bad' GPs</b>
<i>Rules defined by GPs</i>		<i>Rules defined by patients</i>	
Are polite in their dealings with GPs	Are rude and lose their temper	Are polite to patients	Are rude to patients
Are honest with the GP	Lie to the GP	Are honest with patients	Lie to patients
Do not openly criticise the GP	Openly criticise the GP	Value personal care	Are impersonal in their dealings with patients
Do not make complaints about GPs	Make a formal complaint	Are caring	Are uncaring
Want to get better	Are manipulative to achieve their own ends	Are competent	Are incompetent
Are neither violent nor aggressive	Are violent and aggressive		

### 6.3.1 *A summary of each party's account of removal*

Dr Smith was female, in her 40s and a partner in a semi-rural group practice. Mrs Evans was in her 20s. It was a household removal, as both her, her partner, and daughter had been removed.

(a) Dr Smith's account of removal:

Dr Smith reported that Mrs Evans had a long history of being 'difficult' with the GPs and the practice staff. She was known to be 'difficult' even before Dr Smith joined the practice four years previously. Her problematic behaviour consisted of open disagreement with GPs about her treatment and 'inappropriate' requests for home visits for her daughter Amy.

The event that led to removal was set in motion by Mrs Evans turning up at the surgery demanding that her daughter Amy should see Dr Smith that same afternoon. Mrs Evans was very rude to a receptionist. In order to stop tempers rising Dr Smith agreed that she would see Amy and Mrs Evans at the end of her surgery. At this first consultation Mrs Evans is perceived by Dr Smith to have requested an urgent appointment because the family was shortly going away on holiday, not because Amy was acutely unwell. Dr Smith noted that Amy had a history of severe eczema for which she was under the care of a hospital consultant. Dr Smith took time to establish the exact diagnosis (either a flare up of eczema or a skin infection in addition to the eczema) and checked with Mrs Evans that she was in agreement with her diagnosis (skin infection) and management plan (antibiotic medication). She arranged to see Amy three days later. Dr Smith also raised with Mrs Evans the fact that she had been rude to the receptionist and that this behaviour was not acceptable. Two days later there was another altercation with a receptionist. This time, Mrs Evans demanded to speak to Dr Smith in the middle of her surgery. Dr Smith agreed to see Amy at the surgery and noted at this second consultation that while Amy's eczema had not improved on the antibiotics she wasn't acutely unwell. She felt Mrs Evans was happy with her advice. Later that day Mrs Evans made a threatening

phone call to the practice manager. She was very rude about the receptionists' manners. Mrs Evans also informed the practice manager that she'd obtained an appointment at the local hospital to see a hospital doctor that same afternoon and stated to the manager that she would put in a formal complaint if it turned out Dr Smith had given Amy the wrong treatment.

The next day Dr Smith brought up Mrs Evans's behaviour with all the other GPs in the practice and there was a unanimous view that she should be removed from the list because of the threat she made to the manager and also because of previous difficulties. Dr Smith then wrote to Mrs Evans stating that she was being removed because of a 'breakdown in the relationship'. Following receipt of the letter after her return from holiday Mrs Evans made two separate requests for re-instatement back onto the GP's list. Dr Smith spoke to her on the first of these occasions and reiterated that the relationship had broken down and that she should join a neighbouring practice. Mrs Evans declined to do so. When she made her second request for re-instatement the matter was again discussed by all the GPs and the decision to remove was upheld.

(b) Mrs Evans's account of removal

Mrs Evans reported that the receptionists at Dr Smith's practice were extremely rude and that other patients registered with the practice were of the same opinion. In contrast, she saw herself as having a good relationship with Dr Smith.

Mrs Evans began her story of removal by emphasising that her daughter Amy was ill enough to merit an urgent appointment with the Dr Smith and that she had been

advised that this was the correct course of action by Amy's hospital consultant's secretary *before* requesting the appointment. At this first consultation Mrs Evans noted that Dr Smith gave her permission to re-consult in a couple of days if Amy's condition did not improve. As Amy continued to be unwell Mrs Evans took her back to see Dr Smith two days later. At this second consultation Dr Smith carried out a thorough examination of Amy but decided to take her off her treatment for eczema as she felt the correct diagnosis was a skin infection. Mrs Evans did not question this course of action with Dr Smith. At home following this consultation, however, she discussed her anxieties about her daughter's treatment with her partner, who suggested to her that she should seek a second opinion from the hospital consultant looking after Amy. Mrs Evans received confirmation from the consultant's secretary that her daughter needed an urgent outpatient appointment and saw a hospital doctor the next day. At the hospital appointment this doctor stated that Amy did not have a skin infection, that the correct diagnosis was eczema and the correct treatment was long-term skin creams (steroid-based). Mrs Evans reports that she agrees with the hospital doctor's course of action, complies with his medical advice, and states that her daughter's medical condition soon improved.

Mrs Evans reported that the receipt of the letter from the practice stating that she was to be removed from the GP's list was totally unexpected. She did not feel she had done anything to merit removal. She then proceeded to telephone Dr Smith to ask for re-instatement. Dr Smith told her that she was being removed because she complained about the receptionists and they felt they could no longer treat her as a patient. Mrs Evans then argued her case with Dr Smith and emphasised that she only consulted regularly because her daughter was often unwell and that she had been a

patient of the practice since birth. She told KW that her being removed because she had made a complaint about the receptionists was just a pretext. She alleged that the 'real' reason for removal was that Dr Smith had found out from the hospital that she had misdiagnosed her daughter's eczema. She notes that Dr Smith also alleges that she had complained about her treatment of Amy to the hospital doctor. She does not specifically deny this allegation but she makes no reference to her making a complaint about Dr Smith to the hospital doctor.

Following the conversation with Dr Smith the patient was so angry about what had happened that she rang the local Health Authority. She was dismayed to find that GPs could indeed remove patients from their lists. She re-iterated to KW that this was unjust and that GPs viewed themselves as all-powerful. Mrs Evans and her family were able to register voluntarily with another local practice and she was full of praise about the receptionists at the new practice.

### *6.3.2 How each party uses the rules of conduct*

I shall discuss in detail two important rules of conduct which are illustrated by this 'pair': 'politeness/rudeness' and 'uncomplaining/complaining'. I draw on Goffman's (1967a) characterisation of social rules as discussed in chapter 1.

#### (a) Politeness/Rudeness:

One important etiquette rule is that individuals should be polite to each other in face-to-face interaction. The rule of politeness carries with it an obligation that individuals should conduct themselves in a polite manner in their interaction with others but it is associated with an expectation that the others will in turn treat them with politeness.

Rudeness, however, constitutes a breach of this etiquette rule. In this case study both Mrs Evans and Dr Smith present themselves as fulfilling their obligations: they act in a polite manner. But the other party does not reciprocate: instead of behaving likewise the other party is 'rude'.

In each separate account, polite behaviour on the part of the protagonist is met with rude behaviour from the other party. In this extract Mrs Evans presents herself as politely requesting a justified home visit from Dr Smith which is met with a blunt refusal to visit:

[Amy] was very very poorly this particular morning. I didn't know what was wrong with her. My partner was at work at the time, I'd got no, I hadn't got any transport and I knew that something was wrong with her. Anyway I rang this doctor and it was before surgery hours and I rang them as an emergency. "Oh no no you'll have to wait until I come over. I'm not coming out now", she [Dr Smith] refused to come out and see me. She [receptionist] said you will have to come down and I explained to her that you know I've got my little one, I haven't got a car, ain't got transport and I need to see her [Dr Smith]. "No." She didn't want to know, she said "you come and see me here".

(Mrs Evans Extract 1)

Similarly, Dr Smith's polite discussion with Mrs Evans about her rude behaviour towards the receptionists is met with a 'not particularly helpful' reply:

[I] took [her] onto the side and said "look, this behaviour with the receptionist can't go on. You know, there are staff here and they are important as anybody" and, you know, I asked her to appreciate that "they do a difficult job, an occasionally they don't always get it right, but they certainly do a difficult job", to which there was a lot of answers, and I have to say, all of them not particularly helpful. Anyhow it was left at that.

(Dr Smith Extract 1)

A cross-case comparison reveals that ‘rudeness’ is important for both parties. Both parties are in agreement that there is an issue about rude behaviour and the practice receptionists. They report that the other party has alleged that he/she is ‘rude’. Thus Mrs Evans states that Dr Smith claimed that the reception staff can no longer cope with her behaviour:

All she [Dr Smith] gave me was “oh I’m afraid we’ve had a complaint about the receptionist. They don’t feel that they can have you coming in anymore, it’s uncomfortable”.

(Mrs Evans Extract 2)

Similarly, Dr Smith states that Mrs Evans claimed that the receptionists were rude:

Later that afternoon mum phoned the Practice Manager here. There are various quotes, most of them unpleasant, but things like “the receptionist should go to charm school.”

(Dr Smith Extract 2)

What there is no agreement about, however, is which party is rude to whom. Mrs Evans is adamant that she has had a long-standing disagreement with the practice over the ‘bad manners’ of the receptionists:

Mrs Evans: The receptionists were a nightmare, that was another story ...

KW: Really. Tell me about them

Mrs Evans: [gasps] Where do I start [angry tone]. They’re just very rude, extremely rude. Which again is another thing I’m finding. Everyone I speak to when asked about the surgery, they all said the same thing. Everybody, not one person, had a good word to say about the receptionists there.

(Mrs Evans Extract 3)

Note how she draws on third-party accounts to validate her claims and her emotions reveal that she is still very angry about the receptionists' behaviour.

Dr Smith, in contrast, recounts that Mrs Evans was so rude to a receptionist in the week before removal that she reduced a receptionist to tears and she had to 'keep the peace' by agreeing to see her daughter Amy:

In the week concerned, what happened was, on a Monday afternoon, one of the secretaries came in to see me in tears, upset, saying that this particular mother had upset her, demanded to be seen by me ... Anyhow there was a bit of a scene in the waiting room, so to keep the peace I offered to see the child at the end of surgery, and sure enough the child came down at the end of the surgery.

(Dr Smith Extract 3)

(b) Uncomplaining/open criticism

Another important etiquette rule is that patients should not openly criticise their doctors in face-to-face interaction: they should be uncomplaining. As I have shown in my earlier analyses, both patient and doctor see it as desirable that patients should be uncomplaining of their doctors. From the patient's point of view the rule of uncomplaining carries with it an obligation that patients are uncomplaining in their interaction with doctors but is associated with an expectation that doctors will treat the patient to the best of their ability. The latter means that the doctor should be competent and caring. From the doctor's point of view the rule carries with it an obligation that doctors should treat the patient to the best of their ability but is associated with an expectation that the patient will be uncomplaining in their interaction with doctors. The rule of uncomplaining is specific to the doctor-patient

relationship. This rule is breached when the patient is openly critical of the care the GP has provided.

In each separate account both parties attempt to show that they have fulfilled the obligations of this rule but that their expectations are not met by the other party. Dr Smith demonstrates that she is caring by agreeing to Mrs Smith's personal request for a consultation 'that day' even though the child was not acutely unwell. She then proceeded to carry out a full history and examination and gave Mrs Evans a full explanation of her daughter's problems and her treatment plan:

The main reason the mum wanted to be seen that day was they were going on holiday at the end of the week. So I examined the child, went through everything with the mum, and said "yes, the possibilities were, point one, it could have been the child's eczema". She did have quite severe eczema to be fair, and had been under the hospital for that, or it could be a skin infection on top of the eczema. I said "some of the easiest ways to find out is to start treatment and basically see what happens". So I put the child on some antibiotic syrup [drug treatment for skin infection] and arranged to see her three days later if things were not improving, hence they were going on holiday Friday and I didn't want to ruin their holiday.

(Dr Smith Extract 4)

Mrs Evans, however, fails to meet her expectations. Instead, she went, without his knowledge, to seek a second opinion from a hospital doctor and threatened Dr Smith with a formal complaint if she found that her treatment was incorrect:

[Mrs Evans] informed the Practice Manager that she'd rung the hospital, had got an appointment to see one of the skin specialists, her consultant was on holiday, but had arranged to see a registrar [hospital doctor in training] at the hospital that afternoon ... the message ended by saying that "if she found that I'd given her daughter the wrong treatment there would be a formal complaint being made to the practice."

(Dr Smith Extract 5)

Mrs Evans, on the other hand, is keen to show that she was never openly critical of the care that Dr Smith gave her. She also acknowledges that the GP was thorough in her assessment of Amy's condition:

[Dr Smith] examined her, give her her due, she give her a thorough examination ... and she turns round and says "right I think we'll give some antibiotics" ... Anyway, she said "I will prescribe her that and take her off her steroid cream". She took her off her medicine for her eczema. Fine, I sat there listening to her ... I did not once [emphasis] query what she'd said. I didn't.

(Mrs Evans Extract 4)

Dr Smith, however, fails to meet Mrs Evans's expectations. Her concern after this consultation - that Amy was receiving the wrong treatment - led to an urgent hospital appointment. Here the hospital doctor is presented as showing up Dr Smith as incompetent as the correct diagnosis was eczema, not a skin infection:

I went in to see this doctor at the hospital and erm he said "oh no she hasn't got a skin infection. She doesn't need the antibiotics ... He said "no you keep her on her treatment. You keep her on her eumovate [steroid cream], which she's got to be on for the rest of his life", which this particular doctor [Dr Smith] took her off. So I did which [sic] I would have done anyway because I was thinking in my mind, you know how we've been on it all them months and that had sorted him out. So I think I would have done anyway, but this doctor at the hospital told me to do, which is what I did.

(Mrs Evans Extract 5)

Note how Mrs Evans demonstrates that she is both a 'good' parent (trusting her mother's instincts) and a 'good' patient who follows medical advice.

A cross-case comparison shows that each party fulfils its obligations with regard to this rule. Dr Smith demonstrates she is both competent and caring; Mrs Evans demonstrates that she is uncomplaining. Neither party, however, sees the other as meeting their expectations. For Dr Smith, Mrs Evans breaches the rule by her threat to pursue a formal complaint. For Mrs Evans, Dr Smith breaches the rule by her inability to correctly diagnose her daughter's eczema.

### 6.3.3 *Repairing the breach of the rules*

In this case study the rules of politeness and being uncomplaining have been breached. It is possible that they might, however, have been repaired by a sequence of steps in which one (or both) of the parties apologises for his/her 'misdemeanour' and the other party accepts. Goffman (1967b) proposes that such a sequence occurs in encounters as a 'corrective interchange' (box 6.1).

**Box 6.1**      **Goffman's (1967b) 'corrective interchange'**

- *Challenge*: attention is called to the misconduct by first party
- *Offering*: the other party repairs the breach (e.g., by an apology)
- *Acceptance*: the first party accepts offering of the other party
- *Thanks*: the other party thanks the first party)

Applying this sequence to the case study, however, shows that there was no successful repair of the breaches of 'rudeness' and 'complaining'.

a) Rudeness

As far as 'rudeness' is concerned Dr Smith shows that she tried to repair the breach by stating that the receptionists 'don't always get it right' (Dr Smith Extract 1). This can be seen as an offering to Mrs Evans's challenge that the receptionists were 'rude'. But this attempt is unsuccessful as there is no acceptance from Mrs Smith that this apology repairs the breach.

In Mrs Evans's account there is no description of any attempt to repair the breach. As far as she is concerned she was always polite and the receptionists were the ones who were rude. It is significant, however, that in her account of her dealings with her new practice Mrs Evans demonstrates that she is able to apologise when necessary. In this extract she shows how polite behaviour on the part of the receptionists is met by polite behaviour on her part. The challenge from the receptionist about the prescription is met with Mrs Evans offering an apology for not knowing the procedure which is accepted by the receptionist. Mrs Evans is very thankful about receiving the prescription:

I went for a re-order, or what do you call them, a repeat prescription [for her daughter Amy's eczema medication] and the lady in the reception said "oh I'm sorry, you have to bring in that, you know you've got a form on the back of prescription. You have to tick that and hand that in". Ooh I says "I didn't realise that", [she] says "erm well that's alright it's just that we do it differently". I couldn't remember anyway, "I says "I don't know honestly", I says "I don't think so". She said "that's alright, what does she need?" and I told her exactly what she needed and I said to her "I'm sorry it's my fault yes I have left it late. She does need it quite soon, I was prepared to wait 48 hours". "Oh no don't worry about it love, I will go and see the duty doctor right now" and she got a prescription for me there and then.

(Mrs Evans Extract 6)

This account is used strategically by Mrs Evans to ‘prove’ that the fault lies with the receptionists at Dr Smith’s practice.

A comparison of Dr Smith’s and Mrs Evans’s accounts reveals that Dr Smith’s attempt to resolve the issue of rudeness was rebuffed by Mrs Evans and that Mrs Evans shows no willingness to accept that she should offer an apology or explanation for her behaviour.

**(b) Complaining**

The rule of being uncomplaining offers a good example of what happens when the breach cannot be repaired. Dr Smith has already identified from Mrs Evans’s past dealings with the practice that she has often been critical of the care provided by the GPs. To Dr Smith, Mrs Evans’s consultation with the hospital doctor breaks two rules of conduct. She breaks the rule of being uncomplaining as she threatens the GP with a complaint if the GP is incompetent. In addition, she breaks the etiquette rule of being honest: she consults the hospital doctor without telling Dr Smith. Dr Smith regards herself as having fulfilled her obligations: she does not see herself as incompetent; rather, she has managed the patient to the best of her ability. She thus feels she has no alternative but to end the relationship:

I then had the feeling that, you know, that I could no longer offer care to this patient that was basically threatening me with a formal complaint if I didn’t give the standard treatment ... And obviously in medicine, you know, there’s no simple answer to a lot of things. I just felt I could no longer go on offering the care to them, that every time I gave something I’d have a fear that they are either going to make a complaint or they were going to double-check me up with another hospital doctor.

(Dr Smith Extract 6)

This decision was validated by the other GPs in the practice and Mrs Evans received a letter in which this breach of the rules was couched in the publicly acceptable phrase ‘breakdown in relationship’:

I then wrote to the patient explaining that we didn’t feel that we could offer her and the rest of the family – unfortunately the child was innocent, but it’s impossible to separate them as a separate entity - any further care, because of a breakdown in the relationship between us, and wrote to the Health Authority asking them to be removed from the list.

(Dr Smith Extract 7)

For Mrs Evans, the decision to remove was completely unjustified as she fulfilled her obligations as an uncomplaining patient. She presents herself as the innocent victim of a hurtful and totally unwarranted act by Dr Smith:

KW: How did you feel [about removal]?

Mrs Evans: [gasps] Imagine, I can’t, I don’t know. I was lost for words, I just, why. “What had I done”, I couldn’t think. I couldn’t think what I’d done, well John [partner] said “well did you say something to her in the surgery”. I said “I swear on my daughter’s life I wouldn’t say that”. I did not query what she’d done, I did not.

(Mrs Evans Extract 7)

Mrs Evans uses her account of her consultation with the hospital doctor to show that Dr Smith acted incompetently. In addition she highlights the fact that Dr Smith also breaches the etiquette rule of being honest. For her, Dr Smith’s allegation that she was being removed because she complained about the receptionists was a just a pretext:

Mrs Evans: But some how it came out, that I'd been to the hospital with Amy. I thought "well how does she [Dr Smith] know that". She said to me that I'd rang up and complained about her. I don't know to this day how she knew ... And so I said to her [Dr Smith], "oh so that's why". She said "oh no no no, that's not why."

KW: So you asked her if that had anything to do with it?

Mrs Evans: Oh yes. She said "oh no, the receptionists just felt that you couldn't come in and there was an atmosphere or something." I never ever caused an atmosphere, no. Even though they were rude to me, or how they dealt with me. I never once complained, you know, to them, because I thought "well what's the point". I just went in told them that "I've got an appointment" and just walked in, you know what's the point. You know but that's the reason she used and obviously it wasn't at the end of the day. It was, she knew she'd made a mistake ... If she'd admitted to it. If she'd admitted she was wrong. If she'd have admitted she was wrong, I would have thought "well fair enough I will go and see another doctor, I won't see you anymore". Which is what I would have done, what I was going to do.

(Mrs Evans Extract 8)

Thus, in Mrs Evans's account, Dr Smith's incompetence is compounded by the fact that she acts in an underhand manner. Instead of openly admitting to Mrs Evans that she had made a mistake and letting her decide whether or not to continue with the relationship the GP uses the patient's criticism of her to justify removal.

A cross-case comparison shows that each party holds two opposed interpretations of the same event. Moreover, their positions are buttressed by each alleging that the other has broken several rules of conduct. For Dr Smith, Mrs Evans 'goes behind her back' to see a hospital doctor and threatens her with a formal complaint if her management is incorrect. For Mrs Evans, Dr Smith 'goes behind her back' to speak

to the same hospital doctor, finds out that she has made a mistake and then removes her from the list.

#### *6.3.4 Other GP-patient 'pairs'*

Along with politeness/rudeness other symmetrical etiquette rules that are broken include 'telling the truth'/lying. Similarly, open criticism of the practice by the patient constitutes a 'trigger event' for removal in two other 'paired' interviews.

It is a consistent feature of the 'paired' interviews that see a 'trigger event' as the reason why the patient should be removed that each party makes use of the same rules of conduct to show that the protagonist was 'good' and the other party 'bad'. Each party sees him/herself as fulfilling his/her obligations as far as the rules are concerned. The other party, however, does not meet his/her expectations. For example, in one of the other 'pairs', the GP shows that the patient does not act in accordance with the doctor-patient relationship as she is 'rude' on the telephone prior to her home visit and makes a racist remark. She also requests an 'inappropriate' home visit, does not co-operate with the GP and openly accuses him of being uncaring. The patient, in contrast, shows that the GP does not act in accordance with the patient-doctor relationship as he refuses to co-operate with the patient (he declines to show her medical records) and accuses the patient of being 'racist'.

As in this case study, no 'paired' interview (*except* the negative case) offers a narrative in which both parties demonstrate that they have successfully repaired the breach of the rules.

## 6.4 Case Study 2: Removal as 'divorce'

In chapters 4 and 5 I have suggested that an analysis of the separate data-sets demonstrates that both GP and patient consider that they have a 'long term' relationship with each other. For the GPs, the ending of this relationship is given meaning by the metaphor of 'divorce' (box 6.2).

**Box 6.2 Removal as 'divorce' as defined by the GPs, based on analysis reported in chapter 4**

- The GPs present themselves as having a long-term relationship with their patients that cannot easily be ended;
- The GPs establish 'grounds for divorce' on the basis of 'irretrievable breakdown' in the doctor-patient relationship;
- The GPs show that they have acted reasonably and consistently:
  - removal is presented as a 'last resort' and a 'final act' when all practicable attempts to 'fix' the doctor-patient relationship have failed;
- The GPs present removal as allowing this 'breakdown' to be appropriately managed and both parties are seen as benefiting:
  - the GP has ended a dysfunctional and stressful relationship;
  - the patient finds a new GP 'they can get on with'

Patients also value a 'long-term' relationship with a particular GP and/or practice. They stress the fact that they have been registered with the removing practice for a considerable period of time - a fact that demonstrates loyalty to that particular GP or practice and that they have hitherto 'got on' with the practice. Alternatively the

patients demonstrate that they have developed a personal relationship with the ex-GP over a long period of time - one in which the doctor 'knows' the patient as a person.

The following case study is representative of those pairs where 'grounds for divorce' is invoked by the GP. I shall show how each party draws on the metaphor of 'divorce' as defined by the GPs to account for removal.

I begin by summarising each party's account of the removal event and follow this by a discussion of how the GP uses the metaphor of 'divorce' and whether the metaphor is employed by the patient. I conclude by summarising the findings in the other GP-patient 'pairs' where 'grounds for divorce' is invoked by the GP.

#### *6.4.1 A summary of each party's account of removal*

Dr Fletcher was male, in his early 30s and a partner in an inner city group practice. Mrs Johnson was in her late 20s and had two young children: one son and one daughter. They lived on a council estate a mile and a half from the removing GP's surgery.

##### (a) Dr Fletcher's account of removal

Dr Fletcher reported that Mrs Johnson had a long history of being 'difficult' with all the GPs in the practice. Her problematic behaviours included being a frequent attender, moving from one doctor in the practice to another and being openly critical about the previous GP. Dr Fletcher acknowledged that Mrs Johnson had medical problems but stated that none of the GPs in the practice had been able to form a 'good' working relationship with her.

Dr Fletcher emphasised that all the GPs in the practice disliked Mrs Johnson. In addition, they all felt emotionally drained from repeated encounters with her and were concerned that their negative feelings might affect the care she received from them in future. The fact that all of the GPs in the practice agreed that they were emotionally drained from repeated encounters with her was seen as an appropriate reason for removal by Dr Fletcher. All the family were removed at the same time as it was felt difficult to provide care for a family if they were not all registered with the same GP.

The practice wrote to the patient stating their reasons for removal. While Dr Fletcher told me that the 'real' reason for removal was that the GPs were weary of dealing with Mrs Johnson, she herself was not given this explanation. Instead, the fact that the practice had recently restricted their practice area to exclude the estate where the patient lived was used as a pretext for removal. She was told she was being removed because she now lived outside the geographical area covered by the practice.

**(b) Mrs Johnson's account of removal**

Mrs Johnson regarded both herself and her two children as 'ill' and in need of medical care. She suffered from diabetes and her daughter suffered from urinary tract infections and her son from asthma. This justified the fact that Mrs Johnson attended the surgery on a very frequent basis (up to twice a week). Mrs Johnson valued a 'long term' relationship with the GP practice. She emphasised the fact that she had been with the same surgery for over 10 years and that during this time she had had a good relationship with the doctors. Indeed, she stated that she had had a personal relationship with one of the doctors. Mrs Johnson, however, was critical of the care

provided by the practice. She regarded the GPs as uncaring, impersonal and medically incompetent.

Mrs Johnson attributed her removal to a particular instance when she thought she had been perceived as being openly critical of the care given by Dr Fletcher. The event in question was a series of two consultations at the surgery with her son Kevin which occurred two weeks prior to removal. At the first consultation Mrs Johnson brought Kevin to the surgery as she was feverish and unwell. She reported that Dr Fletcher was dismissive of her concerns and told Mrs Johnson that Kevin was well in spite of the fact that he did not examine her. Kevin continued to be feverish and unwell and Mrs Johnson had to bring her back for a second consultation with another GP in the same practice (Dr Barber) the following day. Mrs Johnson politely raised her concerns about Dr Fletcher's care to Dr Barber. Dr Barber examined Kevin and made a correct diagnosis (chest infection). This was followed by Dr Barber explaining to Mrs Johnson how she could use the 'in house' complaints procedure if she remained unhappy with Dr Fletcher. Mrs Johnson stated that she considered making a complaint but decided against it.

Mrs Johnson reported that the receipt of a letter from the practice stating that she was being removed because she no longer lived in the practice catchment area was totally unexpected. Her reaction was one of shock and anger about the GPs' having abused their position. She did not see how her legitimate concern about Kevin's health merited removal. Mrs Johnson felt that she had been lied to by the GPs as she did not believe that she had 'really' been removed because she no longer lived in the practice area. She supported her account that the GPs had acted in an underhand way by

drawing on the 'evidence' of a third party - her midwife. Mrs Johnson would have preferred the GPs to have spoken openly with her about their reasons for removal.

The family were able to register voluntarily with a neighbouring GP practice. The new GP was felt to have a 'good reputation' and Mrs Johnson highlighted the fact that this new GP was medically competent, unlike the removing practice.

#### *6.4.2 How each party uses the 'divorce' metaphor*

I shall take each component of the 'divorce' metaphor in turn and show how its use differs between GP and patient.

##### (a) The 'long term' relationship

As far as Dr Fletcher is concerned the practice have provided long-term care for Mrs Johnson as she has been registered with the practice for many years. In spite of this length of registration he feels that she has never been able to form a long-term relationship with any of the GPs. She has a habit of 'doctor hopping', choosing to see one GP for a while and then moving onto another GP in the same practice:

Essentially it was quite obvious that she wasn't able to form an effective and long term functioning relationship with any one of the partners, so we have done nothing for a while because the partners have changed and the personnel has changed and so on. But over the last few years we have had a stable partnership with no changes in personnel, and effectively she has consulted almost every partner over a protracted period of time and none of them have felt that there has been a good working relationship with her.

(Dr Fletcher Extract 1)

Mrs Johnson, in contrast, argues that her long period of registration with the practice should be seen as ‘proof’ that she can get on with doctors. Indeed, Mrs Johnson states that she thought very highly of one of the GPs in the practice to the extent that she wrote that GP a letter praising his work and now misses not being able to see him (as she has been removed). She feels she had a personal relationship with that GP:

He [Dr Charles] is very nice and he was excellent with Kevin, and the other one, he was wonderful with me and everything and you know his manner he was a real gem he really was. I would give him a due and credit you know, he did do and ... well I wrote a letter saying to him saying “he is a credit to all,” he really is, he is a shining example he really is, I really miss him [emphasis] as a doctor.

(Mrs Johnson Extract 1)

A cross-case comparison shows that both parties agree that the ‘long term’ relationship is important. But there is no agreement on the nature of the relationship. Dr Fletcher sees Mrs Johnson as being unable to form a long-term relationship with any of the partners. Mrs Johnson, however, sees herself as having such a relationship with one of his colleagues.

**(b) The grounds for divorce**

Dr Fletcher sees removal as ‘divorce’ in this case and the ‘grounds for divorce’ are established by the GP. It was a case that ‘enough was enough’. All the GPs in the practice, according to Dr Fletcher, felt that they disliked the patient. But, in addition, they were emotionally drained from repeated encounters with her. Dr Fletcher highlights that Mrs Johnson was a ‘very high user of our service’ and refers to the GPs being fed up with her at three separate points during the interview:

And it was quite obvious that she was never happy, um, and in the end all of us had basically got sick and tired of her. So we felt that now was the time she should leave our list.

(Dr Fletcher Extract 2)

And I think we were just a bit worn out with her really she had nothing specific recently.

(Dr Fletcher Extract 3)

It was just a sort of a gentle drip of attrition.

(Dr Fletcher Extract 4)

The GPs were also concerned that their negative feelings towards Mrs Johnson might affect the care she received from them in future. Dr Fletcher implies that they might miss an important diagnosis in a patient like Mrs Johnson in their haste to terminate the consultation as quickly as possible. As he put it, such a patient may well be the first to complain if the GP made a mistake:

One of the other partners who had a concern about her felt that the difficulty with patients like that was that one of these days there would have something significantly wrong, and we might miss it, and she would be the first to have you for breakfast.

(Dr Fletcher Extract 5)

There is support for this point of view from Dr Fletcher's account of how Mrs Johnson had a habit of openly criticising the care given by the previous GP:

She has not actually had formal complaints but she has always essentially come to the next partner along the line and known about what the previous partner did or didn't do, and when you actually investigate the basis of her complaints they really have no substance and it is easy to say "that's not true because we can say that we have done all of these things for you", [Mrs

Johnson] “ah well, yeah, er, er ...” And it was quite obvious that she was never happy.

(Dr Fletcher Extract 6)

Dr Fletcher does not, however, recount any particular instance of Mrs Johnson complaining about the care she received.

For the GPs, then, emotional involvement with patients was conditional on the doctor’s need to remain objective and the maintenance of a long-term ‘functioning’ relationship. In Mrs Johnson’s case neither of these criteria is met: there is a breach of the boundary rule (M. McCall, 1970) of affective neutrality (Parsons, 1951) and Mrs Johnson is a ‘doctor hopper’.

Mrs Johnson does not express the view that she is ‘fed up’ with the care the GP practice provides. Instead, she attributes her removal to a particular instance when she thinks she has been perceived as being openly critical of the care given by the Dr Fletcher to another GP in the practice. In her account she presents herself as politely raising with Dr Barber her concerns about the care Dr Fletcher had provided for Kevin:

I went back over there [to the surgery] and you might think I stormed in. But I said to Dr Barber, I said I wasn’t very satisfied with what he said, with Dr Fletcher, what he said to me, and you know, he [Dr Fletcher] more or less told me that “um well there was nothing wrong with him”. I said “d’you know” I said “I have been up and down all night three times in the night with him, I said he’s not been right” I said and she [Dr Barber] immediately said “oh it’s a chest infection”, checked him up, he’s hot, “just remove his vest and that and he will be OK, it’s quite cool he will calm down” , and I said well “what [unclear] ?” She said “well you can always lodge a complaint into him” and um [pause] well I said “what will he do” and she said “well that is entirely up

to Dr Fletcher” ... she said “he could either um answer your complaint and that, or he could just you know more or less leave at that.”

(Mrs Johnson Extract 2)

Dr Barber suggests to Mrs Johnson that she could make a complaint about Dr Fletcher but then goes on to suggest this indicates ‘lack of trust’ between doctor and patient. Mrs Johnson, however, emphasises that she was merely acting as any good mother would when faced with a sick child:

She [Dr Barber] said like he [Dr Fletcher] could let you know what's happening and she says “if you don't trust a doctor you're saying that you don't trust that doctor that you don't – that you're not putting your trust in him and all that”. I said “I am”, but I said “I'm not being funny but he [Kevin] has not been well, you know”.

(Mrs Johnson Extract 3)

Mrs Johnson thinks about making a complaint but, being a ‘good’ patient, decides against it:

I thought well shall I lodge a complaint and I thought “no, I will just leave it and see how it goes, you know, I'll leave it”.

(Mrs Johnson Extract 4)

A cross-case comparison shows that ‘grounds for divorce’, with its attendant ‘irretrievable breakdown in the doctor-patient relationship’ is only used by Dr Fletcher. Mrs Johnson believes that she was removed because the GPs felt she had broken a rule of conduct: that she had been openly critical of the care provided by Dr Fletcher.

(c) Removal as a 'final act'

Dr Fletcher emphasised that all three GPs in the practice agreed that they were unable to 'get on' with Mrs Johnson and this legitimated the decision to remove:

If you had a fairly good working relationship with one of the partners and everything was fine then we wouldn't have thrown her off. But in fact every single one of the three partners eventually she was unable to work with, so that was the situation.

(Dr Fletcher Extract 7)

There is no corresponding account given by Mrs Johnson. As I have already noted, she argues that she had a personal relationship with one of the GPs in the practice (Mrs Johnson Extract 1).

(d) The benefits of divorce

A key aspect of the 'divorce' metaphor is that it allows GPs to see patient removal as an appropriate way to manage a 'relationship breakdown'. They see themselves as having ended a dysfunctional and stressful relationship, whereas the GP sees the patient as finding a new GP 'they can get on with'.

It is clear from Dr Fletcher's account that the GPs felt they could no longer remain 'objective' in their dealings with this patient. Removal can therefore be seen from the GP's perspective as ending a dysfunctional relationship. But it is significant that Mrs Johnson was not offered the 'real' reason for her removal by the GPs (Dr Fletcher Extracts 2 - 4). Instead, the fact that the practice had recently restricted their practice area to exclude the estate where the patient lived was used as a pretext for removal.

As Dr Fletcher put it:

And I suppose we chickened out in a way in the letter that we wrote to her saying “you have been removed”, we gave the reasons of being removed, not that she had irritated all the partners and we felt we no longer wished to look after her, but because we had changed our list area. And it was a convenient excuse, so in view of that, we said that “you were no longer on our list and had to register with a local GP.”

(Dr Fletcher Extract 8)

A patient being ‘out of area’ is a publicly acceptable reason for removal, although this practice’s stated policy was in fact not to accept new patients onto their list from the patient’s estate, which is different from choosing to remove existing patients who live there already. By the GP’s own admission, then, the practice acted in an underhand manner – they were not honest with Mrs Johnson about why they were removing her.

Mrs Johnson’s reaction to receiving the letter of removal was one of shock and anger about the GPs abusing their position. She felt she was justified in raising with Dr Barber (Mrs Johnson Extract 2) her concerns about Dr Fletcher’s treatment of her child:

I was shocked [hurt tone of voice] I mean I felt really betrayed by them I really did. I thought it was really dirty handed I did. And of course my husband said to me ... “if you hadn’t opened your mouth, mum”. Oh I just felt like I had to say something though, you know, and I just sensed that there is a lot of care gone out of that place.

(Mrs Johnson Extract 5)

Her sense of anger was compounded by the fact that she felt that she was being lied to by the GPs as she did not believe that she was ‘really’ being removed because she no longer lived in the practice area. She supports her account that the GPs acted in an

underhand way by drawing on the 'evidence' of a third party who is supportive of her version of events – the community midwife:

**KW:** Right, so the reason they gave in the letter was because they were changing their area?

**Mrs Johnson:** Yeah.

**KW:** But did you think that was the real reason?

**Mrs Johnson:** No, no, this is it. I said to the midwife, I said, oh, I said, after about a week after, I said "d'you know they have taken our names off the list". She said "have they taken your names off" she said "just yours?" and I said "no" I said "the whole family". She said "what" and I said "yeah" she said "d'you know?" She said in that particular week she must have known now because she says to me she says well within that week she said ... she says that after, "they round looking for me, Dr Fletcher and Dr Barber went round looking for me" she said "they couldn't wait to tell me".

**KW:** Really.

**Mrs Johnson:** It just shows what they are like, didn't it, "they couldn't wait to come and tell me".

(Mrs Johnson Extract 6)

An image is presented of the two GPs Mrs Johnson saw in consecutive consultations at the surgery 'clubbing together' in order to remove her and showing the practice nurse that they were very pleased to remove her from their list. In contrast, Mrs Johnson claims that she would have preferred the GPs to have spoken openly with her about their reasons for removal. Instead, they are 'bad mannered', having broken the etiquette rule which states that one should be honest in one's conduct with others:

I think sometimes I think that they could um have given us a reasonable explanation ... I think they should have had a word with me and spoke to me about things really. I don't think that they should have just done that [removal], right behind your back, because I think it's very, very bad mannered.

(Mrs Johnson Extract 7)

From Mrs Johnson's perspective if this means 'divorce', then it is a case of one party suddenly and unilaterally deciding that the relationship is at an end and, moreover, being less than honest about their reasons with the other party.

A cross-case comparison reveals that both parties are in agreement about one thing: that the 'real' reason for removal was not the reason for removal given to the patient in the GPs' letter. Dr Fletcher and partners chose not to reveal their negative feelings openly to the patient and used the change in list area as a 'convenient excuse' for removal on the publicly acceptable grounds of the patient now being 'out of area'. Likewise, Mrs Johnson sees the GPs as acting in an underhand manner. She draws on the evidence of a third party (midwife) to support her claim that the GPs had lied to her in their letter of removal. Such behaviour, according to Mrs Johnson, is typical of a 'bad' GP. A 'good' GP, in contrast, would have taken the time to openly discuss their difficulties with her.

#### 6.4.3 *Other GP-patient 'pairs'*

In the four other GP-patient pairs where 'divorce' features, both parties value the long-term doctor-patient relationship. As with this case study, however, these GPs emphasise that they find the behaviour of the patient 'difficult' and that the patient

has trouble forming a long-term relationship with the GP. In contrast, the patient sees him/herself as having an unproblematic relationship with the GP.

It is also a consistent feature of these other pairs that the metaphors of 'grounds for divorce' and 'irretrievable breakdown in the doctor-patient relationship' are only used by the GPs: they are not used by patients. In Case Study 1, for example, Dr Smith emphasises to Mrs Evans that 'we were going nowhere in the relationship' and that removal is the only way to deal with the difficulty. In contrast, Mrs Evans tries several times to get reinstated onto the list as she felt she had done nothing to merit removal.

Similarly, although all of the GPs stress that removal was a 'final act' there is no recognition from the patients' accounts that the all avenues of reconciliation have been pursued. Indeed, the patients all express surprise and shock that removal has occurred at all. As in Case Studies 1 and 2, the GPs unilaterally decide that the relationship is at an end and use the phrase 'breakdown in the doctor-patient relationship' as a publicly more acceptable way of stating that they view the patient with intense dislike.

### **6.5 Case Study 3: a negative 'pair' - removal is followed by re-acceptance back onto the list of the GP**

In one 'paired' interview the initial decision to remove by the GP is followed by a re-acceptance back onto the list of the same GP. This can be viewed as a 'negative' case

because it is inconsistent with the emergent category that removal is viewed as a 'final act' by GPs with no possibility that the patient will be re-accepted back onto the GP's list. I shall present this interview as a case study and explore the ways in which this interview differs from the other interviews with respect both to removal as 'breaking the rules of conduct' and removal as 'divorce'. In explaining why this patient is re-accepted back onto the GP's list I am able to demonstrate under what conditions breaches of rules of conduct and/or boundary rules between doctor and patient can be repaired. This attention to a negative case adds rigour to my analysis (Strauss and Corbin, 1990; Murphy *et al*, 1998).

My categorisation of the GP's side of this 'paired' interview is that the GP predominantly uses the divorce metaphor – she has 'had enough' of the patient's difficult behaviour.

#### *6.5.1 A summary of each party's account of removal*

Dr Gill was female and in her mid 50s. She had worked in a two partner suburban practice for 20 years. Chris is white, single and in his 20s. I use his first name because the GP is on first name terms with the patient and uses his first name in recounting her version of events.

##### (a) Dr Gill's account of removal:

Dr Gill saw Chris as having two problems which made him a very difficult patient to deal with. Firstly, he suffered from mental illness. The GP did not state the exact psychiatric diagnosis. The mental illness was seen to account for Chris's inability to view himself as ill. As a consequence Dr Gill noted that he was regularly admitted to

hospital under a Mental Health Act section as he would not co-operate with Dr Gill and other health care professionals. This caused a great deal of work for Dr Gill as his non-compliance with medication once he had recovered from the acute phase of his illness often led to a relapse. Secondly, he had a mother who was extremely demanding of Dr Gill's and her receptionist's time. Dr Gill brought her receptionist into the interview as a 'witness' to the difficulties Chris's mother had caused. She did not live locally but she was always ringing the practice up and demanding to know Chris's address, something that the GP had agreed not to divulge to his mother without Chris's consent.

Dr Gill states that in her dealings with Chris she had provided care for this very difficult patient over a considerable period of time but there came a time when 'enough was enough'. For her, the fact that she had to put Chris on a Mental Health Act section on a weekend evening was the 'last straw.' At this point she made the decision to remove Chris from her list.

The admission of Chris to hospital was immediately followed by a letter to the Health Authority requesting his removal from the GP's list. This decision, however, was followed several days later by a reassessment of the patient on the psychiatric ward by Dr Gill at the consultant psychiatrist's request. At this meeting the GP told Chris that he would be taken back onto her list.

**(b) Chris's account of removal:**

Chris stated that he suffered from an illness that required medical treatment although he declined to state the diagnosis he had been labelled with. He stressed that he

followed medical advice and used Dr Gill's surgery appropriately. Chris emphasised that he felt he had a good relationship with Dr Gill. He regarded her as both a caring GP and a GP with whom he had a personal relationship. Chris saw his mother as the cause of his difficulties with the GP. Chris stated that his mother rang the GP up every time she and Chris had an argument.

Chris saw the reason for removal as being his mother's behaviour. He believed Dr Gill could not cope with the demands on her time that his mother made with her repeated telephone calls.

For Chris removal came as a great surprise. He felt he had been victimised as an innocent third party caught between his mother and Dr Gill. This feeling was, however, short-lived because when Dr Gill came to the hospital to review his Mental Health Act section she told him that she would like to have him back onto her list. He was very happy about this and stated that the episode had not affected his view of the relationship he had with Dr Gill.

#### *6.5.2 How each party uses the rules of conduct*

A key difference between this negative case and the other 'paired' interviews is that three parties are involved in the removal: Dr Gill, Chris and Chris's mother.

Dr Gill categorises both Chris and his mother as 'difficult'. Chris's mental illness is seen to account for a range of behaviours which lead him to breach an important rule of the doctor-patient relationship: he does not co-operate with medical advice. In this extract, Dr Gill stresses that she has fulfilled her obligation as a caring GP by

admitting Chris to hospital but her expectation that he would co-operate with her advice is not met:

And in that time when we tried to admit him into the hospital it took us three days to just admit this patient because: one he wouldn't open the door, two if he opened the door he would refuse to come out of the room, three even if myself, social worker and the consultant [psychiatrist] went together then he would become more persistent and finally we had to kind of take him into the hospital [under a section of the Mental Health Act], not under pressure, not under, sorry, force or threat of violence - but we had to do a lot of work so you can imagine I did put in, I have put in a lot of work on this patient.

(Dr Gill Extract 1)

Note how Dr Gill emphasises that she has devoted a considerable amount of effort trying to sort out Chris's problem.

Chris's mother was extremely demanding of Dr Gill's and her receptionist's time. Both Dr Gill and her receptionist portray his mother as persistently attempting to breach confidentiality by constantly ringing the surgery up to demand that they divulge Chris's address:

Dr Gill: How long would these telephone calls last?

Receptionist: Sometimes they would last 15 minutes, sometimes 10 minutes, she [mother] wouldn't just put the phone down, very insistent.

Dr Gill: What part of the day was that?

Receptionist: Sometimes in the day time, sometimes in the evening, sometimes in the night as well, in the middle of the night, Dr Gill would come in the next day to find that the mother rang.

(Dr Gill Extract 2)

The 'unreasonableness' of this behaviour is emphasised by the frequency of the calls, the fact that some occurred in the night and by their length.

Chris sees himself as fulfilling his obligations as a patient. He portrays himself as following medical advice and gives the example of attending the surgery for a health check at the request of Dr Gill. He also sees Dr Gill as meeting his expectations: she is a caring GP. Chris particularly appreciates the fact that she seems to 'understand' his illness and seems to try and soften the negative medical and social implications of his illness. She is also shown as putting the interests of the patient first:

I've often felt very much in conflict with the medical profession because of my diagnosis, because of the label, not so much the diagnosis but the label. I think the label is very, very damaging and, um, society doesn't really understand it very much and I've - when I first when to see my GP I talked about how I was feeling and what was going on, and she labelled me as depressed she didn't - well not labelled me, she wrote down "depression" which I was more agreeable with and more um - and I thought it was a truer diagnosis than what I was diagnosed when I went into hospital. But I think she understands that. But she obviously can't do much about it because it's a medical term and she has to use those medical terms, but um I think the quality that I like in my GP is that she does understand.

(Chris Extract 1)

Chris, however, sees his mother as 'bad'. In the following extract she is presented as a manipulative woman who behaves unreasonably both with her son and Dr Gill:

I kept ringing my mum up 'cause we kept arguing about things, and what happened was every time we had an argument my mum would ring the doctor and she would ring the doctor and say, "you know", I don't even know what she used to say to him, but basically she sent the CPN [Community Psychiatric Nurse] around to see me and he said "what's up and what's wrong?" and I said "what are you doing here?" and he basically told me that my mum had rung the doctor.

(Chris Extract 2)

A cross-case comparison shows a feature not present in the other paired interviews. Both Chris and Dr Gill see Chris's mother as breaching the same rules of conduct: she should respect Chris's wish not to divulge his address. Both parties therefore attribute 'blame' to a common third party rather than alleging that the other has broken the rules of conduct.

### *6.5.3 How each party uses the 'divorce' metaphor*

#### (a) The long-term relationship

Both Dr Gill and Chris appear to value their long-term relationship. Although Dr Gill sees Chris as 'difficult' there is no sense that she personally dislikes the patient. Indeed, it is notable that she refers to the patient by his first name – it suggests she knows him well. In none of the other paired interviews does the GP refer to the other party by their first name. Chris, for his part, values the personal relationship he had with Dr Gill and feels it is reciprocated:

I found her very agreeable actually and I got on well with her and I liked her as a GP and I think she felt the same way.

(Chris Extract 3)

#### (b) The 'grounds for divorce'

Dr Gill emphasises that she and the practice receptionists had put up with the 'difficult' behaviour of Chris and his mother for four years and she finally reached a point where 'enough is enough'. This occurred when she had to put Chris on a Mental Health Act section on a Friday evening:

**Dr Gill:** She [social worker] goes and makes a [Mental Health Act] section Friday evening, 7 o'clock. Now it's not a pleasure to do that, and I mean any other normal person would not go, I did go, and I really went out of way and at that point in time at Friday 7 o'clock I made a decision enough is enough, I am not a God.

**TS:** Sure.

**Dr Gill:** I am only a human being, I do not wish to harm the patient if I can't help them and I have really reached the end of my tether.

(Dr Gill Extract 3)

Chris sees the 'grounds for divorce' as being his mother's behaviour. He feels that his mother's incessant telephoning of the surgery has 'worn the GP down'. She cannot cope with the demands on her time that Chris's mother makes:

**Chris:** And I think that's what happened, um my CPN I think he went to see my doctor and she [GP] stopped answering his calls. Now what happened between the time when I'd asked my CPN for my doctor not to answer any calls, and what happened um from her removing on the list, what I think has happened is my mum kept ringing and I think it just wore her down. And in the end I think she wanted me removed.

**KW:** Because ...

**Chris:** Because she just kept ringing and ringing.

(Chris Extract 4)

A cross-case comparison shows that both parties refer to the same 'grounds for divorce', a feature not seen in any of the other paired interviews. Dr Gill states she was emotionally exhausted with Chris's illness and the behaviour of his 'bad' mother. Although Chris makes no reference to his illness being a contributor to his

removal, he also notes that Dr Gill had become emotionally exhausted by the demands of his mother.

#### *6.5.4 Re-acceptance back onto the list of the general practitioner*

Dr Gill does not elaborate on her decision to re-accept Chris back onto her list. One possible interpretation of his account is that she appears to remove in haste (on a Friday evening) and on reflection decides to accept him back, following a reassessment of Chris's mental state in hospital on the psychiatric ward:

And I went and saw him in [name of psychiatric unit] and did all the necessary paperwork, admitted him, and I said "Chris, if you are well we will take you back, for the simple reason yours was a difficult problem which we have tried to solve for the last 4 years, you are out of police mischief, you are not on drugs, you are well looked after, of course sub-optimally as far as mental health is concerned, but that is beyond our limit, I can't force you to take medication if you don't want to take medication". So I told him "we will take you back provided [emphasis] your mother is not involved provided [emphasis] you look after yourself and we will help you to look after yourself" and that is my last, this is my last conversation with Chris.

(Dr Gill Extract 4)

In this extract Dr Gill sees Chris as already complying with a number of rules of conduct (not in trouble with the police, not a drug user and has good social support). Re-acceptance is, however, *conditional* on Chris agreeing to comply with the rule of conduct which Dr Gill feels she has broken: co-operation with the doctor. It is also *conditional* on his mother agreeing not to resume her frequent telephoning of the GP practice, an act which led to a breach of an important boundary rule: that of 'affective neutrality'. Both of the breaches of the rules which led the GP to invoke 'grounds for

divorce' must therefore be put right by Chris. Dr Gill does not give Chris's response to her stated conditions of re-acceptance back onto her list.

Chris felt victimised by removal, as if he was an innocent third party caught between his mother and the GP:

I felt like "oh what have I done wrong" in some respects I thought that's – you know, "what have I done to deserve this". And then I thought "oh it's probably my mum who's been ringing him up." And she [GP] did say that she'd - I can't remember whether she said when she was or just before I went into hospital but she said at some point um "it is the phone calls" or something to do with, you know, "I've been receiving a lot of phone calls" - and I just thought this isn't fair. Well I felt like it wasn't fair and I also felt quite hurt by it because it shouldn't have destroyed my relationship with my GP.

(Chris Extract 5)

This feeling of hurt was, however, short-lived because when Dr Gill came to the hospital to review his Mental Health Act section she told him that she would like to have him back onto her list:

I think when she came into hospital um she was reviewing my section and then she - yeah I think it was when she was reviewing my section - and she basically just turned round to me and she said you know "I'm happy to have you back" and I was like "oh well, that's great" so yeah I don't feel any animosity or any change in the relationship.

(Chris Extract 6)

In this exchange the breach caused by removal is repaired. Dr Gill makes an offer – to take him back onto her list – and this offer is gratefully accepted by Chris who expresses his thanks.

A cross-case comparison shows that both parties believe the breach that led to removal has been resolved. The parties have restored the relationship by a 'corrective interchange' (Goffman, 1967b). But both parties may disagree on the terms of the re-acceptance. Chris appears to see reacceptance as *unconditional* on any compliance with rules of conduct whereas for Dr Gill reacceptance is *conditional*. Dr Gill may view Chris as being 'on probation' with the implication that he could be removed again if he fails to meet her conditions for re-acceptance.

## **6.6 Discussion**

In this chapter I have chosen to present the GPs' and patients' accounts of the same removal event as three 'pairs' of six GP/patient stories. The theoretical position adopted, as set out in chapter 2, is that both parties' accounts are treated as narratives that are constructed in the research interview by the GPs/patients and myself/KW. Such narratives have a variety of functions and not only offer access to the subjective 'experience' of removal but also present the self-image that the interviewee wishes to convey to the interviewer.

In this section I will use the three case studies to reflect on what additional information they offer with regard to the 'breaking the rules' of the doctor-patient relationship and the metaphor of 'removal as divorce'. I then will reflect on the idea of 'repairing the breach' that led to removal and whether the negative case offers any insights into what conditions are necessary for this to be accomplished. Finally, I will use narrative research on marital infidelity and divorce mediation to draw parallels

between GPs' and patients' accounts of removal and spouses' accounts of infidelity and divorce.

My analysis of the 'paired' narratives offers support to the claim in chapters 4 and 5 that each party uses the narrative strategically (Hyden, 1997) to assert their identity as a 'good' GP and a 'good' patient and do so by invoking the same rules of conduct. I follow here Goffman's assertion that the social order is upheld through recurrently validated rules of conduct and that a rule of conduct carries with it both obligations and expectations (Goffman, 1967a; Denzin, 1970) - as I have outlined in chapter 1.

As Goffman puts it:

*Rules of conduct impinge upon the individual in two general ways: directly, as obligations, establishing how he is morally constrained to conduct himself; indirectly, as expectations, establishing how others are morally bound to act in regard to him. A nurse, for example, has an obligation to follow medical orders in regard to her patients; she has the expectation, on the other hand, that her patients will pliantly co-operate in allowing her to perform these actions upon them. This pliancy, in turn, can be seen as an obligation of the patients in regard to their nurse, and points up the interpersonal, actor-recipient character of many rules: what is one man's obligation will often be another's expectation (Goffman, 1967a: 49).*

Although the separate GP and patient accounts show that each party uses similar rules, the 'paired' analysis demonstrates conclusively that each party draws upon the same rules of conduct to explain 'what is happening' in relation to the same removal event. It offers empirical support for Goffman's claim that the rules of conduct are interactionally accomplished.

I have presented an in-depth analysis of two such rules. The first rule I analyse is the etiquette rule of politeness. The rule of politeness carries with it an obligation that individuals should conduct themselves in a polite manner in their interaction with

others, but it is associated with an expectation that the others will in turn treat them with politeness. It may be termed a symmetrical rule, as may most common courtesies. In their narratives of removal, Dr Smith and Mrs Evans each make a claim that they fulfilled their obligations by acting politely, but that the other party has not met their expectations and has instead violated this rule by behaving rudely. Similarly, this approach can be extended to a rule specific to the doctor-patient relationship: that patients should be uncomplaining. From Mrs Evans's point of view the rule of uncomplaining carries with it an obligation that she is uncomplaining in her interaction with Dr Smith but is associated with an expectation that Dr Smith will treat her and her family to the best of his ability. Dr Smith should thus be competent and caring. From Dr Smith's point of view the rule carries with it an obligation that she will treat Mrs Evans to the best of his ability but is associated with an expectation that Mrs Evans will be will be uncomplaining in her interaction with himself and other members of the practice. The rule of uncomplaining is, in contrast to politeness, an asymmetric rule. The obligations and expectations of each party are different. In their narratives of removal, each party shows that they fulfil their obligations. Dr Smith demonstrates she is both competent and caring; Mrs Evans demonstrates that she is uncomplaining. Neither party, however, sees the other as meeting their expectations. For Dr Smith, Mrs Evans breaches the rule by her threat to pursue a formal complaint. For Mrs Evans, Dr Smith breaches the rule by her inability to correctly diagnose her daughter's eczema.

Moving on to the metaphor of removal as 'divorce', I have already shown in chapter 4 that the GPs invoke this metaphor, which mirrors the legal terminology of divorce (Hayes and Williams, 1999), as a way of justifying their own actions and

constructing a publicly acceptable account of removing patients from their lists. One important function this metaphor serves is that it can be used to cover a range of reasons for removing a patient with which the GPs may not wish to openly confront a patient. This strategy is used in Case Studies 1 and 2. In Case Study 1, Dr Smith chose to write to Mrs Evans telling her that there had been a 'breakdown in the relationship' rather than telling her to her face that it was not acceptable to threaten a GP with a formal complaint when the GP had been caring and competent and to 'go behind her back' to check up on her treatment with a hospital doctor. In Case Study 2, Dr Fletcher goes even further in avoiding telling Mrs Johnson the 'real' reasons for removal – the fact that he and his partners were emotionally drained from persistent contacts with Mrs Johnson and felt that this could adversely affect the care she received in future. Rather than tell Mrs Johnson to her face or in writing that they 'couldn't stand her', however, Dr Fletcher and his partners chose to use a change in practice area as a convenient excuse for removal. Unfortunately for Drs Smith and Fletcher, however, their respective patients 'saw through' the reason they were given and felt that the GPs had behaved in a dishonest manner by not explaining their motives for removal.

Mrs Evans and Mrs Johnson use the 'divorce' metaphor in a rather different way from Drs Smith and Fletcher. They use it to make it clear that they were reluctant divorcees and, as discussed in chapter 5, present themselves as innocent victims of an abuse of power by 'bad' GPs. It is as if one of the parties suddenly returns to the marital home to find that his/her spouse has changed the locks and he/she is now homeless. This patient perspective on 'divorce' is therefore a stark contrast to the GP

perspective that sees it as a valid way of ending a dysfunctional and stressful relationship.

The next issue I want to discuss is 'repairing the breach' that leads to removal and whether the negative case offers any insights into what conditions are necessary for this to be accomplished. A consequence of breaking a rule is that it is threatening for both parties. To quote Goffman again:

*When a rule of conduct is broken we find that two individuals run the risk of becoming discredited; one with an obligation, who should have governed himself by the rule; the other with an expectation, who should have been treated in a particular way because of this governance. Both actor and recipient are threatened (Goffman, 1967a: 51)*

If this is applied to the doctor-patient relationship, then a breach of the rules threatens the identity of the doctor as a 'good' doctor and the patient as a 'good' patient. The act of complaining, for example, threatens the identity of the patient – 'good' patients don't complain – and the identity of the doctor – a 'good' doctor acts according to the best of his ability and therefore doesn't have complaints made against him. As I have already suggested, it is this threat that leads each party to use the narrative of removal strategically to assert their identity as a 'good' patient or 'good' doctor. In the process an event – say Mrs Evans's consultation with the hospital doctor – is transformed from a 'real life' interaction open to a number of competing interpretations to a moral tale in which Mrs Evans shows that she has acted as a 'good' parent and 'good' patient and Dr Smith is guilty of being medically incompetent. More generally, in the retrospective accounts of removal given by Dr Smith/Mrs Evans and Dr Fletcher/Mrs Johnson, each party attributes to the other the 'cause' of the difficulties that have led to removal. From the perspective of 'breaking the rules', Dr Smith/Mrs Evans hold

the other as failing to meet their expectations. From the perspective of 'divorce', Dr Fletcher is clear that all the GPs in the practice are unable to care for Mrs Johnson without their feelings of exhaustion and dislike getting in the way of the care provided. In contrast, Mrs Johnson feels that she has a 'good' relationship with one of Dr Fletcher's colleagues. In both these case studies, the GPs view doctor-initiated termination of the relationship (removal) as the only appropriate way to deal with the difficulties.

In the negative case study, however, removal is followed by re-acceptance back onto the GP's list. One can explain this re-acceptance as being due to the fact that there are important differences in how the negative case presents interactional rule-breaking and the metaphor of 'divorce'. As far as interactional rule-breaking is concerned there is no reciprocity of rule-breaking. Dr Gill sees Chris as having difficulty complying with medical treatment. Although a 'trigger event' occurs that leads to removal this is not sustainable, however, because Chris is not felt to be a 'bad' patient by Dr Gill. Chris, for his part, does not see the GP as 'bad'. Instead, both parties attribute blame to a third-party – Chris's mother. Similarly, as far as 'divorce' is concerned Dr Gill and Chris both 'like' each other and there is agreement on both sides that Chris's mother has worn the GP down.

These two properties in the relationship allow Dr Gill, after removal, to offer to take Chris back onto her list and for Chris to be happy with his re-acceptance. Dr Gill and Chris are seen as 'making up' for their relationship difficulty. In essence, each party negotiates a solution that preserves the 'moral order' – in this case the identity of both GP and patient as 'good'. This re-acceptance, however, is *not* unconditional. Dr

Gill makes it clear that Chris should be viewed as on 'probation' as any further breach of the rules by him and/or his mother will mean removal, a view not mentioned by Chris. This imposition of explicit rules of behaviour - contract setting - by Dr Gill echoes the behaviour of the GPs in chapter 4 in relation to how they deal with allocated patients. One can hypothesise that Chris may well be removed from Dr Gill's list in future as his illness makes it difficult for him to comply with medical advice and there is no indication by either party that Chris's mother has altered her behaviour.

I conclude this section by noting that the form and function of each party's account of removal has many parallels with the research literature on marital infidelity and divorce mediation.

In giving their account of removal both interviewer and GP/patient take part in a process of emplotment (Mattingly, 1994). Emplotment means re-ordering events as a plot, to tell a coherent story. All the participants tell a story that is both plausible and coherent. In each case the story has a 'beginning' (the relationship of each party to each other before removal), a 'middle' (the events that led to removal) and an 'end' (the removal itself and its aftermath). As far as *intra*-narrative form (Cobb, 1994) is concerned, the three components of each party's narrative of removal (plot, character roles and value system) mesh together to construct a moral tale in which the identity of the 'good' patient or GP is upheld. The plot (sequence of events that led to removal) therefore defines the role of the characters (the 'good' patient struggling with the 'bad' GP, and vice-versa) as well as the value system that is used to interpret 'what is going on' (the rules of the doctor-patient encounter). The function of the

narrative is to project a particular identity of 'self'. For example, the 'good' patient contrasts with the 'objective' fact that the patient has been removed from a GP's list. Similar 'moral' tales are told in retrospective accounts of divorce and infidelity (Gerhardt, 1991; Riessman, 1989, 1990). Riessman (1990) applies a narrative analysis to the divorce account of a man with a disabling physical condition (advanced multiple sclerosis). The plot (sequence of events that led up to the divorce) defines the role of the characters (e.g., the 'good' husband whose 'bad' wife left him because she couldn't cope with his illness) as well as the value system that is used to interpret 'what is going on' (the 'rules' of the marital relationship). The function of the narrative is to project a particular identity of 'self' - one of a strong masculine identity - which contrasts with his 'objective' physical state (confined to a wheelchair and dependent on others to meet his needs).

Similar parallels are seen at *inter*-narrative level, when the separate accounts of both parties to removal or divorce are compared. A notable feature of the 'paired' accounts of removal (Case Studies 1 and 2) and the accounts that each party to divorce gives to a divorce mediator (Cobb, 1994) is that both are 'conflict narratives'. The general formulation is: party A attributes blame to party B by invoking a rule of conduct and shows the interviewer/mediator that he/she (Party A) has fulfilled the obligations of that rule but that party B has failed to meet party A's expectations. Conversely, Party B attributes blame to party A by invoking the same rule of conduct and shows the interviewer/mediator that he/she (Party B) has fulfilled the obligations of that rule but that party A has failed to meet party B's expectations. In my study of removal, each party makes their accusation about the other party to the interviewer; in divorce mediation, when both parties are present, this constitutes a cycle of

conflict in which accusation by one party is followed by counter-accusation by the other party and so on. The aim of divorce mediation is for a third party to break this cycle of claim and counter-claim by offering the parties an alternative interpretation of events that allows each party to protect their own identities without needing to threaten the identity of the other party.

Although there are clear similarities between accounts of removal and divorce in terms of narrative form and function it should be remembered that, as discussed in chapter 4, 'divorce' and removal are not equivalent in a number of important respects, notably that a power differential between doctor and patient is necessary for adequate medical practice (Maseide, 1991).

## **6.7 Conclusions**

In this chapter I have presented an analysis of the 'paired' data – GPs' and patients' accounts of the same removal event. I used a case study approach to show how each party to removal used two key conceptual themes – removal as 'breaking the rules' and removal as 'divorce' identified from the analysis of the separate accounts presented in chapters 4 and 5.

My presentation of three cases of removal 'in depth' confirmed the findings from chapters 4 and 5 that GPs and patients used their accounts of removal strategically to protect their identities as 'good' GPs and 'patients'. I also showed how the form and function of each party's account of removal is also found in the research literature on

marital infidelity and divorce mediation. In addition, the cross-case (GP-patient) comparison of the themes of removal as 'breaking the rules' (Case Study 1) and removal as 'divorce' (Case Study 2) provided new knowledge about how each party used the rules of the doctor-patient relationship. In removal as 'breaking the rules' I demonstrated conclusively that each party drew upon the same rules of conduct to explain 'what is happening' in relation to the same removal event. In removal as 'divorce', however, I showed that while each party used the 'divorce' metaphor it was interpreted very differently by the GPs and the patients. Finally, I used a negative case (Case Study 3) - where removal was followed by re-acceptance back onto the list of the same GP - to demonstrate under what conditions breaches of the rules of conduct and/or boundary rules between GP and patient could be repaired.

In the next chapter I consider the overall findings of the three main results chapters in relation to ending the doctor-patient relationship.

## **Chapter 7**

### **CONCLUSIONS**

#### **7.1 Introduction**

This thesis is an investigation of the ending of the doctor-patient relationship in general practice as exemplified by the removal of patients from GPs' lists. It has a strongly emergent character. In chapter 3 I lay the foundations for the study by using routinely collected health authority data to describe the descriptive epidemiology of removal in Leicestershire. These data inform the sampling strategy used in chapters 4 and 5 which describe and analyse the accounts of removal as given by GPs and patients. Chapter 6 takes the themes generated by GPs and patients and applies them to the narratives of removal given by each party to the same removal event.

In this final chapter I draw together the findings of my study. I first discuss three important general methodological issues that underpin the conduct of the research and the status of the interview data. This is followed by a discussion of how the three substantive theoretical areas reviewed in chapter 2: patient-centred medicine, power and the doctor-patient relationship and ending the doctor-patient relationship are modified as a result of the findings of this study. I then review the implications of the work for clinical practice and health policy and make policy recommendations on removal based on my empirical findings. I also offer some suggestions as to further research that is required on ending the doctor-patient relationship. I end the thesis by

considering whether the thesis has met its stated aims of providing a detailed description of the process of removal as perceived by both practitioner and patient and placing removal in a wider framework of theory in relation to the ‘difficult’ doctor-patient relationship.

## **7.2 Methodological issues**

### *7.2.1 Conducting research into removal: doing ‘sensitive’ research*

I have already discussed in chapter 2 how removal was seen as a contentious issue at the outset of the research and that I and my supervisors felt it was important to get all key local stakeholders ‘on board’ and to use separate interviewers in order to maximise recruitment into the study. We also felt that the removal was likely to be a ‘sensitive’ topic for both GPs and patients: the GPs might feel uncomfortable about accounting for their actions with regard to a ‘difficult’ patient; the patients might feel angry and distressed about what has happened to them. The issue of patients being distressed about removal had been previously noted by Macleod and Hopton (1998a).

My account of how we (TS, KW) gained access to the study participants and how we conducted the interviews confirms this prior hypothesis that removal constituted a ‘sensitive’ topic for both sets of participants and the researchers. For example, I have noted the high level of emotional distress displayed by many of the patients and the fact that two GPs refused to give their ‘side of the story’ when they learned that a particular ex-patient of theirs had been interviewed. In a review of the literature on researching sensitive topics, Lee and Renzetti (1993) also emphasise that such

research can be seen as threatening to both researcher and participant and offer this definition:

*A sensitive topic is one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or researched the collection, holding, and/or dissemination of research data. (Lee and Renzetti, 1993: 5)*

Lee and Renzetti propose four areas in which research is more likely to be threatening than others: where research intrudes into the 'private' sphere or probes experiences that are deeply personal; where the study is concerned with deviance and social control; where it impinges on the vested interests of those in a position of relative power; and where it deals with things sacred to those being studied that they do not wish profaned. This framework can usefully be applied to my research on removal as it arguably touches on all of these four areas.

For the patients, removal probed areas that were deeply personal and emotionally charged. The patients highlighted the fact that the letter of removal from the GP arrived without any warning and this was the source of much emotional distress ranging from shock and disbelief to anger and indignation at the removing GP. Indeed, in chapter 2 I note that one patient's distress was actually expressed as a threat to harm GPs. This accusation required discussion with the Local Research Ethics Committee and led to KW explicitly informing subsequent study participants that the data might be disclosed to a third party if she felt that there was a risk of harm to the interviewee or another individual identified in the interview. In contrast, for the GPs, removal intruded into their 'private' sphere. The issue of 'public' versus 'private' accounts has been discussed in chapter 2. A good example of intrusion into the 'private' sphere is the question of removing patients on financial grounds.

Although there is some research evidence to support this claim (Munro and Skinner, 1998) and it features prominently in media discourses of removal (Yamey, 1999; Rogers *et al*, 1999a) it is notable that the GPs in this study are unanimous in their condemnation of other GPs who may remove patients for financial reasons and none of the study GPs admitted that he/she had ever removed a patient for financial reasons.

The study can also be seen as dealing with issues of deviance and social control. This is a particular problem for the removed patients, given that they are stigmatised by the removal process. Removal 'spoils' their identity as a patient (Goffman, 1968) and they experience both 'felt' and 'enacted' stigma (Scambler and Hopkins, 1986). Deviance and social control also features prominently in the GPs' accounts: removal is seen by some GPs as a 'sanction' for disobeying the 'rules' of the doctor-patient encounter.

A crucial reason why this research is sensitive for both GPs and their professional bodies such as the General Practitioners' Committee (GPC) of the British Medical Association and the Royal College of General Practitioners (RCGP) is that it potentially impinges on their vested interests. Both the GPC (General Practitioners Committee of the British Medical Association, 1996, 1999) and RCGP (Royal College of General Practitioners, 1997) have felt sufficiently threatened by proposals to curtail the right of GPs to remove patients from their lists without giving a reason (Select Committee on Public Administration, 1999) to issue publicly acceptable guidance to GPs as to how the removal of a patient should be conducted. There may be concern in official circles that research such as this may uncover accounts of GPs

removing patients for reasons that are less than publicly acceptable (e.g., ‘removal as sanction’). I have already discussed the tension that existed between the GPs viewing me as a fellow GP who could be ‘trusted’ with potentially sensitive information and viewing me as a researcher who could uncover discreditable information about the GPs’ actions.

The notion of profaning things sacred to those being studied has its origins in research on fundamentalist religious groups as the act of researching such groups can itself be seen as a profanity by the groups themselves (Lee and Renzetti, 1993). Given the very different research subjects interviewed here this notion may be thought to have little relevance. Nonetheless, as I shall suggest in section 7.4.2, the right of GPs to remove patients from their lists is arguably held as ‘sacred’ by GPs and their official bodies and research that appears to threaten this right could be seen as profanity. Patients, too, may have such strongly held beliefs that removal is unjust that any research suggesting that removal is an appropriate course of action by GPs could also be seen as profanity.

Lee and Renzetti’s (1993) framework thus offers an explanation for why this study has encountered particular difficulties with respect to gaining access and conducting the interview. Dissemination of the research findings – in the form of papers and reports - is also likely to prove ‘sensitive’. Lee (1993) identifies three harms that may result to research participants from publication: feelings of upset at how they have been portrayed in research reports by those able to identify themselves; the attraction of unwanted publicity to research sites and those within them; and disclosure of information about individuals which may permit others to treat them in

an exploitative way. As far as this thesis is concerned key details of extracts taken from the interview data were changed to protect the confidentiality and anonymity of the participants. This should make it highly unlikely that other individuals will be able to identify the study participants. This should avoid the risk of unwanted publicity and exploitation of any study participants (e.g., a local GP identifies a patient allocated to his list from the report). The issue of individuals identifying themselves is more problematic. I suggest that the altering of the extracts reduces the likelihood of this occurring, but it cannot be avoided unless the extracts are so altered as to be entirely fictional in nature. It will therefore be important that the results of the study are presented to the participants before publication so that they learn about, and have chance to comment on, the findings from myself and KW.

#### *7.2.2 The status of the interview data: 'accounts' versus 'experiences'*

A second important methodological issue dealt with in my thesis is my treatment of the interview data. In common with much general practice qualitative research (Britten *et al*, 1995; Britten, 1995; Hoddinott and Pill, 1997) I have used semi-structured interviews with GPs and patients as a way of accessing retrospective accounts and have attempted to understand 'what happened' from the perspective of both GP and patient. Where I differ from such research, however, is that I have paid explicit attention to the status of the accounts produced by the interaction of the interviewer and participant (GP/patient) during the interview process. This subject has received extensive discussion in the sociological literature (Cunningham-Burley, 1985; Dingwall, 1997; Silverman, 1998) but is rarely discussed in the medical literature (Hoddinott and Pill, 1997; Murphy *et al*, 1998). I have adopted a 'middle position' between those who would see interview data on removals as offering access

to the 'experiences' of GPs and patients that could, if it was possible, be verified for their 'truth' and those who would see such 'accounts' as no more than the product of the interaction between interviewer and participant in which the latter presents him/herself as a competent 'doctor' or 'patient'. Like Melia (1997), I acknowledge the methodological difficulties attached to the use of the qualitative interview but argue that it is possible to access the opinions and views of individual patients and doctors and to use these to develop theoretical insights into the doctor-patient relationship.

Drawing on the interpretive tradition in sociology (Blumer, 1969; Denzin, 1989) I use my interview data to show how GPs and patients 'make sense' of their social world and, more specifically, to gain access to the rules and rituals governing the ending of the doctor-patient relationship. I have taken the explanations of removal used by each practitioner and patient and, using the constant comparative method (Glaser, 1965), have placed these explanations within a more general theoretical framework of the rules of the doctor-patient relationship. Thus, applying Schutz's (1953) useful distinction, I have developed a second-order theory of the doctor-patient relationship from the first-order explanations ('obvious' or 'common sense') of removal used by each particular patient or GP.

I am also, however, sensitive to the functions such explanations of removal serve within the context of the research interview. Drawing on Baruch's (1981) study of parents' stories of their encounters with health professionals, I show how the removal 'story' can be conceptualised as an 'atrocious story' (Webb and Stimson, 1976; Dingwall, 1977) or 'moral tale' in which both GP and patient demonstrate their

moral adequacy. Thus in the chapter presenting GPs' accounts of removing patients I show how the narrative of 'breaking the rules' is used by the GPs to present themselves as 'good' GPs. Similarly, in the chapter presenting patients' accounts of being removed I show how these accounts are used by patients to assert a claim to valid patienthood. Moving on to my analysis of the 'paired' data, I draw on the sociolegal work of Allsop and Mulcahy (Allsop, 1994; Mulcahy, 1996; Allsop and Mulcahy, 1998) on complaints-handling in the NHS to show how 'paired' data should be treated as two situated accounts rather than as two contested versions of 'reality' that require external adjudication. I thus treat each party's account of the removal process as a narrative that is constructed in the research interview. My analysis of the 'paired' narratives offers further support to the claim that each party uses the narrative of removal strategically (Hyden, 1997) to assert their identity as a 'good' GP and a 'good' patient and do so by invoking the same rules of conduct.

I therefore argue that by paying attention both to the meanings that the participants ascribe to removal and the functions that the retrospective accounts serve in the interview setting I am able to say something of value about an important phenomenon – the ending of the doctor-patient relationship – without making unjustifiable claims about the validity of the 'events' as described by each participant.

### *7.2.3 Generalisability of the research findings*

The final methodological issue I wish to discuss is to what extent my findings can be generalised beyond the settings in which they were generated. Hammersley (1992) argues that there are two ways in which qualitative researchers can establish

generalisability for their findings: empirical and theoretical generalisation. Empirical generalisation relies on the sample being representative of the population to which generalisation is to be made. In contrast, theoretical generalisation or inference is the extent to which the research findings develop and test relevant theory.

In order to maximise empirical generalisability this thesis explicitly sought to define the population from which the study participants would be drawn. Quantitative methods were used to describe the descriptive epidemiology of removal in Leicestershire for the calendar year prior to the start of the study. This allowed the demographic characteristics of removed patients and general practices to be ascertained. The Leicestershire findings are consistent with published research on the descriptive epidemiology of removal in Sheffield (Munro and Skinner, 1998) and Northern Ireland (O'Reilly *et al*, 1998a). This suggests that if the sample of removed patients and GPs are representative of the Leicestershire population, then the results can be generalised to the rest of the U.K. In order to ensure that the GPs and patients were 'typical' of the population from which they were drawn, a quota sampling frame was set up (*Appendices 1.1 & 1.2*).

As far as the GPs were concerned I was able to use quota sampling with good effect as the majority of GPs approached (74%) agreed to take part. I can therefore be confident that the GPs interviewed were likely to be representative of the population of GPs in Leicestershire. The patients were more problematic. I was able to ensure that the removed patients were 'typical' of the population from which they were drawn as I was able to recruit enough patients to fill the quota sampling frame. Nonetheless, the use of an 'opt in' approach to recruitment and the inability to follow

up non-responders contributed to the low response rate. In contrast to the GPs, only a minority of eligible removal decisions (15%) consented to receive further information about the study. It is not possible to know with any certainty why the non-responders did not wish to participate in the research. One possibility, supported by the data, is that responders wished to take part as they felt distressed or angry about removal and wished to use the interview as a way to make the GPs accountable for their 'wrong' actions. Thus I may have sampled removed patients who were 'typical' of the population of removed patients in terms of their demographic characteristics but who felt much more aggrieved and/or distressed about removal than the non-responders. This is not necessarily a weakness of the recruitment process. An advantage of interviewing such patients is that their removal does allow access to what happens when the doctor-patient relationship 'breaks down'.

This study was set up with the explicit aim of developing and testing relevant sociological theory in relation to the phenomenon under study. One important theoretical concept that has been developed and tested by my research is that of the 'good' and 'bad' patient. This theoretical generalisation has three elements. First, I show how the original theoretical work on 'good' and 'bad' patients in Accident & Emergency patients (Roth, 1972; Jeffrey, 1979) can be applied to GPs' accounts of removing patients. Second, I develop the argument that patients also typify GPs into 'good' and 'bad' doctors and suggest the functions that this typification serves. Third, I use the 'paired' data to show how both GP and patient, in giving their account of removal, draw on the same rules of the doctor-patient encounter to assert their identity as a 'good' GP/patient and to show that the other party to removal is 'bad'.

Using Hammersley's (1992) distinction between empirical and theoretical generalisation I argue that my thesis demonstrates both types of generalisation. I suggest that the findings can be generalised to the population of GPs and patients from which the sample is drawn although I note that I was able to recruit only a minority of patients who were removed. In addition, my findings allow the development and testing of relevant theory, for example, in relation to 'good' and 'bad' patients and doctors.

### **7.3 Implications for theory**

#### *7.3.1 Removal and patient-centred medicine*

In chapter 1 I reviewed the notion of patient-centred medicine as presented in the general practice literature and proposed that this discourse of patient-centred medicine had two components of particular relevance to the removal of patients from GPs' lists. In 'finding common ground' or 'shared decision making', the doctor, by determining and incorporating patients' ideas and expectations into his/her management plan, is able to ensure that both GP and patient 'reach agreement' on an appropriate course of action. This is felt to hold even if both parties enter the consultation with divergent views as to what each wishes to achieve. In 'enhancing the patient-doctor relationship' the relationship is conceptualized as a long-term 'personal' relationship. This doctor-patient relationship is seen wholly in positive terms as it allows a 'therapeutic' relationship to develop. The latter draws on the psychotherapeutic concept of the 'therapeutic alliance'. Following a review of the research literature, I argued that these two components may represent the views of a

professional elite as to how GPs 'ought' to behave rather than describe how GPs actually manage their seven minute consultations. In addition, assuming that a proportion of GPs fully apply these principles in their everyday practice, patient-centred medicine proposes that difficulties with patients can be best conceptualised as a defect in the consultation skills of the individual doctor. This can be remedied by further training in communication or counselling skills (May and Mead, 1999). Patient-centred medicine is unclear as to what the doctor should do if faced with a patient who is unable or unwilling to see the GP's point of view or who evokes in the doctor a strong feeling of dislike. It has limited explanatory value when it comes to complex issues such as removal.

The empirical findings from my study offer additional support to the claim that GPs do encounter patients with whom it is not possible to negotiate a satisfactory management plan and that in some cases the 'long-term' doctor-patient relationship can be a wholly negative experience for doctors. I shall now consider these two key aspects of patient-centred medicine in turn.

(a) When 'finding common ground' isn't possible

Good communication skills are necessary to achieve a shared understanding but my thesis suggests that they are not sufficient. Taking the issue of 'appropriate' service use as an example, the GP and patient may have widely differing views on 'appropriateness' that are not amenable to finding common ground. For the GPs, 'frequent' service use was seen as indicative of a 'difficult' or 'bad' patient. The GPs encountered patients with whom they tried to negotiate an 'acceptable' (doctor-defined) use of the service but who chose to 'ignore' the advice the doctor had given

even when the difficulty that the doctor was facing was repeatedly brought to the patient's attention. From the GPs' point of view, such patients were neither rational nor reasonable. In contrast, removed patients saw their service use as 'appropriate' and either stated that they used the service infrequently or alternatively that they did consult frequently but that this was justified on the basis of their or their children's illness.

The GPs found this situation problematic. The reason for this was that they were not able to rely on the informal rules of the doctor-patient encounter. Thus the 'rule of accessibility' requires the GP to be accessible to his/her patients but is associated with the expectation that the patient will use the service 'appropriately'. Conversely, the patient has an obligation to bring 'appropriate' medical conditions to the GP but this is associated with the expectation that the GP will be available and willing to treat the patient. In this 'difficult' situation each party felt that their obligations had been met but that the other party did not meet their expectations. In these circumstances, the GP attempts to re-assert control of the encounter by highlighting to the patient what he/she sees as the rules (e.g., that home visits are only indicated for particular types of medical problems). This is done first by 'negotiation'. If the patient does not modify his/her behaviour, then the GP may establish a formal rule ('contract setting') as the next step or go straight to 'informal' or 'formal' removal. Although not discussed in detail in chapter 4 a number of GPs stated that they would set explicit, doctor-defined, contracts with such patients (e.g., that they should only request home visits as judged 'appropriate' by the GP). If this contract was broken then sanctions would be imposed, including removal from a GP's list. In such

situations, as I shall argue in the next section, the power differential between doctor and patient that is usually hidden becomes visible.

The implication here is that the general practice discourse of patient-centred medicine should be explicit about the fact that there are sometimes occasions when it is not possible to 'find common ground' between patient and doctor and that this problem does not arise out of a failure of the doctor's communication skills but as a result of the patient and doctor being unable to accomplish their mutual roles in the encounter. It should also acknowledge that in such situations, doctors may need to openly use the power differential that exists between doctor and patient, as demonstrated by explicit contract setting (Norton and Smith, 1994) and/or removal.

(b) When a doctor 'hates' a patient

The existence of the 'heartsink' phenomenon (O'Dowd, 1988), as reviewed in chapter 1, should make one wary of assuming that relational continuity – when the GP sees the same person over a period of time - always leads to a 'therapeutic' relationship with benefits for both practitioner and patient. My findings confirm that it is naïve to see doctors as always deriving benefits from the long-term relationship and that difficulties can always be resolved through appropriate deployment of counselling or communication skills by the doctor.

Although the GPs were keen to stress the long-term nature of their relationship with patients, they identified situations in which relationship difficulties had developed over time and which, moreover, did not appear to be amenable to resolution. I have identified that in situations where the GP had been experiencing difficulties with a

patient over a considerable period of time, a decision was made that 'enough was enough' and the relationship between doctor and patient was terminated by the GP removing the patient from the practice list. In such cases the dislike the GP felt towards the patient was of such intensity that it was a source of considerable emotional distress to the GP and affected the ability of the GP to provide medical care for the patient. Conversely, the removed patients also put value on the long-term relationship and felt their loyalty to the GP and/or practice and any personal relationship they had with a particular doctor was swept aside with removal. One paired interview (Case Study 2: Dr Fletcher/Mrs Johnson) reveals the gulf between practitioner and patient. Dr Fletcher stressed that Mrs Johnson could not form a working relationship with any of the GPs and that she was removed because all the GPs were 'sick and tired' with her to the extent that they felt they could no longer provide her with appropriate medical care. Mrs Johnson, however, saw herself as having a personal relationship with one of the GPs in the same practice.

In accounting for 'break down' of the doctor-patient relationship in these circumstances, the GPs see formal removal as 'divorce' - an uncommon but necessary step to resolve a situation that caused the GP considerable emotional stress. In this situation GPs are no longer able to meet their obligations of the doctor-patient relationship because an important boundary rule (M. McCall, 1970) of the relationship - 'affective neutrality' (Parsons, 1951) - has been broken. As a consequence the GP's emotions 'get in the way' of treating a patient.

My reflection here is that the general practice discourse of patient-centred medicine needs to be more open about the fact that sometimes the long-term doctor-patient

relationship can be, echoing Balint (1964: 249), more ‘mutual frustration’ than ‘mutual satisfaction’. In such circumstances the GP may see the doctor-patient relationship as having ‘broken down’ and attention needs to be paid as to how this process should be managed by *both* GPs and patients.

In sum, the accounts of both the GPs and removed patients render two key tenets of patient-centred medicine as conceptualised in the general practice literature - ‘finding common ground’ and ‘enhancing the patient-doctor relationship’ – problematic. I have identified circumstances in which both ‘common ground’ and a ‘therapeutic’ doctor-patient relationship are impossible to accomplish. I offer practical recommendations as how to handle such circumstances later in this chapter. But in the next section I return to the key issue of power in the doctor-patient relationship and what light my findings shed on how the power differential between doctor and patient is produced and maintained.

### *7.3.2 Power and the doctor-patient relationship*

I have argued in chapter 1 that power in the doctor-patient relationship should be seen to result from the interaction of doctor and patient in any given encounter and that it is a necessary and often benign aspect of the doctor-patient relationship (Maseide, 1991; Lupton, 1994). As Strong (1979, 1988) has shown, a key way that power is produced and maintained in the doctor-patient relationship is through the ritualised or ‘ceremonial’ nature of the doctor-patient encounter, with its mesh of formal and informal (‘etiquette’) rules that govern the ‘correct’ behaviour of doctor and patient and define the respective roles of patient and doctor.

In this section I shall use my findings to show that power is produced in the doctor-patient relationship in general practice through the 'ceremonial order of the GP surgery' and that this power is usually 'hidden' from both participants. I shall show that sometimes, as in the case of removal, this power may be displayed openly by one of the party and that when this happens the ceremonial order is disrupted and the other party feels threatened.

(a) The ceremonial order of the GP surgery

In giving their accounts of removal both GP and patient are shown to draw upon the formal and informal rules that govern the doctor-patient encounter to assert their identity as 'good' doctors and 'good' patients. There is a striking symmetry between each party's definition of what constitutes a 'good' GP and also their definition of what constitutes a 'good' patient. A 'good' GP is polite, honest, caring, values a long-term relationship with the patient and is clinically competent. A 'good' patient tries to cope with illness and follow medical advice, uses the service 'appropriately', is uncomplaining, polite with the GP when voicing any concerns and values a 'long-term' relationship with the GP. An analysis of the 'paired' accounts demonstrates the complementary nature of these rules of conduct. In the ceremonial order of the GP surgery, then, all doctors are polite and competent and all patients are polite and uncomplaining.

These ceremonial 'rules' of the doctor-patient relationship should be seen as guides that patients and doctors use to inform their conduct. As Howitt *et al* (1989) note:

*The essential aspect of a rule is that it offers the possibility of doing one thing or another. Rules can be broken and they can also be changed, either in the course of conduct or by the agreement of those who utilize them. Breaking*

*social rules may precipitate sanctions in the form of punishments or admonishments. Indeed, at times rules may be more important for their role in making social life appear orderly than for actual influences on action (authors' emphasis) (Howitt et al, 1989: 25).*

These 'taken-for-granted' rules that order relations and interactions in the doctor-patient relationship are exposed when they are broken. As Giddens and others have noted (Scott, 1995), these 'taken-for-granted' rules are fundamental to social order. Thus examples of breaches of the rules are rich in their potential to offer insight into how and under what circumstances the doctor-patient relationship can function optimally. For example, GPs may be unaware that they require patients to be polite to them until someone is rude to them. Their account of this rule-breaking allows us to generalise about the importance of politeness as a requirement or obligation in the relationship.

**(b) Removal and the power differential between doctor and patient**

'Breaking the rules' is also important for another reason. It offers a way of gaining access to the differences in power that maintain the ritual order. As Strong (1988: 234) observes, 'the ritual order is simply an overt display, a performance, which may well conceal great covert differences in opinion and power'. Usually this power is maintained by asymmetrical rules – like the rule of complaining - that allow power to be exerted covertly either through authority (the GP's technical expertise or 'competence gap') or dominance (GPs carry out their social role on a regular basis; patients carry out theirs much less regularly and so the GP knows the 'script' much better than the patient). In the context of the doctor-patient relationship, removal of a patient from a GP's list lays bare these covert differences in power and shows that GPs do sometimes exercise power through the use of coercive force, a process that is perceived as an 'abuse of power' by removed patients.

For the GPs, the power to remove such patients is seen as a necessary aspect of the doctor-patient relationship. Several GPs raised the possibility that GPs may lose the right to remove patients from their lists and this was viewed negatively - as a threat to the nature of the doctor-patient relationship. The power of GPs to remove patients from their lists is officially bestowed (Department of Health, 1989). In addition, both the Royal College of General Practitioners (1997) and the British Medical Association (General Practitioners Committee of the British Medical Association, 1999) have offered guidance to GPs as to the grounds for removing a patient and how removal should be carried out. These may be viewed as formal rules of conduct (Denzin, 1970). In their accounts the GPs invoke these formal rules of conduct, notably 'irretrievable breakdown of the doctor-patient relationship' (General Practitioners Committee of the British Medical Association, 1999), to publicly justify their actions. But when their accounts of the process of removal are examined in detail it is clear that the GPs, and other practice staff, draw on the tacit informal rules of the doctor-patient relationship in making the decision to remove. Removal requires either a 'trigger event', in which the GP views the patient as having broken a rule of conduct (Denzin, 1970); or, as in 'enough is enough', the steady drip of attrition caused by a 'heartsink' patient leads to a break in the boundary rule (M. McCall, 1970) of 'affective neutrality'.

This 'break in the rules' leads to a naked display of power by the GP. In 'informal removal' the 'appeal to gentility' is disregarded and patients are told to their face that their behaviour is unacceptable and that they should re-register with another GP. Formal removal results in the patient receiving a letter of removal from the local

health authority, with or without a 'publicly acceptable' explanation of removal from the GP. Removal, officially authorized in a GP's terms and conditions of service (Department of Health, 1989, 1992), is therefore an open display of force by the GP in which the patient is coerced into leaving the list of the GP. It is therefore not surprising that patients perceive removal as an event which threatens their identity as patients. They present themselves as 'victims' (Holstein and Miller, 2001) of an abuse of power by 'bad' GPs which leads them to suffer emotional distress and also see removal as a threat to their identity as a 'patient' - removal is seen as stigmatising (Goffman, 1968). A further reason why such patients felt 'powerless' was that they felt that their version of events would be less likely to be believed by any third party than the doctor's version of events - the odds were seen as stacked in the GP's favour.

In contrast to the patients' portrayal of themselves as 'victims'; one could argue that some GPs portray themselves as 'victimizers' through their use of the metaphor of removal as 'sanction'. Here, 'breaking the 'rules' of the doctor-patient encounter is seen as a deviant act that leads to a penalty - removal - being imposed on the patient by the GPs. Removal may arguably be seen, using Lipsky's (1980: 124) resonant phrase, as 'a sanction to punish disrespect to routines of order'. The metaphor of removal as 'sanction', with its accompanying image of the parent/doctor disciplining an unruly child/patient, suggests that some doctors view their relationship with removed patients in paternalistic terms (Szasz and Hollender, 1956) and see coercive force as a benign form of power in this particular relationship.

(c) Patients and resistance to medical power

The above discussion should not lead one to think that GPs should always be viewed as powerful and patients as powerless. Power may well be institutionally bestowed on GPs but patients are capable of resisting medical dominance. As Silverman (1987) notes:

*It is a tried and trusted sociological truism ... that even people at the foot of hierarchies of authority have certain strategic counters to play (Silverman, 1987: 31).*

Often patients resist medical power covertly, choosing not to comply with medication (Kelly and May, 1982) or expressing their dissatisfaction with the doctor to significant others outside the consultation (Webb and Stimson, 1976). Direct confrontation with the GP and a breach of the 'appeal to gentility' is thereby avoided. This strategy is used, for example, in Case Study 1 (Dr Smith/Mrs Evans). Mrs Evans reports that in her second consultation with Dr Smith she did not openly question his judgement but voiced her concerns after the consultation to her partner, who suggested that she should seek a second opinion.

Patients may also openly challenge the doctor. This high risk strategy is used less often as direct confrontation with the doctor leads to interactional rule breaking and the possibility of subsequent sanctions by the doctor (Stimson and Webb, 1975; Bloor and McIntosh, 1990). This point is well illustrated by Case Study 1. In this case study the power differential is not fixed and static in favour of Dr Smith but rather the product of the interaction between the two participants. Power is seen to ebb and flow between the two parties before the GP finally decides to remove. Mrs

Evans is able to demand that Dr Smith sees her daughter at the surgery that same afternoon, is able to support her contention that Dr Smith is 'incompetent' by drawing on the evidence of an 'expert' third party (hospital doctor) and finally threatens to exercise her right to pursue a formal complaint. In threatening to pursue a formal complaint Mrs Evans breaks the ceremonial order of the consultation and produces an open display of force. There is no doubt Dr Smith felt very threatened by the possibility that Mrs Evans might pursue a formal complaint. Her response was to see the threat of a complaint and the patient seeking third-party advice as evidence of a 'lack of trust' that merited removal from the practice list. She wished to avoid any further confrontation with a woman whom she saw as very difficult and so wrote her a letter informing her of removal and justified it with the publicly acceptable reason 'breakdown in the relationship'. Other GPs, in their accounts of removal, also highlighted that they felt 'threatened' by a patient making a formal complaint and that the complaint could lead to the removal of the patient.

#### (d) Power and personal identity threat

The focus in this thesis has been on the doctor's open display of power – the removal of a patient from a GP's list. The patients demonstrate how removal leads them to suffer emotional distress and threatens their identity as a 'patient'. In giving their retrospective accounts of removal, the patients attempt to establish themselves as 'good' patients. In particular, removed patients assert a claim to valid patienthood, demonstrated by their compliance with the rules of the patient-doctor relationship and by the authenticity of their medical problems. In contrast, the removing GP is 'bad', having broken the rules of the relationship and is described in negative terms such as 'only in it for the money' and 'can't be bothered'.

Similarly, an open display of power by patients – a formal complaint about a doctor by a patient – is perceived as threatening by doctors. This ‘threat’ has been described in this thesis and is also a feature of studies exploring doctors’ accounts of receiving a complaint (Mulcahy, 1996; Jain and Ogden, 1999). As Allsop and Mulcahy have demonstrated (Mulcahy, 1996; Allsop and Mulcahy, 1998), a complaint leads doctors to suffer emotional distress and threatens their identity as a ‘doctor’. Thus the doctors interpreted complaints as a challenge to their competence and expertise as professionals, not as issues troubling the complainant or as legitimate grievances. In giving their retrospective accounts of complaints the doctors attempt to establish themselves as ‘good’ doctors. The doctors demonstrate that they have acted in accordance with the rules of the doctor-patient relationship. Conversely, the complainants were ‘bad’, having broken the rules of the relationship, and are described in negative terms such as ‘moaners’ and ‘malcontents’ (Mulcahy, 1996: 404).

I therefore propose that an open display of power by either party in the doctor-patient encounter disrupts the ceremonial order of the surgery and in doing so threatens the identity of the other party. This, as I shall suggest in the next section, is an important cause of relationship ‘breakdown’.

To conclude, I have taken as my starting point Maseide’s (1991) proposition that the power in the doctor-patient relationship is often benign, sometimes abusive and always necessary. Drawing on the work of Strong (1979, 1988) I suggest that an important way that power is produced and maintained in the doctor-patient relationship is through the ritualised or ‘ceremonial’ nature of the doctor-patient

encounter, with its mesh of formal and informal rules that govern the 'correct' behaviour of doctor and patient and define the respective roles of patient and doctor. I use my findings to support my argument that power is produced in the doctor-patient relationship in general practice through the 'ceremonial order of the GP surgery' and that this power is usually 'hidden' from both participants. I show that the process of removing a patient from a GP's list lays bare the power differential between GP and patient and that removal constitutes an open display of force by the GP in which the patient is coerced into leaving the list of the GP. I also show some of the ways in which patients can resist medical power and demonstrate that patients, by pursuing a formal complaint, openly confront the GP and force the GP to account for his/her actions. I conclude by suggesting that this naked display of power by either GP or patient threatens the identity of the other party.

### *7.3.3 Ending the doctor-patient relationship – a proposed model*

An important aim of this thesis is to provide a detailed description of the process of removing a patient from a GP's list and thereby provide insight into how the doctor-patient relationship can be ended in general practice. To do this I have had to use the method of interviewing both parties after the event in order to determine 'what happened'. Such an approach is commonly used in research exploring 'breakdown' in personal relationships, not least because of the methodological difficulties in prospectively interviewing partners who are experiencing relationship difficulties (Duck, 1981). As I have elsewhere argued, this approach is legitimate but requires attention to both the attribution of cause of the relationship 'breakdown' *and* the function this explanation serves for each party.

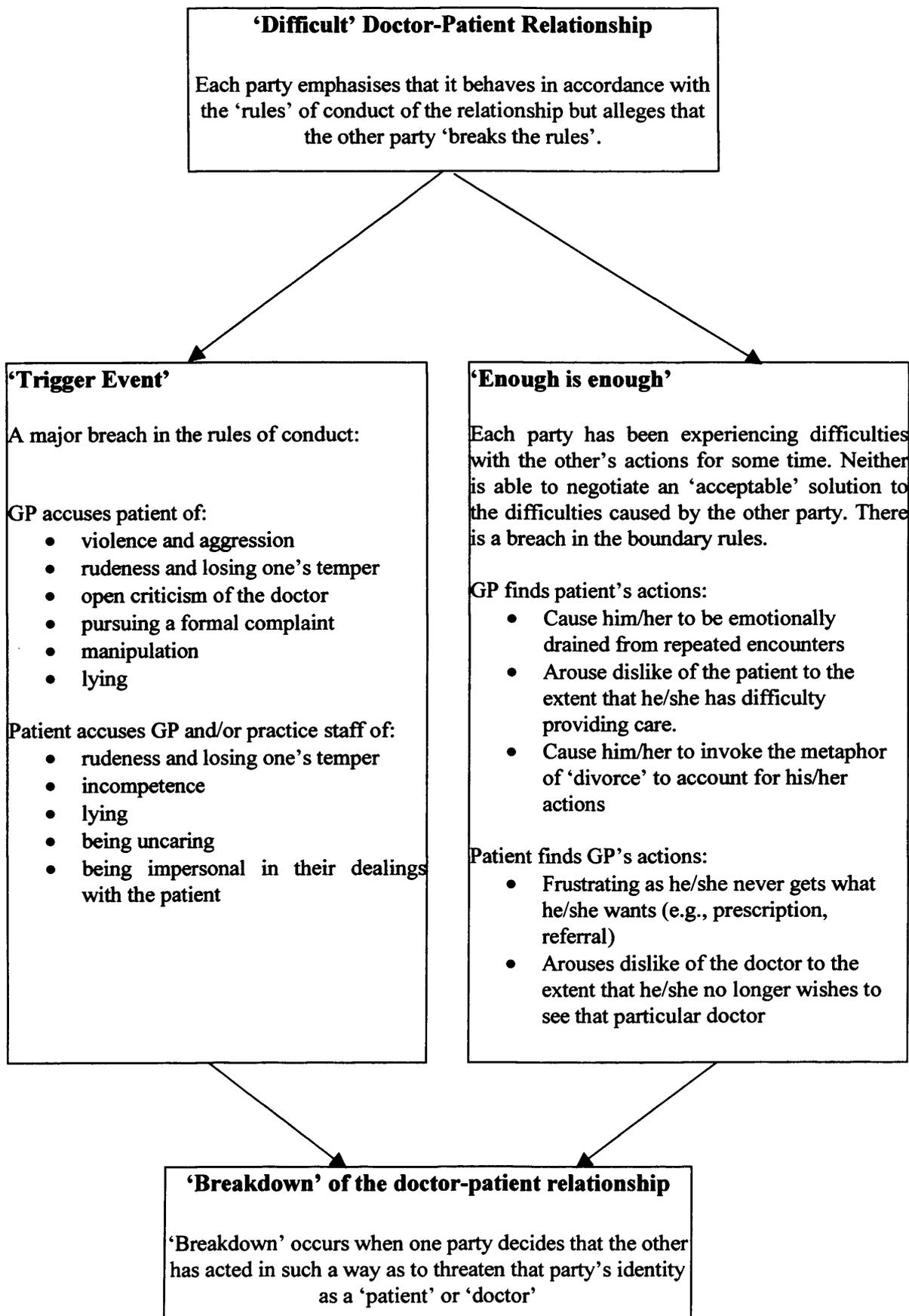
With this caveat, I present here a model of ending the doctor-patient relationship in general practice. The basis of this model is my empirical work on removals as presented in chapters 4, 5 and 6. In addition, I draw on the work of Gandhi *et al* (1997) who conducted a qualitative interview study of a sample of patients in Birmingham who were identified as having changed GP without changing address. These patients can be seen as exhibiting patient-initiated termination of the doctor-patient relationship. This is in contrast to my own work, where removal can be conceptualised as a doctor-initiated termination of the relationship.

The theoretical basis for my model has been reviewed in chapter 1. I argue that the ending of the doctor-patient relationship can be conceptualized as a stage in the career of a social relationship (G. McCall, 1970) and show how Hayes-Bautista (1976a) used this approach to construct a model of the termination of the doctor-patient relationship derived from Mexican-American patients' accounts of health care. In addition, I use Duck's (1981, 1982) useful distinction between 'breakdown' (disorder in the relationship that may or may not lead to dissolution) and 'termination' (the permanent dismemberment of an existing relationship).

(a) 'Breakdown' of the doctor-patient relationship

Figure 7.1 presents an outline of the process of 'breakdown' of the doctor-patient relationship.

**Figure 7.1** *An outline of the process of 'breakdown' of the doctor-patient relationship*



'Breakdown' is usually preceded by a variable period of time in which each party views the other as being 'difficult' owing to their inability to conform to the rules of the doctor-patient relationship. For the GP, sometimes this 'difficulty' or minor breach of the rules is couched in openly moral terms ('bad' behaviour, 'inappropriate' service use) or the patient is labelled with a medical diagnosis that explains the 'bad' behaviour (e.g., drug addiction, personality disorder). For the patient, a range of problematic actions of the GP were identified but I have not systematically determined whether these were viewed as 'major' or 'minor' by the patient.

Being a 'difficult' patient or doctor does not appear, however, to be sufficient for the doctor-patient relationship to break down. Breakdown can happen in one of two ways. Firstly, there is a major breach of the rules of the relationship to the extent that one party feels this act constitutes 'breakdown'. The GPs' accounts of what constitutes such a violation have been explored in detail and I have argued that breaches of the rules such as rudeness and losing one's temper and pursuing a formal complaint violate the core properties of 'trust' and 'respect'. In contrast, while I have determined the rule violations that patients attributed to the removing GP, I have not determined in detail under what conditions this would lead patients to view the relationship as 'broken down'. Nonetheless, the findings from the 'paired' data show that both parties allege that the other has broken the same rules of conduct. Thus each party would view 'losing one's temper' as a major breach of the rules. Similarly, an allegation by the patient that the GP is incompetent or lies to the patient would be seen as a major breach of the rules. These findings receive empirical support from Gandhi *et al* (1997) who found that a patient's decision to change GP was often

triggered by the GP and/or practice staff being 'rude', the GP not being 'interested' in the patient and by the patient viewing the GP as incompetent. Hayes-Bautista (1976a) also found that the evaluation by a patient that the practitioner was incompetent led to a patient-initiated termination of the relationship.

The second way that the doctor-patient relationship can break down is when one party has been experiencing difficulties with the other's actions for a considerable period of time. I have clearly demonstrated this phenomenon in my analysis of the GPs' accounts. Minor rule violations not amenable to negotiation with the patient and committed over a period of time breach a key boundary rule (M. McCall, 1970) of the doctor-patient relationship: 'affective neutrality'. The GP becomes emotionally exhausted or develops such strong negative emotions towards the patient that medical care is potentially compromised. The GPs themselves draw on the 'metaphor' of 'divorce' to account for such a state of affairs: 'enough is enough'. As far as patients are concerned, it is theoretically plausible to suggest that patients may also come to develop negative emotions towards a particular doctor such that they have difficulty in separating such negative feelings from an evaluation of the care provided. This could happen in circumstances when the patient repeatedly expects a certain treatment from the GP but the GP refuses to offer this treatment and is not open to negotiation on this.

I suggest that 'breakdown' occurs when one party decides that the other has acted in such a way as to threaten that party's identity as a 'patient' or 'doctor'. This threat is often a consequence of an open display of power. For example, a formal complaint by a patient against a GP accusing the GP of incompetence is a threat to the

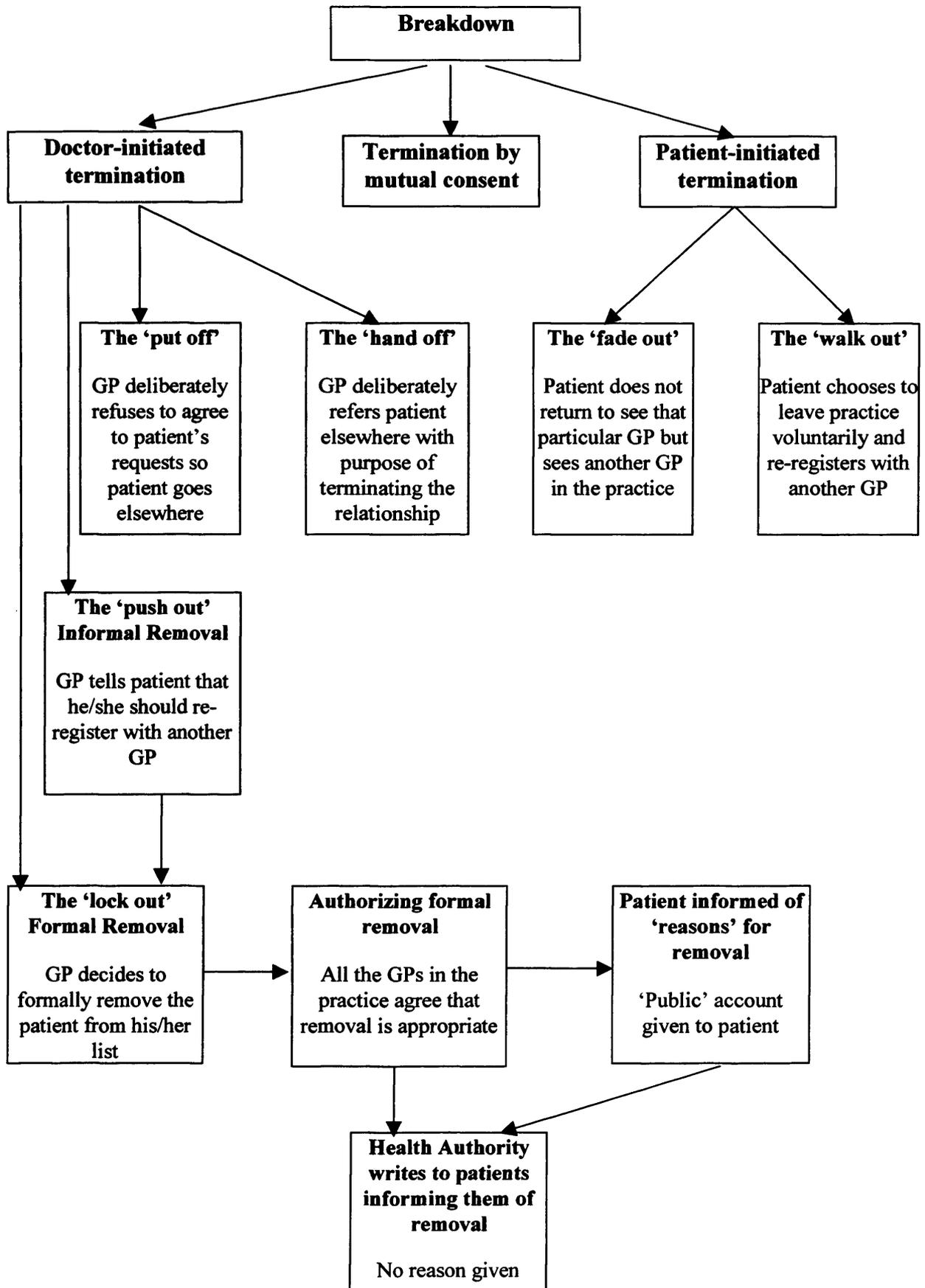
professional identity of a doctor: 'good' doctors are competent. Similarly, a GP openly accusing a patient of being awkward or complaining constitutes a threat to the professional identity of a patient: 'good' patients are uncomplaining. Other empirical research supporting the idea of 'identity threat' comes from Mulcahy's (1996) work with consultants' responses to complaints and Coyle's (1999) work exploring the meaning of 'dissatisfaction' with health care.

**(b) Termination of the doctor-patient relationship**

Figure 7.2 presents an outline of the process of 'termination' of the doctor-patient relationship. It should be emphasised that 'breakdown' and 'termination' are not synonymous. In giving their accounts of removal, the prevailing view of the GPs was that some doctor-patient relationships irretrievably break down and are followed by termination. Conversely, it is possible to conceive of situations for termination to occur in the absence of any breakdown in the relationship. Two good examples of this would be when a GP leaves or retires from a practice or when a patient genuinely moves outside the practice area. In addition, the negative case presented in chapter 7 (Case Study 3: Dr Gill/Chris) provides an example of where 'breakdown' is not necessarily followed by 'termination'. In this case the breach that led to removal is repaired by both parties and Chris is re-accepted back onto Dr Gill's list.

Termination of the doctor-patient relationship can be conceived as being patient-initiated, doctor-initiated or by 'mutual consent'. The focus of this thesis is on doctor-initiated termination, but I am able to present a more general model of termination by drawing on other relevant sociological and general practice literature.

**Figure 7.2** *An outline of the process of 'termination' of the doctor-patient relationship*



Patient-initiated termination was specifically explored by Hayes-Bautista (1976a). He coined the phrase the 'fade out' to refer to patients who, having decided to terminate the relationship, choose not to return to that particular practitioner. I suggest that in U.K. general practice this can be conceptualised as patients who stay registered with a particular group practice but who choose to consult another GP in the practice. A further category I term the 'walk out'. Here, patients choose to terminate the relationship with a particular practice by voluntarily re-registering with another local general practice. Although Gandhi *et al* (1997) do not offer a theoretical model of relationship breakdown or termination, choosing instead to describe the patients as 'dissatisfied', their qualitative research offers support for the hypothesis that relationship 'breakdown' can lead to the 'walk out': their participants recount stories of 'voting with their feet' and re-registering with another GP. In giving their accounts of removal the GPs also recognise that patients may well 'vote with their feet' and 'walk out' of the relationship without being explicitly asked to do so by the GP.

Hayes-Bautista (1976a) proposed that termination could sometimes be accomplished by mutual consent. Here, both parties come to an agreement that the relationship has not worked out the way both had hoped and that there appears to be no remedy other than mutually agreeing to terminate the relationship. He notes that this can only occur if *both* parties mutually agree to termination. I have not been able to find any empirical support for this hypothesis from the 'paired' interviews.

Doctor-initiated termination was conceptualised by Hayes-Bautista (1976a) as the use of disengagement tactics by the doctor to 'rid himself' of a patient. Two commonly used strategies were the 'hand-off' and the 'put-off'. The 'hand-off' is when a

practitioner refers a patient to another practitioner and does so for the specific purpose of terminating the relationship. Empirical evidence for this approach in U.K. general practice comes from a qualitative study of the process of referring patients for minor mental illness (Nandy *et al*, 2001). Nandy *et al* found that referring a patient with minor mental illness to a counsellor was a commonly used strategy when the GP had 'had enough' of a particular patient and wanted relief from the negative emotions engendered by the patient. Using the theoretical framework employed here, this can be seen as a particular example of doctor-initiated termination - the 'hand off' - following 'breakdown' due to a breach of affective neutrality. In contrast, the 'put off' is when a practitioner, seemingly on purpose, refuses to accede to a patient's demands so that the patient loses patience with the practitioner and consults another doctor; either within the same practice or by choosing to leave the list. The GP thus provokes a 'walk out'. It is perhaps not surprising that none of the GPs admitted that they used this strategy, even to a fellow GP, as it hardly portrays the interviewee in a favourable light given its implication that the GP is 'dumping' the patient on one of his colleagues.

My thesis, however, goes beyond the theoretical categories developed by Hayes-Bautista (1976a) and explores the phenomenon of the removal of a patient from a GP's list. Two categories of doctor-initiated termination of the doctor-patient relationship were identified from the GPs' accounts: 'informal' removal and formal removal. The first category, 'informal removal', or following Hayes-Bautista's (1976a) lead what I term the 'push out', is when the GP directly proposes to the patient that he/she would be better served by re-registering by another doctor. 'Informal' removal could also be used as a prelude to 'formal' removal if, after a

defined period of time, the patient had not left the practice 'voluntarily'. 'Formal' removal occurs when the practice writes to the Health Authority requesting removal of a patient. The GPs present formal removal as 'divorce' - it is a 'last resort' and 'final act' when all practicable attempts to 'fix' the doctor-patient relationship have failed. Removal is a 'last resort' and a 'final act' when all reasonable attempts to 'fix' the doctor-patient relationship have failed. Removal is presented by the GPs as allowing this 'breakdown' to be appropriately managed. The patients, in contrast, present removal as an abuse of power by 'bad' GPs. The extent of this abuse is shown by GPs being able to remove patients and their families from their lists without warning, without the need to justify their actions and without the patient having any right of appeal or redress. In contrast to the GPs' use of the 'divorce' metaphor, the patients are reluctant divorcees, rather as if they've been 'locked out' of the marital home. Thus I coin the phrase the 'lock out' to describe formal removal.

The final stage of termination may be termed 'grave dressing', to use Duck's (1982) vivid phrase. Each party, in telling his/her 'story' of removal some time after the event, uses the narrative of removal strategically (Riessman, 1990; Hyden, 1997) to reassert their identity as 'good' GPs and 'good' patients and this involves the attribution of blame to the other party (Felstiner *et al*, 1980).

What is striking in this model of termination of the doctor-patient relationship is how termination by 'mutual consent' would seem to be an 'ideal type' of termination that rarely happens in practice. Instead, each party goes to considerable lengths to use confrontation-avoidance as a strategy for terminating the relationship. Thus patients, rather than confronting the GP, choose to re-register with another practice. Similarly,

GPs may choose to remove a patient without warning or else to write a short letter tersely stating 'relationship breakdown' as the reason. There is, in fact, good reason for the use of such strategies as research suggests that an attempt by one party to terminate by 'mutual consent' is unlikely to succeed because it leads to the development of strategic cross-complaining (Duck, 1984). As Hayes-Bautista (1976a) notes, the fact that one party openly broaches termination leads to the other becoming angry at the suggestion and as a result a 'confrontation' develops, in which positions become entrenched – a complaint by one party is countered by a complaint from another, and so on. Indeed, it may not be possible to avoid confrontation and thereby achieve termination by mutual consent unless mediation is used. Mediation can be defined as:

*A form of intervention in which a third party - the mediator - assists the parties to a dispute to negotiate over the issues which divide them ... the mediator has no power to impose a settlement on the parties, who retain authority for making their own decisions (Roberts, 1997: 4)*

Third-party mediation is successful in resolving disputes because its interactional organization allows disputes to be discussed and agreement reached without argument (Garcia, 1991). Nonetheless, mediation can only occur if both parties are willing to co-operate, both are competent to make decisions and there is equality of bargaining power (Roberts, 1997).

To conclude, I have used theoretical insights from interpretive sociology (G. McCall, 1970; Hayes-Bautista, 1976a) and social psychology (Duck, 1981, 1982, 1984) to construct a model of 'ending the doctor-patient relationship' that sees the GP-patient relationship as a 'career' which has rules and rituals governing its 'breakdown' and 'termination'.

## **7.4 Implications for clinical practice and health policy**

I shall now use the above model, together with my review of the theoretical implications of the study, to offer a critique of current written guidance on the removal of patients from GPs' lists. This will be followed by a set of recommendations that are grounded in my empirical findings.

### *7.4.1 A critique of official guidance on removal*

Guidance on the removal of patients from GPs' lists has been published by the Royal College of General Practitioners (1997) and the General Practitioners' Committee (GPC) of the British Medical Association (1999) and has been reviewed in chapter 1. Both these documents constitute what the RCGP and BMA would consider as 'good' practice by GPs. Although, as previously discussed, the RCGP guidance is more explicitly 'patient-centred', both sets of guidance contain more similarities than differences. They both emphasise that removal is a rare event that should only be undertaken as a 'last resort' by GPs and should be a consequence of 'irretrievable' or 'irreparable' 'breakdown' of the doctor-patient relationship. Neither set of guidance offers a detailed definition of 'irretrievable breakdown'.

Drawing on the findings from the GPs' (chapter 4) and patients' (chapter 5) accounts of removal I suggest that these two sets of guidance can be criticised on three grounds: they assume an equality of power in the doctor-patient relationship; they use the 'divorce' metaphor to provide a publicly acceptable account of the removal process and they ignore the fact that removal policy is actually made by GPs and practice staff 'on the front line'.

(a) An equality of power?

As far as initiating and terminating the doctor-patient relationship is concerned, the guidance sees the fact that under a GP's terms of service GPs can remove any person from their list without giving them a reason (Department of Health, 1989) as being equivalent to the fact that patients can change their doctor without the need for them to give a reason to their GP. Thus the guidance assumes that there is an equality of power between patient and GP in terms of initiating and terminating the doctor-patient relationship and attempts by doctors and patients to resolve their difficulties using the practice-based complaints procedure. The guidance also advises GPs to use their power to remove patients in a benign way. Thus removal is justified when there is 'irretrievable' breakdown in the doctor-patient relationship but not when a patient 'costs too much' or has simply complained about the GP or other member of staff.

I have previously argued that there is a power differential between doctor and patient that is always necessary, often benign and sometimes abusive (Maseide, 1991). In the context of initiating and terminating the relationship I have shown that the power rests firmly with the GP. It is incorrect to see the removal of a patient by the GP as equivalent to a patient removing themselves from that GP's list and re-registering elsewhere. The removed patients interviewed in this study experienced a great deal of emotional distress. They also experienced felt and enacted stigma (Scambler and Hopkins, 1986): the removing GP has the power to 'mark' patients' notes to the effect that the removed patient becomes labelled as a 'difficult' patient. Removed patients may find it difficult to voluntarily re-register with another GP and end up requiring allocation to the new GP. Both GP and patient view allocation as stigmatising for the patient. It is therefore important that recommendations

acknowledge that the balance of power rests with the GP and that the risk of patients being stigmatised by removal is both acknowledged and minimised.

Moving onto possible resolution of difficulties, both the GPC and the RCGP advocate the use of the practice-based complaints procedure as a way of dealing with disagreements between GP and patient. The practice-based complaints procedure was set up in response to the Wilson Report (Department of Health, 1994) and is intended to ensure that complaints from patients about the care they receive are resolved whenever possible through early discussion and face-to-face communication. In the context of removal the patient could be invited by the practice to attend a meeting with the practice complaints manager to discuss the difficulties the practice are having with the patient. While research on the complaints procedure suggests that the principle of local or 'in house' resolution is sound, it can fail to take account of the power imbalance between practitioner and patient, lack impartiality and lack public accountability (Wallace and Mulcahy, 1999). There is arguably a danger that the use of this procedure with patients for whom removal is being considered represents not a 'real' attempt to resolve differences, but one of the GP and/or practice wishing to give a decision to remove a publicly acceptable gloss of 'following recommended procedures'. In any case, there is no empirical evidence that the GPs use this strategy. In fact, the reverse appears to be true. Once a decision was taken that 'break down' had occurred, removal was seen as inevitable and the GPs appear to minimize the likelihood of any confrontation over removal by not providing any reason to the patient or alternatively by writing a short letter giving a publicly acceptable account of the reasons for removal. An alternative approach would be to seek the services of a skilled independent third-party mediator to attempt the termination of the relationship

‘by mutual consent’. Although this approach is commonly used in family disputes (Roberts, 1997) it does not appear to have been used to facilitate the successful termination of the doctor-patient relationship and it remains to be seen whether it would be acceptable to doctors as well as patients.

(b) Removal as ‘divorce’?

The official guidance mirrors the legal terminology of ‘divorce’ by emphasising that there is a need to establish that the doctor-patient relationship has ‘irretrievably broken down’ before removing a patient. The metaphor of ‘removal as divorce’ is therefore officially sanctioned and allows a publicly acceptable account of removal to be constructed. ‘Irretrievable breakdown’ is left undefined by the GPC (General Practitioners Committee of the British Medical Association, 1999) although the RCGP offer this definition: ‘occasionally patients persistently act inconsiderately and their behaviour falls outside that which is normally considered to be reasonable’ (Royal College of General Practitioners, 1997: 6).

The ‘divorce’ metaphor is one which the GPs themselves use in giving their accounts of removal. Thus persistently unreasonable behaviour on the part of the patient (‘failed negotiation’) or the GP feeling that he/she can’t cope with a patient any longer (‘enough is enough’) is seen as grounds for divorce by the GP on the basis of ‘irretrievable breakdown’ in the doctor-patient relationship. Removal is a ‘last resort’ and a ‘final act’ when all reasonable attempts to ‘fix’ the doctor-patient relationship have failed. Removal is presented as allowing this ‘breakdown’ to be appropriately managed and both parties are seen as benefiting - the GP has ended a dysfunctional and stressful relationship; the patient finds a new GP they ‘can get on with’.

There are, however, two main criticisms of this metaphor as it relates to removal. It does not take account of the other main reason why GPs say they remove patients: 'breaking the rules'. Here, a major breach of the formal and informal rules governing the doctor-patient relationship, some of which are officially sanctioned (e.g., violence, lying), leads to removal. In such cases, removal may be seen by the GPs as a necessary penalty for 'bad' behaviour that in some cases may lead to an improvement in the patient's behaviour with the next GP. The 'divorce' metaphor is also used by patients, but in a very different way. The patients present themselves as victims of an acrimonious and unwanted 'divorce' – it has occurred without any warning, without any prior justification by the GP and without the patient having any right of appeal or redress. 'Divorce' is seen by the patients as the source of considerable psychological distress and is not seen as an appropriate way to manage difficulties in the doctor-patient relationship. It is therefore important to recognize that the metaphor of 'divorce', as constructed in official guidance, serves the interests of GPs as opposed to those of patients.

(c) Removal policy is made by 'front-line' staff

My final criticism of the published guidance is that it constitutes what GPs 'ought' to do as viewed by their professional bodies. It is not based on any empirical research and I would propose that what practitioners are actually doing is likely to be different. I suggest that policy on removals is actually made on the front-line, through the day-to-day interactions of GPs and practice staff and their patients. Such 'unofficial' policy may or may not coincide with 'official' policy on removal recommended by the GPC and RCGP. The case for 'front line' or 'street level' staff 'making' policy is lucidly argued by Lipsky (1980) in his classic study of the U.S.

public sector: *Street-Level Bureaucracy*. Although he writes from a U.S. perspective his definition of ‘street-level bureaucrats’ - ‘public sector workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work’ (Lipsky, 1980: 3) - is met by U.K. GPs. Lipsky’s thesis is that ‘the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out’ (1980: xii).

Through the accounts of removal given by both GPs and patients I have shown how ‘unofficial’ policy on removal is made and implemented in GP surgeries in Leicestershire. ‘Unofficial’ or ‘street level’ policy:

1. Differentiates patients into ‘good’ and ‘bad’ patients. It is necessary but not sufficient for a removed patient to have an illness or exhibit behaviour that the GP and/or practice staff find problematic;
2. Relies on the ‘bad’ patient breaching tacit ‘taken-for-granted’ rules of conduct. This can either be a single major violation (‘trigger event’) or a repeated series of minor violations (‘enough is enough’). These rules are rarely explicit and openly available to patients prior to their ‘breach’;
3. Views ‘termination’ as inevitably following ‘breakdown’;
4. Regards ‘termination’ as best accomplished by conflict-avoidance. The patient may simply be told to find another GP (‘informal’ removal). Alternatively, if ‘formal’ removal is used, the patient may not be given a reason for removal or else be given a publicly acceptable form of words, drawing on official guidance: ‘breakdown in the doctor-patient relationship’;

5. Holds the right of GPs to remove patients as sacrosanct. If GPs cannot remove patients then a patient could conceivably severely compromise the GP's and practice's ability to provide care to its other patients. Removal is, as Lipsky (1980: 124) would put it, a 'procedural coping device' necessary to the functioning of U.K. general practice.

#### *7.4.2 Recommendations on the removal of patients from GPs' lists*

Drawing on the above critique of official guidance I make the following set of recommendations with respect to the removal of patients from GPs' lists. I have deliberately avoided making prescriptive recommendations about which category of patient 'should' or 'should not' be removed. Instead, these recommendations acknowledge that GPs and practice staff 'make' removal policy and also that account needs to be taken of patients' views on removal.<sup>1</sup> This latter point is particularly important given the inequality that exists as far as the termination of the doctor-patient relationship is concerned.

These recommendations receive additional support by the fact that they are broadly in line with the conclusions of Macleod and Hopton's (1998a) unpublished study of the removal of patients from GPs' lists in Edinburgh.

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<sup>1</sup> It is accepted that this thesis has not explored the accounts of removal that could be given by other practice staff, notably receptionists. Ideally, recommendations on removal should draw on these accounts as well as those given by the GPs.

1. *GPs should retain the right to remove patients from their lists.* It is clear from their accounts of removing patients that GPs occasionally have to deal with a patient whose behaviour is such that the ability of the GP and/or the practice to provide care either for this patient or for other patients would be compromised if the patient is not removed.
2. *GPs should be accountable to the NHS for their decision to remove a patient from their list.* GPs should be required to inform the local Health Authority of the reasons for removal of a patient. It is accepted that GPs may chose, in such circumstances, to give the Health Authority publicly acceptable reasons for removal rather than the reasons for removal presented in the GP interviews in this study.
3. *Patients should have the right to obtain an explanation for and to complain about their removal from a GP's list and have access to independent third-party review of their removal, which could include access to third-party mediation as outlined in 5a.* They should not, however, have the automatic right to be reinstated onto their previous GP's list.
4. *Before making a decision to remove a patient GPs should:*
  - a. *Consider whether the 'difficulty' lies with the patient's illness or behaviour, the 'difficulty' lies with a particular doctor or whether the 'difficulty' is primarily the result of the interaction between the two parties. Organizational factors within the practice that may also be contributing should also be considered.* It is clear from their accounts of removal that the GPs tend to locate the 'difficulty' with the patient rather than considering alternative explanations for the patient's behaviour.

- b. *Consider whether it is appropriate to convene a practice-based meeting with the patient to try and resolve difficulties.* This may be appropriate in the early stages of 'break down' in the relationship. The rules of conduct may be interpreted differently by each party and it should not be assumed by the GP that the patient has consciously violated a rule. Resolution is, however, unlikely to succeed once the GPs have decided that removal is likely to be 'inevitable' (see recommendation 5a).
  - c. *Remember that the removal of a family or household poses particular problems as 'innocent' parties, often children, may be involved.* Careful consideration should be given as to whether it is appropriate to remove all members of the family or simply the party thought responsible for the 'breach' of the rules.
5. *Once the decision to remove a patient has been made GPs should:*
- a. *Consider whether the removal is likely to be problematic and, if so, whether independent third-party mediation should be used to help manage the termination of the relationship.* There is a strong possibility that unskilled 'in house' attempts to manage removal by 'mutual consent' will lead to cross-complaining and an escalation in the difficulties experienced by both GP and patient.
  - b. *Inform a patient of the reasons for their removal.* GPs should be required to inform a patient of his/her reason for removal. This should either be verbally or in writing. This requirement acknowledges the asymmetrical nature of the doctor-patient relationship and that the patient needs to be safeguarded from being removed from a GP's list 'without warning'. It is accepted that GPs may choose, in such circumstances, to give the patient

publicly acceptable reasons for removal rather than the reasons for removal presented in the interviews with GPs in this study.

- c. *Ensure that the patient knows that they are entitled to re-register with another GP and that the Health Authority will find them another GP if necessary.*
  - d. *Consider informing the new GP of the difficulties experienced by the GP and/or practice.* It should be remembered that patients may feel that their notes have been ‘marked’ and that they will be stigmatised. Care should be taken to ensure that a ‘fair’ description of the difficulties encountered is communicated.
6. *Consideration should be given to independent third-party review of patients who are repeatedly removed from a GP’s list.* Patients who are repeatedly removed from a GP’s list appear to be a small subset of removed patients that GPs find highly problematic. Such patients should have a right to continuity of medical care but this may require an obligation on the part of the patients to limit their ‘inappropriate’ (doctor-defined) behaviour.

## **7.5 Implications for further research**

In this penultimate section of the thesis I shall make some suggestions as to areas for further research based in my model of ‘ending the doctor-patient relationship’.

The model of ending the doctor-patient relationship needs to be refined and tested.

My own research has focused on doctor-initiated termination of the relationship by

use of 'removal'. Further research is needed to explore how, in a general practice setting, GPs end the relationship with a patient without recourse to the tactics of 'informal' and 'formal' removal. Patient-initiated termination also requires further study. It is accepted that the patients interviewed in the study may be viewed as 'extreme' cases and may not be representative of patients who chose to leave a GP's list voluntarily. Rigorous qualitative research is therefore needed, using the same conceptual framework, to explore why patients choose to leave a GP's list without changing address. This phenomenon could, like removal, be explored by interviewing both parties.

The model should also be extended to develop the concept of the doctor-patient relationship as a 'career' (G. McCall, 1970; Hayes-Bautista, 1976). Empirical work, using the interpretive approach advocated in this thesis, is needed to delineate the rules and rituals governing entry into and maintenance of the doctor-patient relationship in general practice as well as those that govern its ending. Such research would be methodologically challenging. There will be a need to conduct prospective interview studies with patients and practitioners to determine how the doctor-patient 'career' develops and changes over time. In this context it is encouraging that researchers are starting to advocate a similar approach to looking at the process of continuity of care with an emphasis on the need for longitudinal studies and attention to the patient's perspective (Freeman *et al*, 2000). The research suggested here would have particular relevance to the concept of 'relational continuity' (the long-term 'therapeutic' doctor-patient relationship). Such research should critically evaluate the assumption, held by the general practice discourse of patient-centred medicine, that relational continuity of care is always beneficial to both patient and practitioner. My

research suggests that discontinuity of care, as exemplified by ending the doctor-patient relationship, is sometimes valued by GP and patient. Such 'sought' discontinuity of care is a phenomenon that requires further exploration, touching as it does on the difficulties both parties face in maintaining the boundary rules of a relationship that, in general practice, may last for a number of years.

## 7.6 Conclusion

I conclude by reflecting on my aims for this thesis.

The first aim of the thesis is pragmatic - to obtain a detailed description of the process of removal as perceived by both GP and patient in order to draw up policy recommendations on removal that take account of each party's 'side of the story'. The findings highlight the fact that removal was problematic for both parties. The GPs did occasionally face patients who behaved in such a way as to break the formal and informal rules of the doctor-patient relationship or who engendered feelings of exhaustion and/or dislike in the GP to the extent that the GP no longer felt able to provide care for that patient. In such cases the GPs felt they had no option but to exercise their right to remove the patient from their list. Patients, for their part, regarded removal as a threatening event that caused them to suffer much emotional distress and 'spoilt' their identity as a patient – they experienced felt and enacted stigma. Account is taken of the problems faced by both GP and patient in the policy recommendations. Thus it is recommended that GPs should retain the right to remove patients from their lists *but* that GPs should be accountable to the NHS for their

decision to remove a patient and patients should have the right to obtain an explanation for why they have been removed.

The second aim of the thesis is to further an understanding of how a doctor's relationship with a patient may be ended through placing removal in a wider framework of theory in relation to the 'difficult' doctor-patient relationship and social relationships. The empirical findings of the thesis were used to develop a model of ending the doctor-patient relationship which conceptualised the process as relationship 'breakdown' followed by 'termination'. This model drew on relevant sociological theory, notably that power is produced in the doctor-patient relationship in general practice through the 'ceremonial order of the GP surgery' and that this power is usually 'hidden' from both participants. It is argued that the process of removing a patient from a GP's list lays bare the power differential between GP and patient and removal constitutes an open display of force by the GP in which the patient is coerced into leaving the list of the GP. Patients can, however, resist medical power and can themselves openly confront the GP and force the GP to account for his/her actions. Such a naked display of power by either GP or patient threatens the identity of the other party and thereby causes 'breakdown' of the doctor-patient relationship. If this 'breakdown' is not repaired by both parties then 'termination' of the relationship follows.

It is the argument of this thesis that the removal of a patient from a GP's list offers unique insight into a relatively uncharted area of the doctor-patient relationship: the ending of the doctor-patient relationship. By providing a detailed description of the process of removal as perceived by both GP and patient and by developing theory in

relation to the 'difficult' doctor-patient relationship this research has contributed to the published literature on the doctor-patient relationship in general practice.

## **APPENDIX 1**

### **QUOTA SAMPLING FRAMES**

### 1.1 Quota matrix (GPs): Interviews with General Practitioners

Category	Quota range	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total
<b>GP &amp; Removals</b>																											
Paired interview	10+	√		√			√			√		√	√	√		√			√			√	√				11
'Low' remover	10+			√	√	√	√	√	√	√	√		√	√	√		√			√	√						14
'High' remover	5-10	√	√									√				√		√	√			√	√				8
<b>Sex</b>																											
Male	15-17	√	2	√	√	√		√		1	√	√	√	√		√		√	√		√	√	√				18
Female	8-10		1				√		√	1					√		√			√							7
<b>Age</b>																											
<34	1-5					√	√							√													3
35-55	10-15	√	3		√					2	√	√			√	√	√	√	√	√	√	√	√				18
>55	1-5			√				√	√				√														4
<b>Hours worked</b>																											
Full time	15-20		3	√	√	√				2	√	√	√	√		√		√	√		√	√	√				18
Part time	5-10	√					√	√	√						√		√			√							7
<b>Practice type</b>																											
Single handed	4-5			√							√		√						√		√		√				6
Group	15-20	√	√		√	√	√	√	√	√		√		√	√	√	√	√		√		√					16
Training	5-10	√			√	√						√				√											5
Non-training	10+		√	√			√	√	√	√	√		√	√	√		√	√	√	√	√	√	√	√			17
<b>Location</b>																											
<i>City of Leicester</i>																											
a) high deprivation (inner city)	10+	√	√				√	√					√		√			√	√		√		√				10
b) low deprivation (urban)	1-5													√			√			√							3
<i>County</i>																											
a) urban	1-3								√	√	√	√	√			√											5
b) semi-rural/market town	1-3					√																	√				2
c) rural	1-3			√	√																						2
<b>Ethnicity</b>																											
a) UK graduate	20+	√	1	√	√	√	√	√	√	2		√		√	√	√	√	√		√	√	√	√				18
b) non-UK graduate	1-5		2					√			√		√						√					√			7
<b>Deprivation</b>																											
Deprived		√	√				√	√				√	√		√	√		√	√		√		√				12
Affluent				√	√	√			√	√	√			√			√			√		√					10

## 1.2 Quota matrix (patients): Interviews with removed patients

Category	Quota range	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total
<b>Pt &amp; Removals</b>																											
Paired interview	10+	√		√		√	√	√			√	√		√	√								√		√		11
Unpaired	10-15		√		√				√	√			√			√	√	√	√	√	√			√		√	14
<b>Sex</b>																											
Male	12-13	√					1		1		√	√	√				√		1		√	√		√			11
Female	12-13		√	√	√	√	1	√	1	√				√	√	√		√	1	√			√		√	√	17
<b>Age</b>																											
16-24	4-5		√																			√				√	3
25-39	10-14	√			√	√	2					√		√		√			2						√		11
40-64	4-6							√		√	√		√				√	√		√			√	√			9
65+	2-4			√					2						√							√					5
<b>Removal type</b>																											
Individual	15-18	√	√	√	√			√		√	√	√	√	√		√		√		√	√	√		√	√	√	17
Household	7-10					√	√		√					√		√	√		√				√				8
<b>Location</b>																											
<i>City of Leicester</i>																											
a) high deprivation	14-19	√	√		√	√	2			√				√	√	√			2	√				√	√	√	16
b) low deprivation	3-6																				√	√					2
<i>County</i>																											
a) urban	1-2			√							√	√		√				√					√				6
b) semi-rural/market town	1-2								2				√														3
c) rural	1-2							√																			1
<b>Ethnicity</b>																											
<i>South Asian</i>																											
a) surname/first name	5-7				√		2			√							√		2		√	√				√	10
b) non-English speaker	? 0-3				*																						
Other	16-18	√	√	√		√		√	2		√	√	√	√	√	√		√		√			√	√	√		18

\* needed help with English from family member

## **APPENDIX 2**

### **LETTERS OF INVITATION AND INFORMATION LEAFLETS**

**2.1 Printed on Department of General Practice and Primary Health Care,  
University of Leicester Note Paper**

«TitleGP» «InitialGP» «SurnameGP»  
«Street1GP»  
«Street2GP»  
«TownGP»  
«CountyGP»  
«PostcodeGP»

01 March 1999  
Ref: gprecrut6.doc

Dear «TitleGP» «SurnameGP»,

**Tell us about GPs' experiences of removing patients from  
their lists:  
Gain 1 hour of PGEA**

I am a GP who is interested in what happens when GPs decide to remove a patient from their list.

The removal of patients from practices is seen as an increasing problem for GPs and the issue has been hotly debated in the 'medical tabloids'. What is lacking is any proper study of the process of removing patients which fairly reflects the difficulties GPs experience in dealing with such patients.

I am conducting a study (described in the attached leaflet) that aims to find out more about GPs' views on this important issue. Currently, I am attempting to identify GPs who would be prepared to take part in the study (and who will gain an hour of PGEA in return!).

**There is no need for you to reply to this letter.** I will telephone you at your surgery in the next two weeks to answer any questions you may have and to see if you wish to take part in what promises to be a very interesting study. Thank you for your time and consideration.

Yours sincerely,

**Dr Tim Stokes**  
**Leicester GP and Lecturer**  
**Direct Dial: 0116 258 4395/4367**

## **2.2 GPs' EXPERIENCES OF REMOVING PATIENTS FROM THEIR LISTS**

### **What is the background to the study?**

- *A very topical issue.* The Health Service Ombudsman has recently been involved in a number of high profile cases of patient removal.
- *Little is really known about why GPs remove patients from their practices.* There is a lack of rigorous research from the GP's perspective looking at why GPs remove patients. This research involves an analysis of routinely collected Health Authority data, interviews with GPs and interviews with patients.

### **What would the study involve for you?**

- You will be interviewed by me.
- The interview will be tape recorded and last for up to one hour.
- The interview will cover your experiences of removing particular patients from your list, experiences of removing patients in general and how you deal with 'problem patients'.
- I can offer you one hour of PGEA approval for taking part in this study.

### **How would disruption to your work be minimised?**

*I am a GP and am aware of the difficulties in fitting such an interview into a busy working day. I will help by:*

- Interviewing you at your surgery or at any other venue convenient to yourself.
- Interviewing you at a time convenient to yourself.
- Not asking members of your staff to do work on the project.

### **What about confidentiality?**

- The interview data will remain strictly confidential. The tape will be destroyed after the study is completed.
- The Leicestershire LMC has been consulted about the study and in principle supports its overall aims and objectives. The study also has the approval of the Leicestershire Research Ethics Committee.

### **Is it worthwhile?**

- **YES!** It is extremely important to document GPs' experiences of removing patients so that a balanced view of the issues surrounding removal can be presented to the media, Health Authorities and Patient Advocacy Groups. The results will be important to all GPs.

### **2.3 Printed on Leicestershire Health Note Paper**

From the Office of Mrs C A Braidwood  
Data Services Manager  
Direct Dial: 0116/258 8986

Our Ref: CAB/bh

Date as Post Mark

**Dear**

#### **What is it like for people who have to leave their doctor?**

Leicestershire Health and researchers at the University of Leicester are looking at what happens when patients are 'removed' from their GP's list of patients.

This letter is being sent to people who have been removed from a GP's list to allow them the chance to tell a trained researcher, in confidence, what happened.

The researchers are very keen to hear from you as very little is known about how people feel about being removed from a GP's list. The researchers would like you to 'tell them your story'.

- If you would like to receive further information about this study please fill in the green slip and return to me in the prepaid envelope provided. You will then be sent further information by the researchers which tell you more about the study. If you do decide to take part, complete confidentiality and anonymity are guaranteed.
- I would stress that your name and address will not be passed on to any researcher without your consent.

Yours sincerely

**Mrs Colette Braidwood**  
**Data Services Manager**

2.4 *Printed on Department of General Practice and Primary Health Care,  
University of Leicester Note Paper*

«Titlept» «Initialpt» «Surnamept»  
«Street1pt»  
«Street2pt»  
«Townpt»  
«Countypt»  
«Postcodept»

01 March 1999  
Ref: ptreruit.doc

Dear «Titlept» «Initialpt» «Surnamept»,

**What is it like for people who have to leave their doctor?**

Thank you very much for returning your reply slip from the letter telling you about our research on people's experiences of being 'removed' from their GP's surgery.

Your name and address have now been passed onto us and we are writing to you to tell you more about the study. The enclosed *Information Leaflet* tells you what is involved. We would be very interested in you telling us what happened.

If you would like to tell us your story, please return the reply form on the next page, or telephone us. A researcher will then phone (or write if you have no phone) to arrange a visit to suit you.

**If you have any queries please telephone this number and leave your name and phone number on our answerphone:  
0116 258 4910**

Yours sincerely,

**Tim Stokes**  
Lecturer

**Kate Windridge**  
Research Associate

## **2.5 THE EXPERIENCES OF PATIENTS WHO HAVE BEEN REMOVED FROM GPs' LISTS**

### **What is the purpose of the study?**

- *Little is really known about patients' experiences of being removed from GPs' lists.* The aim of this study is to investigate the views of patients who have recently been removed from a GP's list. Leicestershire Health Authority has provided the researchers with the names and addresses of patients who have been removed from a GP's list who have indicated that they wish to receive information about the study.

### **What will be involved if I agree to take part in the study?**

- The interviewer will contact you by telephone, or by letter, or by visiting you to answer queries and arrange a suitable place for the interview to take place: this could be your own home.
- You will be asked to sign a written consent form before the interview.
- The interview will be tape-recorded and last for approximately one hour.

### **Am I likely to experience any problems being interviewed?**

- We recognise that you may have found the experience of being removed from a GP's list stressful and unpleasant. We can reassure you that our interviewer will handle the matter carefully and with tact. You are free not to answer any questions you do not wish to answer. You will be encouraged to express any concerns you may have during the interview.
- At the end of the interview the interviewer will be able to give you the contact number of an officer of the Health Authority who deals with patients who are removed from GPs' lists.

### **Will the information obtained in the study be confidential?**

- The interviewer is not a medical doctor and will not have access to your medical records. The interviewer will not know anything about you other than information you wish to reveal during the course of the interview. The interviewer has no contact with your previous or current GP.
- Although the interview will be recorded on tape it will remain confidential. All information recorded on tape will be destroyed after the study is completed.

### **What is the benefit of me agreeing to be interviewed?**

- The results of the study will improve our understanding as to what happens to patients when they have been removed from GPs' lists. The information will be used to help make local health services better equipped to deal with the needs of patients who have been removed from GPs' lists and will, we hope, reduce the number of removals made by GPs.

2.6

**Consent form for patients agreeing to be interviewed as part of a study of the experiences of patients who have been removed from GPs' lists**

I \_\_\_\_\_ give consent to being interviewed by a trained interviewer as part of a study looking at the experiences of patients who have been removed from GPs' lists. I have received and read a copy of the patient information sheet.

Signed:

Date:

## **APPENDIX 3**

### **INTERVIEW TOPIC GUIDES**

### 3.1 TOPIC GUIDE: 'UNPAIRED' GP INTERVIEWS

#### Research objectives

To explore the accounts of general practitioners who rarely remove patients from their lists

#### 1. Introduction

- Outline purpose of interview, stress confidentiality  
*Get GP to feel comfortable and talk about self*

#### 2. Background

- When qualified as a Doctor
- Working part-time/full-time
- The practice  
*Probe: elaborate on how GP finds working in practice/'practice culture'*
- The practice population  
*Probe: elaborate on what GP perceives to characterise his/her patient population*
- Under what circumstances does practice/GP remove a patient?  
*Probe: practice policy/RCGP guidelines/written vs unwritten/account of process (RCGP: violence/crime & deception/'breakdown' in Dr-Pt relationship)*

#### 3. General issues about the 'doctor-patient relationship'

- What types of patient cause the GP 'trouble'  
*Probe: meaning of 'difficult to deal with'/'relationship break-down'*

#### 4. How GP deals with difficult patients:

- a) actual/intended verbal/physical violence
- b) 'inappropriate' use of services
- c) 'heartsink' patients/somatisers  
*Probe: idea of 'appeal to gentility breached' (when patients breaks unwritten practice rules, what happens)*

#### 5. Relationship of 'difficult patient' with general practitioner/practice

*Ask GP to reflect on recent 'problem patient' (who may/may not have been removed):*

- How long with that GP/practice
- Use of services  
*Probe: who saw/how often/where (home visit/out of hours)/same GP twice*  
*Probe: other staff involved*
- Relationship with practice  
*Probe: feelings towards patient/family in general*  
*Probe: loss of affective neutrality*
- Relationship with general practitioner(s)  
*Probe: description of relationship with patient/family - good things/bad things*
- Would removal of patient be considered? (if not removed)  
*Probe: use of 'informal' versus 'formal' removal*

#### 6. Other issues

- How GP deals with 'allocated' patients  
*Probe: issues around 'stigma'*  
*Probe: does 'punishment work?'*
- Current media issues on removal  
*Probe: GP views on Pts 'costing too much'/refusing immunisations, etc.*

## 3.2 TOPIC GUIDE: 'PAIRED' GP INTERVIEWS

### Research objectives

To explore the accounts of general practitioners who have removed patients

#### 1. Introduction

- Outline purpose of interview, stress confidentiality  
*Get GP to feel comfortable and talk about self*

#### 2. Background

- When qualified as a doctor
- Working part-time/full-time
- The practice  
*Probe: elaborate on how GP finds working in practice*
- The practice population  
*Probe: elaborate on what GP perceives to characterise his/her patient population*
- Under what circumstances does practice/GP remove a patient?  
*Probe: practice policy/RCGP guidelines/written versus unwritten/account of process (RCGP: violence/crime & deception/'breakdown' in Dr-Pt relationship)*

#### 3. General issues about the 'doctor-patient relationship'

- What types of patient cause the GP 'trouble'  
*Probe: meaning of 'difficult to deal with'; 'relationship breakdown'*

#### 4. How GP deals with difficult patients:

- actual/intended verbal/physical violence; crime & deception
- 'inappropriate' use of services
- 'heartsink' patients/somatisers

*Probe: idea of 'appeal to gentility breached'  
(when patients breaks unwritten practice rules, what happens)*

#### 5. Relationship of recently removed patient/family with general practitioner/practice

- How long with that GP/practice
- Use of services  
*Probe: who saw/how often/where (home visit/out of hours)/same GP twice/other staff*
- Relationship with practice  
*Probe: feelings towards patient/family in general  
Probe: loss of affective neutrality*
- Relationship with general practitioner(s)  
*Probe: description of relationship with patient/family - good things/bad things*

#### 6. Removal of recently removed patient/family

- Get GP to tell how and why the decision to remove the patient was made  
*Probe: one event/several? 'Real' versus 'Official' reason?*
- Were alternatives to removal considered?  
*Probe: use of 'informal' vs 'formal' removal*
- How would GP view future relationship with patient/family if allocated to practice  
*Probe: issues around 'stigma'*
- Effect on patient of actions considered?

#### 6. Other removals

- How 'typical' was recent removal
- Descriptions of other removals that come to mind

#### 7. Other issues

- How GP deals with 'allocated' patients  
*Probe: issues around 'stigma'  
Probe: does 'punishment work?'*
- Current media issues on removal  
*Probe: GP views on Pts 'costing too much'/refusing immunisations, etc.*

## 3.2 TOPIC GUIDE: PATIENTS

### Research objectives

- To explore the accounts of patients who have been removed from general practitioners' lists.

### 1. Introduction

- Outline purpose of interview, stress confidentiality  
*Get patient to feel comfortable and talk about self*

### 2. Background

This should cover:

- General Health
- Current health problems
- Household composition

### 3. General issues about the 'doctor-patient relationship'

- What qualities do patients most value in their GP/practice  
*Probe: meaning of 'personal relationship'/'listens'/etc.*
- What qualities do patients dislike about their GP/practice  
*Probe: meaning of 'offhand manner', 'rudeness', 'didn't listen'/etc.*

### 4. Relationship with general practitioner/practice (BEFORE removal)

- How long with that GP/practice
- Use of services  
*Probe: who saw/how often/where (home visit/out of hours)/same GP twice*
- Relationship with practice  
*Probe: feelings towards practice in general*
- Relationship with general practitioner(s)  
*Probe: description of relationship with GP - good things/bad things*

### 5. Removal by general practitioner

- Get patient to tell how they felt when they received letter of removal from Health Authority  
*Probe: elaborate - expected/unexpected; how practice dealt with it; suspected 'reasons'; 'justified' or not*
- What should GP/practice have done instead?
- Feelings about GPs being able to remove patients
- How do they NOW view relationship with GP who removed them  
*Probe: meanings of 'relationship breakdown' (if mentioned)*

### 6. Position now

- Get patient to tell how they went about finding another general practitioner
- How they view relationship with new GP/practice
- How they perceive new GP views them  
*Probe: issues around 'stigma'*

**APPENDIX 4**

**DATA ANALYSIS**

#### **4.1 THEMED CODING FRAME FOR GENERAL PRACTITIONER INTERVIEWS**

##### ***GPs' ACCOUNTS OF REMOVING PATIENTS FROM THEIR LISTS DEFINITIONS OF GP INTERVIEW CATEGORIES***

##### **THEME 1: 'THE RULES OF THE GAME': WHAT MAKES THE DOCTOR-PATIENT RELATIONSHIP WORK?**

###### **The foundations of the doctor-patient relationship**

Statements about the conditions necessary for the doctor-patient relationship to 'work'.

###### **1.1 The particular nature of the GP-patient relationship (memo)**

Statements relating to the particular nature of the GP-patient relationship, including:

- 1.1.1 long-term relationship
- 1.1.2 taking the 'rough with the smooth'.

###### **1.2 The duties of patients (memo)**

Statements about the duties of patients to make the doctor-patient relationship 'work', patients should:

- 1.2.1 respect the GP
- 1.2.2 have 'faith' in the GP
- 1.2.3 listen to the GP
- 1.2.4 want to get better
- 1.2.5 take responsibility for their own actions
- 1.2.6 defer to the GP, especially if the GP has made the effort to be reasonable.
- 1.2.7 stick to the same doctor where possible (continuity of care)

###### **1.3 The duties of doctors (memo)**

Statements about the duties of doctors to make the doctor-patient relationship 'work', including:

- 1.3.1 respect the patient
- 1.3.2 operate 'reasonable' practice policies

###### **1.4 The duties of both parties to each other (memo)**

Statements that both GP and patient must:

- 1.4.1 be aware of the importance of 'trust' and 'honesty' in the relationship
- 1.4.2 be able to express their views in the consultation
- 1.4.3 be able to reach a 'shared understanding' of the problem brought to the GP by the patient
- 1.4.4 negotiate a solution acceptable to both parties.

## **THEME 2: THE 'DIFFICULT' DOCTOR-PATIENT RELATIONSHIP (memo)**

### **2.1 Problematic behaviour by patient (memo)**

Statements about such patients exhibiting a range of behaviours seen as problematic by the GPs, including:

- 2.1.1 excessive service use
- 2.1.2 'doctor hopping'
- 2.1.3 complaining
- 2.1.4 'wanting their own way'
- 2.1.5 being manipulative, including manipulation by patient's relatives
- 2.1.6 being knowledgeable

### **2.2 Patient has certain types of illness (memo)**

Statements about such patients having certain types of illnesses by the GP, including:

- 2.2.1 'heartsinks' and somatisers
- 2.2.2 drug addicts
- 2.2.3 alcoholics
- 2.2.4 personality disorder
- 2.2.5 mental illness

### **2.3 Some patients are 'hard to like' (memo)**

Statements about such patients arousing feelings of dislike in the GP towards the patient, including:

- 2.3.1 frustration
- 2.3.2 pejorative comments about patient
- 2.3.3 adverse effect on well-being of GP and other health care workers
- 2.3.4 GP concerned negative feelings may affect care of patient.

## **2.4 Practice organisational features can lead to unreasonable behaviour from patients (memo)**

Statements about practice 'factors' that can lead to patients becoming 'difficult', including:

- 2.4.1 difficulty in gaining access to GP
- 2.4.2 difficulty in seeing the same doctor each time &/or GP of one's choice
- 2.4.3 GP 'stressed out' at the time (e.g., workload)

## **2.5 Organisational arrangements within the practice to deal with 'difficult' patients (memo)**

Statements about *organisational arrangements* within the practice to deal with 'difficult' patients, including:

- 2.5.1 the GP having developed a team approach for dealing with 'difficult' patients.
- 2.5.2 the use of formal practice procedures to deal with 'difficult' patients (e.g., informal complaints procedure)
- 2.5.3 the 'culture' of the practice being one of 'not removing' patients.
- 2.5.4 the need to deal with patients 'grumbles' early before they become complaints. The need to 'defuse' potentially violent situations, including training needs. The possibility of third party resolution of disputes.
- 2.5.5 'spreading the load'. All GPs have difficult patients and GP moves patients to another GP to 'get a break' or following a 'breakdown in relationship'.

## **2.6 The 'difficult' patient and the 'doctor-patient relationship'**

Statements about the inability of the patient to establish a 'working' or 'therapeutic' relationship with their GP, including:

### **2.6.1 (memo) the properties of the relationship that stop it 'working', including:**

- 2.6.1.1 patient as 'doctor hopper'
- 2.6.1.2 patient 'wants their own way'
- 2.6.1.3 patient &/or relatives is manipulative
- 2.6.1.4 patient is a 'complainer'
- 2.6.1.5 patient is aggressive
- 2.6.1.6 patient arouses intense dislike in the GP - 'drives the GP up the wall'
- 2.6.1.7 patient 'hates' GP &/or refuses to see particular GP.

### **2.6.2 (memo) The strategies GPs use *in the consultation* to manage patients with whom they have difficulty in establishing a 'therapeutic' relationship, including:**

- setting contract with patient
- manner in which GP broaches 'difficulty' with patient

### **2.6.3 Patients 'vote with their feet' (memo)**

Statements about a patient choosing to consult another doctor within a practice and/or consult another doctor in a different practice when the patient has difficulties with a particular doctor or practice. Statements about practice not re-accepting patients back onto the list who have chosen to leave.

### **THEME 3: BREAKING THE 'RULES OF THE GAME': BECOMING A REMOVED PATIENT (memo)**

#### **3.1 'Trigger event' with a difficult patient (memo)**

Statements about the GP having experienced difficulties with the patient previously *AND* statements about a 'trigger event' by which a difficult patient becomes a removed patient. Such behaviour on the part of the patient includes:

**3.1.1** aggression

**3.1.2** rudeness

**3.1.3** losing one's temper

**3.1.4** racist remarks

**3.1.5** open criticism

**3.1.6** pursuing a formal complaint against a doctor &/or other health care professional

**3.1.7** lying, being insincere

#### **3.2 'Trigger event' in the absence of prior difficulty with the patient (memo)**

Statements about a 'trigger event' in the absence of prior difficulty with the patient, including statements about immediate breakdown on the basis of one doctor-patient encounter.

#### **3.3 GP has experienced difficulties with the patient for some time (memo)**

Statements about the GP having experienced difficulties with the patient for some time *AND* there is no specific 'trigger event', including: the patient 'drives the GP up the wall'. Statements about dislike being so intense as to lead to loss of affective neutrality with consequences for GP's ability to care for the patient.

#### **3.4 Removed patients as 'culpable'**

Statements about removed patients being 'culpable'.

In the transformation of a difficult patient into a removed patient the patient must be shown as culpable.

Culpability is achieved by:

##### **3.4.1 'Failed Negotiation' (memo)**

Statements to the effect that the patient has been made aware of the problem they are having with the GP/practice either orally or in writing but no attempt has been made by the patient to change their behaviour.

##### **3.4.2 No mitigating circumstances (memo)**

No mitigating circumstances are presented by the GP, including: mental illness or 'stress' on the part of the patient. Statements about removal of patient being avoided as mitigating factors are present. Statements about GP feeling 'guilty' about removal because potential mitigating factors were present.

### **3.5 Removal process seen by GPs as 'therapeutic' for patients**

#### **3.5.1 Removed patients as 'model patients' (memo)**

Statements about GPs finding patients who had been previously removed by another GP and/or who were allocated to their list to be 'model patients'. The GP has no difficulty dealing with them.

#### **3.5.2 Removal process is educative (memo)**

Statements that the removed patient realises that they cannot go on behaving as they have been doing if they are to stay registered with a particular GP. Statements about removal being a 'shock' to patients which acts as a spur to them to change their behaviour. Statements about the 'threat to remove' changing the patient's behaviour.

#### **3.5.3 'Horses for courses' (memo)**

Statements that particular GP/practice and particular removed patient do not see 'eye to eye' and so the patient needs a new Doctor-Patient relationship. Patient can start again with a 'clean sheet'. Statements about the 'threat to remove' improving a patient's relationship with the GP.

#### **3.5.4 'The three monthlies' (memo)**

Statements to the effect that there is a failure of removal process to have any effect on the removed patient's behaviour. Statements identifying a particular difficult group of removed and/or allocated patients.

### **3.6 How GPs deal with patients removed by other doctors (memo)**

Statements about how GPs deal with patients who have been previously removed from another doctor's list. This includes statements about GPs 'screening' patients before admitting them onto their list. This category includes:

**3.6.1** those who have joined their list voluntarily

**3.6.2** those who are allocated to them.

## **THEME 4: A JUST POLICY OR JUSTIFICATION AFTER THE EVENT? - GPs' POLICY ON REMOVALS**

### **4.1 Stated policy on removals (memo)**

**4.1.1** Statements about GP &/or practice *policy* on removal, including:

**4.1.1.1** violence and/or aggression

**4.1.1.2** 'unreasonable service use'

**4.1.1.3** 'breakdown' in doctor-patient relationship

**4.1.2 (memo)** Statements about whether policy written or unwritten.

**4.1.3 (memo)** Statements about GPs removing patients on financial grounds

### **4.2 'Informal' and Formal removals (memo)**

Statements about 'informal' and formal removals.

**4.2.1** An 'informal removal' is when the GP proposes to the patient that he/she would be better served by re-registering by another doctor.

**4.2.2** 'formal removal', is when the practice writes to the Health Authority requesting removal of a patient.

### **4.3 Description of the removal process (memo)**

**4.3.1** Statements about involvement of other members of staff in removal decision.

**4.3.2** Statements about how the decision to remove was communicated to the patient.

**4.3.3** Statements about behaviour of removed patient with removing practice following removal.

### **4.4 The use of sanctioning by the GP (memo)**

Sanctioning refers to the way GPs will seek confirmation from others that the difficult he/she is having with a patient are the fault of the patient, not of the GP. Hence:

#### **4.4.1 Patient difficult with others**

Statements about patient being difficult with others (e.g. other GPs, members of the Primary Health Care Team, other patients).

#### **4.4.2 GP has discussed patient with others**

Statements about GP having discussed patient with others and having received affirmation that the patient is 'difficult'.

#### **4.4.3 GP asks others present at interview to agree that his actions were appropriate.**

Statements by the interviewer that he had done similar things to the interviewee.

#### **4.5 Removal as ‘final resort’ (memo)**

Statements about the fact that the GPs view removal as a ‘final resort’ or ‘last act’ and rarely remove patients. Statements about the need for GPs to have this ‘final sanction’. Statements about the media misrepresenting GPs’ actions in removing patients.

**4.5.1** Statements about GPs taking back onto their lists patients whom they have removed (memo)

#### **4.6 ‘Breakdown’ in the doctor-patient relationship (memo)**

Statements of GPs’ definitions as to what constitutes a ‘breakdown’ in the doctor-patient relationship.

## 4.2 EXAMPLE OF A MEMO FROM THE GENERAL PRACTITIONER INTERVIEWS

### MEMO (category 2.6.1) THE PROPERTIES OF THE RELATIONSHIP THAT STOP IT 'WORKING'

28/11/99

An important theme seems to be that DPs, RPs, APs can all arouse negative feelings in the GP towards them. In certain cases these feelings are so strong that the GP is driven up the wall and therefore is having problems managing the Pt appropriately (113a).

This theme is present in a large number of open codes:

- 12e. criteria for removal is that Pt 'drives GP up the wall'
- 36a. pejorative comments about RP by GP.
- 38. Frustration at Pt's behaviour
- 63. RP has adverse effect on GP's well-being
- 63a. DP as adverse effect on GP's well-being
- 711. DPs arouse negative emotions in GP

McKeganey offers a theoretical perspective on the doctor-patient relationship of opiate abusing patients by applying Parson's (1951) functionalist model. He argues that the strong negative feelings that the general practitioners had towards these patients is at variance with Parson's ideal of emotional detachment.

Again, a key question is: DPs and RPs are disliked by GP for a variety of reasons and this affects the Dr-Pt relationship. But why are some DPs removed and not others?

20/5/00

This theme relates to teasing out what exactly the properties are of the 'difficult' Dr-Pt relationship that stop it 'working'. There are a number of subcodes as at present it is unclear which appear to be the most important.

GP8 introduces new subcode - not only can GP 'hate' patient but patient can 'hate' GP and demonstrate this openly in the consultation.

1/6/00

GP 14 sees 'lying' as the key difficulty in the 'difficult' doctor-patient relationship. GP14 sees heartsinks and Pts with mental illness as unproblematic if they are 'honest'. What makes a patient 'difficult' is not their illness per se, but whether they are 'honest' or not. Hence the lack of 'trust' with patients with a personality disorder or drug addiction is the key 'difficulty'.

12/6/00

GP16 offers a definition of 'breakdown' as being met when 'you're not giving the standard of care you would expect to someone', which means: BOTH a) excess demand/want their own way AND b) loss of affective neutrality. Could this meet the criterion for 'enough is enough' (3 3)?

15/6/00

GP20 stresses difficulty of IC practice as one of being unable to communicate with certain groups of individuals (e.g., Somalis) and therefore being unable to initiate the Dr-Pt relationship. See coding of

21/8/00

**2 6 1 THE PROPERTIES THAT STOP IT WORKING**

Previous work and concept mapping around theme 1 and theme 2 – behaviours has allowed these categories to be refined and reorganised.

Hence:

NO 'TRUST' (1 4 1)

**2 6 1 3 patient &/or relative is manipulative**

Link:

3 1 7 Lying

2 1 5 Manipulation

**2 6 1 4 Complainer (formal complaints)**

See GP19 - surprised when she joined that practice hadn't removed someone who'd sued the practice.

Link:

2 1 3

NO RESPECT

NO NEGOTIATION

**2 6 1 2 Patient 'wants their own way'**

Link:

2 1 4 'Wanting their own way'

**2 6 1 1 Doctor Hopping**

2 1 2 Doctor Hopping

AGGRESSION

**2 6 1 5 Patient is aggressive**

Link:

3 1 1 Aggression

4 1 1 1 Violence &/or aggression

This code has not been properly coded and should be looked at in terms of 3 1 1: breach of rules.

In what way does aggression/threat of physical violence threaten the doctor-patient relationship. Can it be described as:

AFFECTIVE - fear of assault/violence.

AFFECTIVE - INTENSE DISLIKE OF PT BY GP or vice versa

**2 6 1 6 Patient arouses intense dislike in GP 'up the wall'**

Link:

2 3 3 Adverse effect on GP

2 3 4 Adverse effect on care of Pt

3 3 Difficulty with Pt for some time

4 6 Breakdown in Dr-Pt relationship.

If the GP feels they can no longer deal with the patient according to the rules of the Dr-Pt relationship, they terminate the relationship.

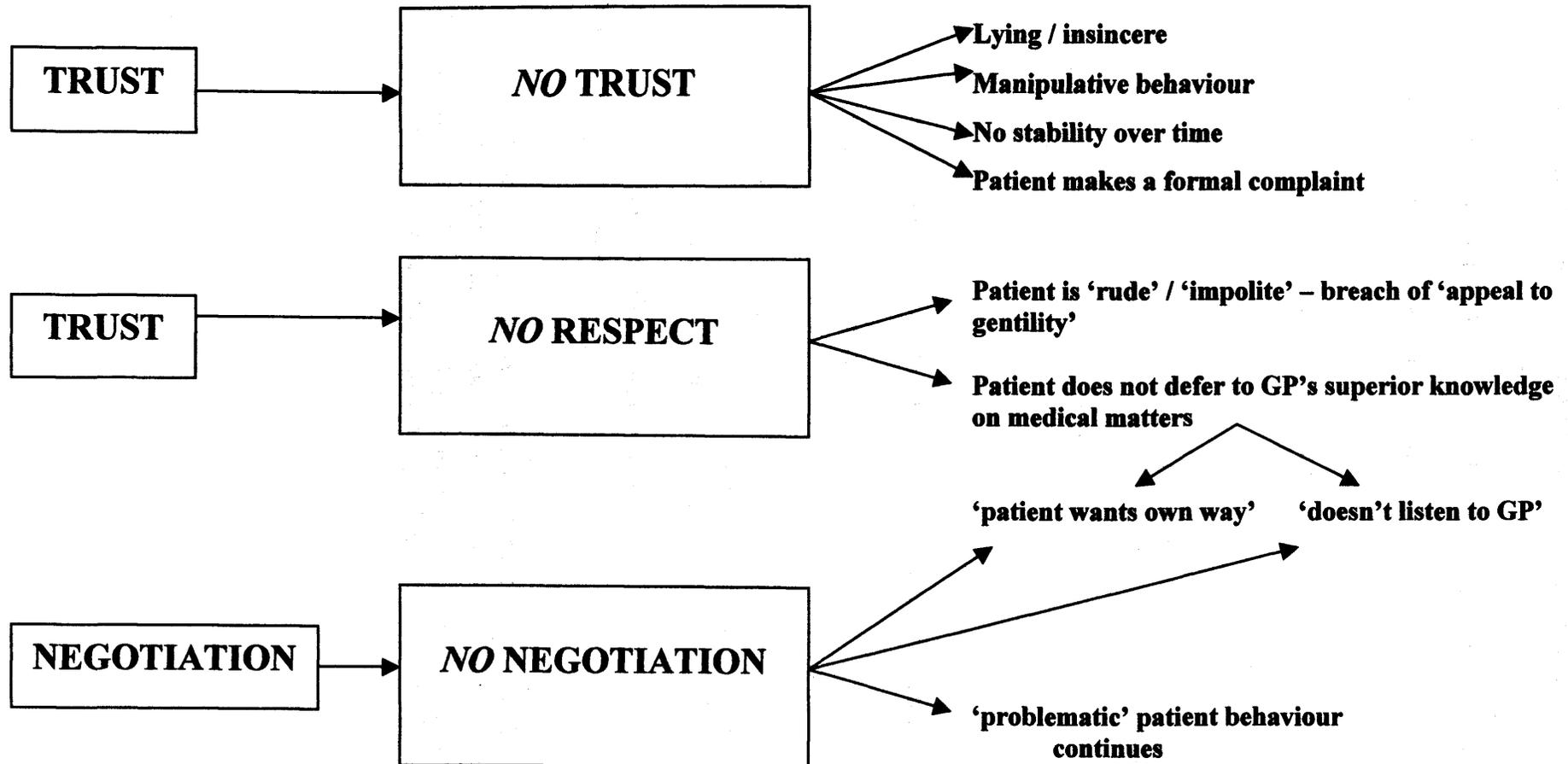
See memo 2 3 4

**2 6 1 7 Pt 'hates' GP**

GP20 & GP8 note that when a patient resents/hates the GP it is very difficult to treat patient. The reciprocal of 2 1 6 6 ?

4.3 EXAMPLE OF A CONCEPT MAP FROM THE GENERAL PRACTITIONER INTERVIEWS

WHAT STOPS THE DOCTOR-PATIENT RELATIONSHIP WORKING? (21/8/00)



#### **4.4 THEMED CODING FRAME FOR PATIENT INTERVIEWS**

##### ***PATIENTS' ACCOUNTS OF REMOVING PATIENTS FROM THEIR LISTS***

##### **DEFINITIONS OF PATIENT INTERVIEW CATEGORIES**

##### **THEME 1: REMOVAL AS A THREATENING EVENT (memo)**

##### **1.1 Removal as 'catastrophe' (memo)**

Statements about removal being a source of emotional distress for patients. The distress can be verbal or indicated by additional comments relating to non-verbal behaviour

(e.g., crying while talking). The emotions shown include:

- 1.1.1. shock and disbelief**
- 1.1.2. distress**
- 1.1.3. anger and indignation**

**1.2 Statements about the removal of household members being unjustified (memo).**

##### **1.3 Removal as stigmatising for patients (memo)**

##### **1.3.1 Felt stigma**

Statements about feeling discredited or worthless following removal, including feelings of guilt and alienation (e.g., from the NHS). Statements about not telling new GP 'whole truth' about why patient has chosen to move practice.

**1.3.1.1** Statements about rejecting the medical profession and going without a GP or using private medical care.

##### **1.3.2 Enacted stigma**

Statements about others treating removed patient differently because they know he/she has been removed. Statements about removal leading to a permanent 'black mark' in patients' medical records. Statements about other GPs 'checking up on you', statements about being taken onto another GP's list temporarily only.

## **THEME 2: REMOVED PATIENTS AS CREDIBLE PATIENTS (memo)**

### **2.1 Patient is 'ill' (memo)**

Statements about being an 'ill' person in need of medical care, includes:

- 2.1.1 going to see their GP as 'ill'
- 2.1.2 having had a medical condition for a long time
- 2.1.3 having lots of different illnesses
- 2.1.4 showing interviewer that they are 'ill' (e.g., physical evidence of illness, presenting medication, behaviour and talk used)
- 2.1.5 needs medication from GP therefore 'ill'
- 2.1.6 needs referral to hospital/hospital care as 'ill'

### **2.2 Patient is a 'good' patient (memo)**

#### **2.2.1 Patient acts in accordance with the rules of the doctor-patient relationship**

Statements about acting in accordance with the unwritten rules of the doctor-patient relationship, includes:

- 2.2.1.1 trying to cope with illness
- 2.2.1.2 using service appropriately
- 2.2.1.3 doing as 'one is told'/being uncomplaining
- 2.2.1.4 polite with GP/staff when voicing concerns
- 2.2.1.5 being registered with the practice a long time
- 2.2.1.6 being personal friends with the GP/practice staff
- 2.2.1.7 minimises or denies any altercation with GP or alleges provocation

#### **2.2.2 GP had acted wrongly in removing them from the list (memo)**

Statements about feeling that the GP had acted wrongly in removing them from the list.

Statements that show that the patient did not meet criteria for being removed from a list, including:

- 2.2.2.1 GPs should remove patients who are violent, I was not violent
- 2.2.2.2 GPs should remove patients who abuse the service, I did not abuse the service
- 2.2.2.3 GPs should remove patients who are rude, I wasn't rude
- 2.2.2.4 GPs should remove patients who openly criticise doctors, I don't openly criticise doctors.

### **2.3 Sanctioning (memo)**

Statements by which the patient demonstrates that he/she 'is in the right' by showing that other people are in agreement with his/her actions &/or would have done exactly the same under the circumstances. This includes statements that:

- 2.3.1** 'significant other' present at interview and/or the interviewer is asked to agree with patient's account, including expressions of agreement with patient by interviewer.
- 2.3.2** family member or 'significant other' agrees with the patient.
- 2.3.3** other patients are also critical of the removing GP or practice, including leaving practice voluntarily or avoiding seeing particular GP.
- 2.3.4** another doctor or health care professional agrees with the patient.

### **2.4 Patient is 'reasonable' about ex-GP and/or ex-GP practice (memo)**

Statements by which the patient demonstrates that he/she is 'reasonable' about the ex-GP by showing that he/she recognises 'good' qualities in the ex-GP and/or circumstances that may lead to unreasonable behaviour by ex-GP (e.g., workload, fundholding).

### **THEME 3: DISCREDITING THE REMOVING GP / GP PRACTICE**

#### **3.1 The doctor's / member of staff's behaviour is unacceptable (memo)**

Statements about the removing GP's or member of staff's behaviour being unacceptable, in other words, it violates the unwritten rules of the doctor-patient relationship. This can include references to verbal and non-verbal behaviour.

##### **3.1.1 GP/staff member is 'rude'**

Statements about the removing GP and/or practice staff openly losing his/her patience with the patient, treating the patient as 'dirt' and talking about them 'behind their backs'. Statements about GP being flippant or condescending to patients.

##### **3.1.2 GP/staff member acts capriciously**

Statements about GPs and/or practice staff removing patients 'off the cuff' and without warning simply because they 'feel like it'.

##### **3.1.3 GP/staff member is vindictive**

Statements about GPs and/or practice staff being vindictive to patients. Statements about 'household removal' being a vindictive act.

##### **3.1.4 GP/staff member lies to patient**

Statements about GPs and/or practice staff lying to patients.

##### **3.1.5 Behaviour of removed patient's relatives is unacceptable**

Statements about relative's behaviour being unacceptable in terms of the unwritten rules of behaviour governing the doctor-patient relationship.

#### **3.2 GP is a 'bad' doctor (memo)**

Statements about the removing GP falling short of lay expectations of what a 'good' GP should be. This can also apply to other health professionals.

##### **3.2.1 Doctors don't listen to patients**

Statements about doctors not listening to patients and not acknowledging their concerns. Statements about feeling that one is 'talking to a brick wall', that talking to doctor makes the patient feel 'silly' or 'neurotic' and that the doctor can even make patients feel that they (patients) are lying.

##### **3.2.2 Doctors are incompetent**

Statements about the doctor not finding out what was really wrong with the patient and about doctors giving 'inappropriate' treatment.

### **3.2.3 Doctors and/or staff 'fob patients off' (memo)**

Statements covering the feeling that the GP and/or practice staff 'fob' the patient off. Description of a range of behaviours including presenting the doctor as a 'time server', 'can't be bothered' just wants the patient 'out the door' and is reluctant to do home visits.

**3.2.3.1** Statements to the effect that getting the patient 'out the door' is accomplished by the doctor writing a prescription or telling the patient that he/she has other patients to see.

### **3.2.4 GPs are 'only in it for the money' (memo)**

Statements about GPs not being altruistic or being 'only in it for the money'. Statements about GPs charging patients for inadequate medical reports or removing patients from their list because they cost the GP money.

### **3.2.5 GPs are only interested in protecting each others' backs (memo)**

Statements about GPs putting their own interests first before those of patients, including agreeing present a unified front to patients. Statements about GPs clubbing together to present a version of removal that presents the GPs in a favourable light.

## **3.3 Discrimination by the GP and/or practice staff (memo)**

Statements about the patient being treated differently than other patients because of race (including 'white' patient by 'asian' practice, as well as vice-versa), gender, sexual orientation or age.

## **3.4 Other GPs are 'good' GPs (memo)**

Statements comparing other GPs favourably with the removing GP, including the new GP. Descriptions of having 'no problems' with the new GP. Descriptions of having 'no problem' with any other GP other than the removing GP.

**3.4.1** Other health practitioners (orthodox/alternative) offer better care than GP. Statements comparing other health professionals favourably with the removing GP.

## **3.5 What constitutes a 'good' GP (memo)**

Statements of lay expectations as to what a 'good' GP should be. Statements saying that the GP should 'know' patient as a person and also their medical history.

**3.5.1** Listens

**3.5.2** Explains

**3.5.3** Is competent

**3.5.4** Is honest

## **THEME 4: PATIENTS' ACCOUNTS OF BEING REMOVED**

This theme treats the patients' accounts as a description of what the patients say has 'happened'. It takes what the patient says 'at face value'.

### **4.1 Reasons for the patient's removal (memo)**

Statements about why the patient felt they had been removed from the GP's list, including 'official' reason given by the GP and own thoughts as to 'unofficial' reason.

**4.1.1** increasing difficulty dealing with GP and/or practice

**4.1.2** description of a single 'trigger event'.

### **4.2 Notification of removal to patient**

#### **4.2.1 Use of 'informal' removal**

Statements about the patient being told by the GP he/she should re-register with another GP.

#### **4.2.2 Formal removal (memo)**

Statements about feelings on receipt of the health authority letter. Statements about whether or not the GP had communicated his/her reasons for removal to the patient. Statements about whether this was verbally or 'in writing'. Statements about what reason for removal had been given by the GP. Statements about how the current system of removal should be changed.

### **4.3 Finding another GP (memo)**

Statements about the process of finding another GP. Statements about any difficulty experienced in finding another GP. Statements about trying to re-register with 'old' GP.

### **4.4 Reason for participating in research (memo)**

Statements about reasons for participating in research project, including statements that he/she is 'telling the truth'.

#### 4.5 Example of matrix from the 'paired' interviews

<i>Pair</i>	<i>Relationship prior to removal</i>	<i>Grounds for Divorce and/or Trigger event</i>	<i>The decision to remove</i>
<b>Pair 9</b>		<b>Detailed story by both parties</b>	
<b>GP</b>	A 'difficult' patient in so far as she lived a long way from the surgery and 'quite frequently' requested home visits. The GP visited her as she lived alone and he liked her.	<p><b>Trigger Event – Patient breaks a number of rules, including ? being a racist</b></p> <p><i>Request for home visit</i> - GP justifies his delay in returning her call for a visit on the grounds he is busy. Patient is 'rude'</p> <p><i>At patient's house – 'breaking the rules':</i></p> <ol style="list-style-type: none"> <li>a) inappropriate visit as had symptoms for several days</li> <li>b) does not co-operate with the GP</li> <li>c) lack of respect shown to the GP</li> <li>d) accuses him of only being in it for the money</li> </ol> <p>GP makes it plain to the patient her behaviour is unacceptable and, using very neutral language, told patient she may be being 'difficult' because she was white and he was a South Asian GP</p>	<p>The decision to remove is seen as stemming from the patient. She requests that he find her a new GP. She also is presenting as agreeing with his publicly acceptable statement that the relationship 'has completely broken down'.</p> <p>The GP writes her a letter stating that removal is by mutual consent.</p>
<b>RP</b>	'Good' patient – 'ill' as has heart trouble; appropriate service use; values long-term relationship 'Bad' GP – is uncaring (never has time) and incompetent (HT)	<p><i>Request for home visit</i> – made in am but GP didn't ring her until late afternoon. She admits she was 'rattled' but excuses this on the grounds that she was fed up waiting all day for the GP to come.</p> <p><i>At the patient's house</i> – The GP is 'rude' as he:</p> <ol style="list-style-type: none"> <li>a) refuses to show her her medical records</li> <li>b) accuses her of being racist just as he was leaving the house ('you would rather have a white doctor')</li> </ol>	<p>The patient makes <i>no</i> reference of any subsequent conversation with the GP about finding another doctor or agreeing that the relationship has 'broken down'.</p> <p>I am not a racist:</p> <ol style="list-style-type: none"> <li>a) credentialing (previous African GP, daughter agrees she's not racist)</li> <li>b) thought about suing GP for false accusation</li> </ol>
<b>Comparison</b>	Little concordance	Note how both parties raise 'race' issue, but in different ways.	Modifiable: The accounts of the decision to remove are very different

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