Original Scientific Paper

Opting out:
Why patients change doctors

Warren Nicholls MBChB MGP (Otago) FRNZCGP Dip.Obs RCOG DA (London) is a GP in Feilding. He shares his work time between general practice, geriatric medicine, and GP liaison for Mid Central Health. Chrystal Jaye is a lecturer in the Department of General Practice at the Dunedin School of Medicine, University of Otago. She teaches postgraduate courses in medical anthropology and research methods.

ABSTRACT

Aim

To explore patients' reasons for leaving their doctors.

Method

This was a qualitative case study design of patients who had left their doctor for reasons other than change of address. Responses to a mailed questionnaire formed the basis of face to face interviews with respondents.

Results

Thirty participants were recruited to the study. Changing doctors had been a difficult decision for most participants. Reasons for leaving their previous doctor varied and included a perceived wrong diagnosis, delayed diagnosis or no diagnosis at all. Despite their perceived poor treatment, most patients were remarkably loyal to their doctor. They eventually left when they perceived that the doctor was not listening to them. Power issues, guilt and the debilitating effect of illness were frequent reasons for lack of communication between doctors and patients after the decision to leave had been made.

Conclusions

This study suggests that patients become disenchanted with their doctor for a variety of reasons. However, it was the doctors' unacceptable attitudes as much as their diagnostic errors that affected patients the most. This study highlights the need for doctors to maintain effective channels of communication with patients, particularly when the patient-doctor relationship begins to break down. It also reinforces patients' desire to be actively involved in their medical care and to work in partnership with their doctor.

Key words

Changing doctors, patient-doctor relationships, communication

(NZFP 2002; 29:402–407)

Introduction

The doctor-patient relationship can be likened to a marriage of two people where certain loyalties and expectations are expected of both parties. For example, the doctor has traditionally been expected to provide medical care 'for better, for worse, for richer or poorer, in sickness and in health, till death us do part'. In return, the patient has been expected to 'honour and obey' their doctor and remain loyal to that person and the services they provide. However, this traditional, paternalistic model has recently undergone significant change.[1] A commitment within general practice to patient-centred medicine encourages a greater participation by patients in decision making and management of their health care. Similarly, a growing consumerist attitude by patients towards medicine has seen a diminution of patient-doctor loyalties (many patients now have more than one doctor or seek alternative health care providers), and there are new expectations of medical care.[2,3]

A growing consumerist attitude by patients towards medicine has seen a diminution of patient-doctor loyalties

Past research into doctor-patient relationships has focused on how this process has been initiated (choosing a doctor) or how the relationship is developed over time.[4,5] There are few studies examining why this relationship deteriorates to the point where the patient seeks another doctor. One British study[6] suggested the physical distance from the doctor was the most important, with other factors including dissatisfaction with the care given by their GP or the practice administration. Another study[7] found accessibility to be the most important issue, but this term encompassed distance from the patient's home,

nature of the locality, appointment systems and the ability of the doctor to make a home visit.

The phenomenon of patient defection is not freely or comfortably discussed amongst doctors or patients. Anecdotal evidence suggests that when patients leave, this can be seen as a failure by the attendant doctor, who can feel hurt, ashamed, even fearful and betrayed. Patients are also reluctant to challenge their doctor who may be perceived as powerful and authoritative.

The present study was undertaken to explore the reasons why patients in a New Zealand setting leave their doctors, and to explore the influence of communication and expectations on this decision.

Method

This research was conducted in the central North Island region of New Zealand. Qualitative methods were used to collect data and to build a case report for each participant. Responses to a brief open-ended mailed questionnaire asking participants to identify attractive attributes for GPs provided the basis for a semi-structured interview on participants' experiences and reasons for leaving their GP. In this way, there was consistency across all interviews, while remaining flexible and responsive to each unique emerging narrative.

Participants were recruited by advertising in a local newspaper. An information sheet, consent form, and questionnaire were sent to those who replied to the advertisement. This was considered the most appropriate and ethical means of recruiting. It was impractical and insensitive to recruit from the local GPs, to whom the researcher (WN) was known. Similarly, it was considered inappropriate to select purposely from the researcher's own patient population. Ethical approval was obtained from the University of Otago Ethics Committee.

A total of forty replies were received. Thirty participants were recruited to the study. Six were excluded because they did not return the signed consent form and four excluded because they lived more than 50 kilometres from the interviewer's residence. None were known to the interviewer. Participants were told that he had a medical degree and was in active primary care. Participants chose the interview venue. Twenty were interviewed in their own home, nine at the interviewer's surgery, and one at a neutral venue.

In order to maximise the quality of the interviews, participants were given the interview schedule to consider prior to the interview. Interviews lasted between 30 minutes and two hours. They were tape-recorded and later transcribed. Participants were offered the opportunity to review their transcript prior to analysis. Only two accepted this offer. This data was then analysed manually (cutting and pasting) using a combination of both immersion/crystallisation and template analytical styles. That is, the interview guide provided a coding template for sorting segments of original text that were then subjected to reflection and further abstraction.[8]

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Results

The GP

Choosing the GP

Most (28) participants had not chosen their original doctor. They 'inherited' the GP by default, often assuming the new doctor would be exactly the same as the previous one.

"We took the easy way. I'd been in the practice for many years and when that was sold we just stayed with it and hoped that we'd get on well with the new doctor." (Participant 5)

Endurance of patient/GP relationship

Most respondents stayed with the GP described in the previous section for a reasonably long time. This length of contact varied from 15 minutes (one consultation) to 25 years, with an average period of 12 years.

Leaving the GP

Deficiencies in the GP's practice of medicine

Misdiagnosis and mismanagement were commonly reported reasons for leaving the GP. Thirteen participants left their GP because of a misdiagnosis or no diagnosis at all. Several participants reported that they were misdiagnosed as suffering from 'stress'. In four cases, the misdiagnosed conditions were life-threatening (Guillain-Barré syndrome, diabetes, prostatic cancer and end stage renal failure). Four participants had made complaints to the NZ Medical Council, two of which were successfully upheld. Reasons for leaving and case details are outlined in Table 1. In the following case, a participant described her feelings after her GP mismanaged her husband:

"We finally...saw Dr A for about an hour. All that time (my husband) was like an old man, moving his fingers and shaking. The doctor asked (him) if he was feeling stressed out and (he) shook his head. The doctor decided he had stress and depression and he prescribed him some medication. He never examined him, all he did was look at him...We were eventually referred to the A&E Department because I was having difficulty coping. Within two hours they came back and said, 'Look, I'm sorry, it's end stage renal failure.' I knew it wasn't stress and depression." (Participant 5)

GP's attitudes and behaviour toward patients

Many participants reported a paternalistic attitude by the doctor. The inability and/or unwillingness to listen to the patient was often cited as the primary reason for changing GP. Participants did not articulate any

Table 1

Patient	Reason for leaving	Details
Male 62 yrs	Misdiagnosis	Bronchiectasis (diagnosed as asthma)
Female 70 yrs	Misdiagnosis	Gastric ulcer treated with VitB12 injection
Female 41 yrs	Doctor's attitude	Dr's lack of interest. Hurried consultations
Male 53 yrs	Misdiagnosis	Gillain-Barré syndrome (diagnosed as stress)
Female 22 yrs	Mismanagement	Failure to inform family re grandmother's shift to nursing home
Female 52 yrs	Misdiagnosis	Failure to diagnose son's deafness
Female 28 yrs	Doctor's attitude	Dr's lack of interest. Hurried consultation
Female 31 yrs	Misdiagnosis	Hypothyroidism (diagnosed as stress)
Female 65 yrs	Doctor's attitude	Second opinion while on holiday. Doctor not sensitive about Multiple Sclerosis
Female 37 yrs	Accessibility	Doctor not available when needed by patient
Female 50 yrs	Doctor's attitude	Diabetic on insulin pump. Patient management criticised by doctor
Female 55yrs	Misdiagnosis	Hypertension (diagnosed as migraine)
Male 54 yrs	Receptionist	Dispute over non-payment of $10 account
Female 43 yrs	Mismanagement	Failure of doctor to follow up child's UTI
Male 51 yrs	Misdiagnosis	End stage renal failure (diagnosed as stress)
Female 66 yrs	Misdiagnosis	Myasthenia Gravis (no diagnosis made)
Female 45 yrs	Doctor's attitude	Crippling muscle contractures. Lack of time during consultation
Male 47 yrs	Misdiagnosis	Carcinoma prostate (diagnosed as stress)
Female 51 yrs	Doctor's attitude	Failure of GP to refer for counselling
Female 49 yrs	Misdiagnosis	Bronchiectasis (diagnosed as asthma)
Female 52 yrs	Mismanagement	Perforation of uterus during insertion of IUCD
Male 47 yrs	Doctor's attitude	Delay in referral of patient with haemoptysis
Female 47 yrs	Doctor's behaviour	Sexual assault by doctor
Female 48 yrs	Doctor's attitude	Failure to refer for low back pain
Male 51 yrs	Patient's illness	Belief that GP was not acting in best interest of father
Female 57 yrs	Doctor's attitude	Rude comments about patient in GP's referral letter
Female 45 yrs	Misdiagnosis	Diabetes (no diagnosis made by GP)
Female 62 yrs	Misdiagnosis	Fractured pelvis (diagnosed as muscle strain)
Female 34 yrs	Doctor's attitude	Lack of interest. Mismanagement of child's asthma
Female 47 yrs	Doctor's attitude	Patient requested counselling for depression, given medication instead

clear distinction between relational and communication deficiencies on the part of their GP and what they perceived to be undesirable attitudinal characteristics. However, as the following excerpt illustrates, a GP's poor communication and relational skills may be interpreted as undesirable attitudinal characteristics by patients. Whether intentional or not, this participant interprets her GP's inability to listen as a lack of respect, and feels no longer able to trust her GP as a result:

"I just felt there was no discussion because she would not listen to me and if she was not going to respect me as a person I felt I could not trust her." (Participant 11)

Most participants presented with some idea of a diagnosis, and had some

expectations of treatment (even if these proved to be wrong). In the present study four participants offered a diagnosis to their doctor (who chose to ignore their opinion but which later proved to be correct). One respondent was diagnosed with Guillain-Barré syndrome by another GP after two years of presenting symptoms.

"It was a relief to have somebody [else] listen and take it seriously and also for me to have a diagnosis. At least some label which I could begin to build an understanding 'cause up till that time I didn't know. I was terrified. I was scared shitless." (Participant 4)

Dishonest behaviour by the GP was another reason given by participants for leaving. In one case, the doctor was untruthful in his response to a formal complaint by the participant to the Medical Council.

"We made the first complaint (to the Medical Council) and then they wrote to him and said this is the complaint, please respond. To put it very bluntly it really got us very angry because of the things that he said in the letter was just a lot of garbage. So then we got angry and thought, you know, we've given you a chance. So he hung himself really. If he'd been honest and apologised and said I'm sorry, it would have been okay." (Participant 14)

Other examples given included rude comments about the patient in the GP's referral letter, and one case of sexual assault.

Practice management

Sometimes it was not the GP, but other aspects of practice management that facilitated the decision to leave. In one case, it was the unavailability or inaccessibility of the GP when the participant needed to see him that was the trigger for changing GPs. In another case it was the practice receptionist's attitude that provided the stimulus to leave.

"Then we get this bill in the mail. It was an ACC thing which we had paid. We took it up with her (the receptionist) and got nowhere. She dug her heels in and said 'no, you didn't pay.' She got quite het up about it. The blame was on us, she was clean. So we went back and paid; it was ten bucks which is not the amount, it's the principle. Then we asked to sign the forms for our files to be sent to a new GP." (Participant 8)

Communicating dissatisfaction to the GP

Respondents were often reluctant to voice their fears, apprehension and disappointment with their doctor. Many of those interviewed resisted questioning the 'authority' and 'wisdom' of their doctor, or were too disabled by their illness to do so.

"In those days you were really afraid. The doctor was flaming God and who are we to argue with these people? You just didn't do these things in those days. He's God. I mean, what am I, who am I to question?" (Participant 1)

"The trouble is you're so low. You can't think, you can't think straight. I mean I should have known to damn well get on the phone and say 'look I'm seriously ill here, I need hospital,' but you're so low and cannot think, you're debilitated and you're so weak." (Participant 19)

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Leaving the GP

Once the decision to change doctors had been made, there was usually very little communication between the two parties. Most respondents explained this in terms of their own anger or exhaustion. Leaving their GP was an emotional event for all participants. Respondents described feelings of anger, sadness, fear, shame, guilt, confusion, and apprehension. Many felt betrayed. Despite these strong emotions, only two patients had the courage to let the doctor know the reasons for leaving.

"Part of me was angry that I hadn't received the best attention I should have and the other part was grateful to him for all sorts of kindness. All those things mounted up and gave me all sorts of mixed feelings. I didn't want to go and see him. I guess I'm basically a coward. When I wrote my letter I looked back a bit and thought 'crikey, that all sounds a bit nasty'. I did the right thing but I should have done it in a better way. I always think, 'crikey, I've done the dirty on him'." (Participant 2)

One participant described how difficult it was to leave the GP who had delivered her children, even after she felt that he no longer listened to her. She wrote her GP a carefully drafted letter, written over a long period of time, but in it absolved him from any

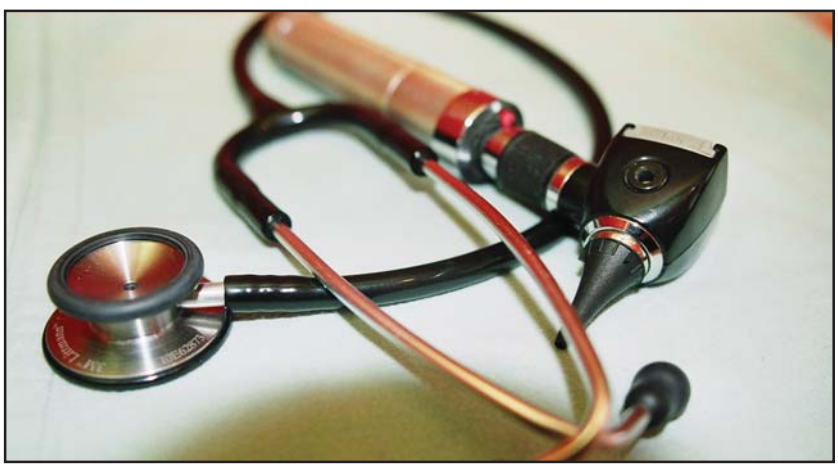

Photo: Michael Long

part in her decision to leave by blaming herself for not communicating with him effectively in the consultations.

"I wrote him a letter. I'd been going over it, you know. I did rough copies and things...I couldn't tell him that he was doing anything wrong." (Participant 4)

Lessons learned

Advice to other patients

Most participants encouraged those who were thinking of leaving their doctor to do so. Some suggested that it might be possible to repair the damaged relationship by talking with their doctor and being honest, although most commented that they themselves had lacked the courage to do this.

"If they have any qualms about their doctor, just go straight in and not be like me and beat about the bush. Either go in and say, 'Look, I'm not very happy' or something. I never had the courage to do that." (Participant 16)

Some participants advised those who had decided to leave their GP not to feel guilty about doing so.

"If the relationship isn't working out, or if you're dissatisfied with the treatment you're getting, I don't think you've got much option but to look for a change." (Participant 16)

This advice was often tempered with suggestions to plan the move. These included carefully evaluating the reasons for leaving the current GP, and researching potential new GPs.

"You have to be very thorough. You should not do it precipitantly...I think you've got to take a very long term look." (Participant 28)

Advice for doctors

Participants were also very clear about what they would like to say to their doctor. The first piece of advice was that the doctor should not rush the consultation. Many participants were aware that their doctor was very busy and that they, as the patient, only had a few moments to get their story across. The second piece of advice was that doctors listen carefully and courteously to patients.

"Don't rush the patient and for goodness sake listen to them. That's my biggest hassle, getting him to listen to me...You feel like you don't want to take up too much of his time, which is wrong. They don't get the whole picture." (Participant 14)

Making the decision to change doctors can be difficult and, in some cases, traumatic for patients

The ideal GP

Participants were also in agreement about the attributes of an ideal GP. In particular, a GP should be able to listen and hear what the patient is saying (14 participants). He or she should also acknowledge the patient as an individual and respect their concept of their own illness (nine participants). GPs should also be willing to form a therapeutic relationship with the patient, and be able to apologise when things go wrong (eight participants). It was also important that the GP make an effort to understand the reason for the consultation (17 participants).

A GP should ...acknowledge the patient as an individual and respect their concept of their own illness

"It would have helped if he said he was sorry." (Participant 12)

"I'm very happy with the doctor I've got now. He's all the things that I want in a doctor. He's an excellent listener and has a sense of humour. He is like a real person rather than someone who sits so professional. Some doctors can be so professional that the ordinary person doesn't feel able to communicate with them. My GP is someone that I see as a real person, almost as a friend." (Participant 23)

Discussion

Limitations of this research

One potential limitation of the present study is that all participants were self selected. It is possible that they had an 'axe to grind' and therefore were not typical of patients who leave their GPs without changing address. Given that the aim of the research was to explore patients' experiences from their own perspective, and the small sample was consistent with qualitative research, we do not claim that participants were necessarily representative of, or that these results are generalisable to, all patients who leave their GP. However, our findings have external validity in that they corroborate those of Gandhi et al[7] in that doctor-patient dissatisfaction (for whatever reason) is given as the major reason for changing GPs. While all participants reported a bad experience with their care, it is apparent from the interviews that most had been very loyal to their GP over a long period of time. What is not known is whether itinerant patients have the same difficulties, given that they are less likely to form strong relationships with any one GP.

Another concern is that the participants may have reported what they thought the GP-interviewer wanted to hear rather than being honest. There are issues of power and acquiescence involved when GPs are also interviewers, especially on the matter of patient (dis)loyalty.[9] However, the intensity and spontaneity of participants' stories suggests that this was not the case. Participants talked frankly and openly in response to the interviewer's cues.

The third limitation and perhaps the most important, was the inability to collaborate with the original doctor and hear his or her version of what happened in each doctor-patient relationship. However, the promise of anonymity for the participants precluded this option.

Implications for the future of general practice

Patients now have more choices about medical providers than ever before. Not only are patients better informed, but they also have a wider range of options as to who will provide their medical needs, be it chemists or other complementary 'health providers'.[10,11] Although this suggests more competition in primary care, the present study indicates that making the decision to change doctors can be difficult and, in some cases, traumatic for patients.

Our findings suggest that changing GPs can be a difficult task for patients. Most of our participants assumed that their GP was competent, a finding consistent with previous research[2] and gave their GP every chance to prove this, even when the relationship began to break down. However, the assumption of GP competence can have serious consequences, especially when a misdiagnosis has potentially fatal outcomes. Patients also need to consider seriously whether it is better to stay with a 'default GP' or to find another one. Certainly, those in this study who felt forced to seek a new doctor were far more selective in their next choice. One study that examined patient movements between practices[12] found that personal recommendations from other patients are an important part of the process of choosing a doctor.

Respondents in the present study wanted their doctor to be their counsellor, their advisor and their advocate, giving them their time, their interest and their understanding – a finding compatible with previous articulations of the role of the GP and the practice of patient-centred medicine.[1,13,14] The GP was seen as a familiar, often kind, source of healing and support, and a strong therapeutic symbol of care. Loyalty to the GP was not simply based upon their role as a health care provider. It was based rather on the belief that their GP knew them well and cared about them as a person within the context of a genuine relationship.[15] It is therefore not surprising that most participants spent several years with their doctor and demonstrated remarkable tolerance to their perceived poor treatment and management.

Conclusion

Patients need to take more care in choosing their doctor. They should make this choice themselves and not be content to inherit a doctor by default.

Effective communication is the basis of good general practice and lack of this seems to be one common cause of dissatisfaction. Another is the patronising attitudes and behaviours of the doctor. Doctors should constantly be reflecting back to their patients what they perceive to be the problem and patients should be given the opportunity to correct them if they are wrong. It is essential for doctors to convey genuine feelings of concern and care and to try to understand the reasons why the patient has come to see them.

While good communication can help avoid problems, doctors need to appreciate that their relationships with patients are constantly evolving and sometimes a change of doctor is in the best interests of both parties. As such there should be no rancour or regret; rather this could be seen as an inevitable part of providing good medical care.

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