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A QUALITATIVE STUDY ON GENERAL PRACTITIONERS CAN UNDERSTAND "REVOLVING DOOR" PATIENTS IN THEIR PRACTICE

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ABSTRACT

General practitioners (GPs) repeatedly remove 'revolving door' patients from their lists. We present the results of our first mixed methods study of marginalized patients based on an analysis of the qualitative data collected during the study. To characterize revolving door patients from the perspective of practitioners and general practitioners in Scotland, we conducted qualitative semi-structured interviews using Charmazian grounded theory. There are three necessary characteristics of patients who present at the revolving door; unreasonable expectations, inappropriate behavior, and unmet health needs. There were also reports of boundary violations when NHS staff interacted with 'revolving door' patients. Our analysis draws on literature about 'good and bad' patients, as well as the notion of dirty work in order to utilize the 'sensitizing concepts' of legitimacy. Health service professionals understand and work with 'revolving door' patients based on medical and moral schemas, which can be related to the core work of general practice.

Key words: General Practice, Patients, Medical, Health.

INTRODUCTION

Patient removal from GP lists General practices in the country maintain a list system for identifying their patients. The term 'revolving door' refers to patients who are repeatedly removed from the general practitioner's (GP) list due to conflict between the doctor and patient or violence. Geographic relocation is not included in the definition. The majority of National Health Service (NHS) services can only be accessed if you are registered with a general practitioner. In general practice, patients' needs are covered, continuity is maintained, and relationships are maintained to a high standard [1]. Research on revolving door patients in primary care was reviewed to determine whether any studies had been conducted on such patients. The doctor patient relationship literature is mapped to four domains using a conceptual framework. There are four domains: psychodynamics, clinical observation, social psychology, and sociology [2].

The review included a number of influential papers relevant to the field of general practice, particularly work, literature related to patients and substantive literature pertaining to frequent attendance in general practices [3 - 6]. Smith examined difficult patients from the perspectives of sociological, clinical observation, and psychodynamic perspectives [7]. These domains include several papers that discuss patients with 'medically unexplained symptoms' [8, 9]. Before the last iteration of the GP contract, several investigators studied patient removals [10-21]. There is explicit consideration of evidence of patients who have been repeatedly removed from their GP lists in a paper that excludes patients who have been repeatedly removed from their GP list from their analysis. The second study addressed how to manage patients who recur after being removed for repeated reasons without taking their characteristics into account. Another study describes some participants as being removed and reallocated repeatedly.

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In a separate study, GPs interviewed patients who moved between psychiatric hospitals.

There were overlaps between patients in these groups and those described as 'revolving door' patients in general practice, but this was not explored further. Both the research literature and the system of care appear to exclude 'revolving door' patients, and they deserve further study. An analysis of repeat patient removals in general practice is presented in this paper, which is part of a larger mixed methods study [22]. We developed a definition of 'revolving door' patients as those who have been removed four or more times from GP lists in seven years based on qualitative interviews with Practitioner Services staff and GPs with a specific role in working with such patients. A review of NHS data on 'revolving door' patients revealed a high level of psychiatric, addiction-related, and physical morbidity in these patients. Most of these patients were male, had a median age of 34, and a mean age of 34. The mortality rate of general practitioners was also much higher than that of general practice patients [23].

METHODS

Once initial key informant contacts have been made with practitioners and health board managers, and all participants have given their written consent. Purposefully selected practitioners who administered the general practice registration system were interviewed in semi-structured interviews. Each of the three regional offices was asked to provide their thoughts and experiences regarding the registration process. It was primarily through telephone contact with these 'revolving door' patients that they had developed strong relationships, despite dealing with thousands of patient registrations each year. Furthermore, they viewed this as an important problem that required time and resources and were eager to participate in the study. Additionally, we purposively sampled two GPs whose experience of dealing with 'revolving door' patients was gained through their managerial or clinical responsibilities in the NHS. Two of them served as both general practitioners and managers of large city health board primary care divisions, while the other worked in a service specializing in 'challenging' patients. The research also included interviews with four general practitioners who have practices in areas where the number of revolving doors is high. According to our analysis of all removal data, the number of 'revolving door' patients has fallen dramatically over the last few years. Three towns and one city were served by these general practitioners in the West of Scotland, spread across two health boards. Of the four GPs, three practiced in practice, while the fourth worked within the NHS as a manager or as a GP. The primary care manager was the main role of one GP participant. According to literature on single episode patient removals, superficial accounts of GPs' professional practice might be possible. Participation in the study was readily accepted by the GPs approached. Audio recordings were made by AEW during interviews. During the topic guide, patients who stopped revolving, future care for 'revolving door' patients, the reasons for repeat removal, and the importance of their existence were covered, along with the characteristics, impact, and reasons for their repeated removal. As part of the interview process, the reasons for the change in patient numbers were discussed as well as the reasons behind the change.

Codes were developed based on an analysis of the interviews conducted with GP participants. Participant validation of the transcripts of the general practitioners' interviews was not conducted. There were some codes that were different in the PSD interviews from the PSD interviews. It has been determined at this stage that saturation of the data has been reached by AEW, KM, and PW. We will not conduct any further interviews at this time. For the purpose of explaining the differences between the results, dialectical comparisons were conducted. Moreover, because they contribute to the theory of revolving doors, they were analytically generalizable. Accordingly, we supported this assumption based on sociological theories' notions of sensitization.

RESULTS

'Revolving door' patients must possess the following three characteristics

Expectations that are unreasonable

One important finding of the study was the perception that all 'revolving door' patients had unreasonable expectations of the health care system. The expression of this could take many forms. For instance, patients frequently requested consultations based on perceived health needs.

A lack of appropriate boundaries of behavior

'Revolving door' patients were also perceived to be difficult to accept because of their boundaries of behavior. When patients interacted with practice staff, including receptionists and practitioners who handled registrations, they made them feel threatened and exasperated. As a result, patients become frustrated when the medical professional is unable or unwilling to alter their behavior. Revolving door patients were perceived to be those who consistently abuse or impolitely treat receptionists or health professionals.

Health care needs that are unmet

Study participants reported that a third characteristic necessary for 'revolving door' patients was that they personally felt they had health needs. In addition to physical and psychological needs, insurance benefits may also take into account medical needs. Patients might stop seeing their general practitioner after leaving the old practice, and may avoid joining a new one once they no longer associated with it. Patients referred to as 'revolving

door' patients were described as having health problems. As a result of the Practitioner Services program, there were a large number of high dependency patients who were seen as revolving door patients. Those who participated in the study were housebound patients who needed nursing assistance regularly, or agoraphobic patients who needed house calls on a regular basis.

An analysis of deviant cases

The three major areas of data that stand out when examining participants' perceptions of 'revolving door' patients' health issues stand out when examining the necessary characteristics of 'revolving door' patients.

Patients with alcohol dependence

In the first instance, participants considered alcohol dependency patients to be less likely to use a revolving door. There is a possibility that this could be attributed to the fact that most alcohol dependent patients are able to form reasonable doctor-patient relationships with their general practitioners. Positive contacts with general practice and relative stability were perceived.

Mental health problems of major importance

Asked what characteristics characterized 'revolving door' patients, the GP participants agreed that patients with severe and enduring mental health problems did not 'revolve' despite being difficult to care for and interacting in similar ways with the practice. There may have been no link between the expectations and behaviors of GP participants and their decision to repeatedly remove patients, as they did when removing patients with problem drinking, learning disabilities or schizophrenia.

Patients with substance abuse problems

Thirdly, problem drug use continues to be an unmet health need. Prior to the development of addiction treatments and services, patients with problems using drugs were most frequently reported as 'revolving door' patients. As treatment services were set up and made available, this pattern changed in different Health Board areas. General practitioners gained knowledge and skills regarding the treatment of drug abuse problems and began prescribing maintenance methadone treatment. Patients with drug problems are less likely to become and remain "revolving door" patients as a result of these factors, as stated by the GP participants. GPs' approach to working with patients changed as a result of this change in approach. There is a perception among participants that some general practitioners have not provided adequate treatment to drug abuse patients in the past.

A professional's responsibilities and roles

Respondents from practitioner services as well as general practitioners noted that there was no structure in place nor were they well-equipped to work effectively with patients with a revolving door. The overwhelming feeling that all 'revolving door' patients have unreasonable expectations and inappropriate behaviors is coupled with the perception that they cross many of the normative boundaries that most patients follow. There was a perception that 'revolving door' patients were high workload patients because they took up a lot of time. Frequently, the Practitioner Services participants reported having to register, be removed, and be reinstated. Large amounts of written correspondence were generated as a result of complaints addressed to patients' previous general practitioners and redirected to Practitioner Services. Patient and practice phone calls were frequent. GPs often spent most of their time responding to unmet health needs of 'revolving door' patients.

DISCUSSION

As a follow-up to our presentation of our results, we now consider the 'sensitising concepts' we applied to inform the development of our further theory and conclusions. GPs' core functions are demonstrated through the application of this concept, building on Strong's work.

Legitimacy and its role

During the analysis of participant interviews in this study, the critics emphasized several important points that should be considered when generating theories. A striking similarity between these experiences and the themes and categories identified in this report is that they began by describing illness, symptoms, behavior, and judgments of staff that were observed by the patients. A discussion of discrepancies and contradictions between 'good' and 'bad' studies is presented in the study, and it concludes that the topic lacks external validity. According to the researchers, this can be attributed partially to the choice of research tools, but most importantly to the lack of rigorous definition of the concepts used. Study participants were asked about their opinions about patients, and assumptions were made regarding what it meant to be 'aggressive' or 'inappropriate'. The labels applied in this study must not be viewed structuralistically when compared to, say, a clinical diagnosis. A doctor-patient relationship was deemed to be unsuitable for these actions [24]. The role unwritten rules might have for patients with 'revolving door' situations will be re-examined in a future paper based on psychological theories. Consequently, this aspect played a significant role in our choice of the study topic. Furthermore, they stated that, with very few exceptions, the literature tends to focus on an individualistic approach to theory rather than taking social context into account [25].

General practice's core duties

We will examine the core roles of general practice and, consequently, the boundaries of its legitimate work, having considered the context of this study as general

practice. A consensus has been reached in the literature regarding two areas of core work [26]. The first area of care is the biomedical aspect, which is delivered by general practitioners and practices. GPs are responsible for a wide range of health-related problems or refer patients to other healthcare professionals if they cannot resolve them. The participants were all in agreement that revolving door patients posed a variety of problems in their professional lives. We believe, however, that GPs' medical schema of understanding may be able to frame the attitudes, behaviors, and health presentations of 'revolving door' patients. Consequently, we believe that these negative characteristics are inherent to the doctor-patient relationship rather than to the patients who are involved in the 'revolving door' program. Evidence has been presented about how professional perceptions have changed patients' behavior regarding alcohol and problem drugs. Upon reviewing the literature on problem doctor patients, we were struck by the relevance of our theoretical perspectives [27]. Patients possessed aspects of a moral schema of understanding for understanding their behavior or health presentations that threatened the legitimacy of the core work of general practice. In the future, this perspective may provide useful insights into conceptualizing the issue of problem doctorpatient relationships and provide a unifying theory with which to understand a diverse body of literature.

CONCLUSION

We have identified the characteristics needed for 'revolving door' patients in general practice in our study. Patients' expectation levels were unreasonable, their behavior inappropriate, and their perceptions of their health needs unmet were unanimous among participants. As a result of patients interacting with NHS staff through the 'revolving door', a number of boundary violations were reported, both in general practice and in the administrative environment of Practitioner Services, which manages the registration of GPs.

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