The Disgruntled Patient: How Family Practice Residency Programs Handle Requests for a Physician Change

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The purpose of this study was to investigate the alternatives available in family practice residency programs for handling patients who expressed dissatisfaction with their physician. Letters were sent to 150 family practice residency programs asking how they handled this problem. Of those who replied, it was determined that this problem is generally handled in one of three ways: (1) patient automatically transferred to another physician, (2) patient referred to original physician for discussion, or (3) patient referred to a designated authority. The rationale and implications of each method are discussed.

Patient dissatisfaction with the physician represents a real dilemma to a program director. He/she must balance the needs of resident education with those of finance, physician style, and patient relations. There have been few research or descriptive articles published on the topic of options employed to deal with this problem.

During a period of physician scarcity, such as has occurred in the past, one might expect that few complaints would be officially registered. However, with the availability of physicians increasing, it is possible that patients are becoming more critical and verbal. In addition, with the rise of consumer interest groups, and government intervention and regulation, there are now central authorities to receive these complaints.

Much has been written about physician-patient conflicts, but no data have been collected regarding large numbers of patients and their reasons for transfer requests. Collection of such information is difficult because access is limited and there are many perspectives from which to view the conflict.

Schuller views the physician-patient interaction problem as a relationship problem and suggests the physician choose an alternative mode of relating to the patient should difficulties arise. He notes that "there is no such entity as a problem patient without an overwhelmed, drained, and powerless physician."[1]

Szasz and Hollender analyzed the physician-patient relationship and found three general types based on the degree of control of each participant.[2] The choice of relationship is dictated by the type and severity of illness, as well as the personality and preference of the patient and physician. Szasz and Hollender state that problems arise when the treatment of an illness requires an alteration in the pattern previously used.

Vanderpool deals with the six patient types that are prone to give physicians the greatest difficulty and therefore conflict: regressed and childish patients, angry and aggressive patients, seductive patients, dying patients, dependent and needful patients, and chronic complainers and incurables.

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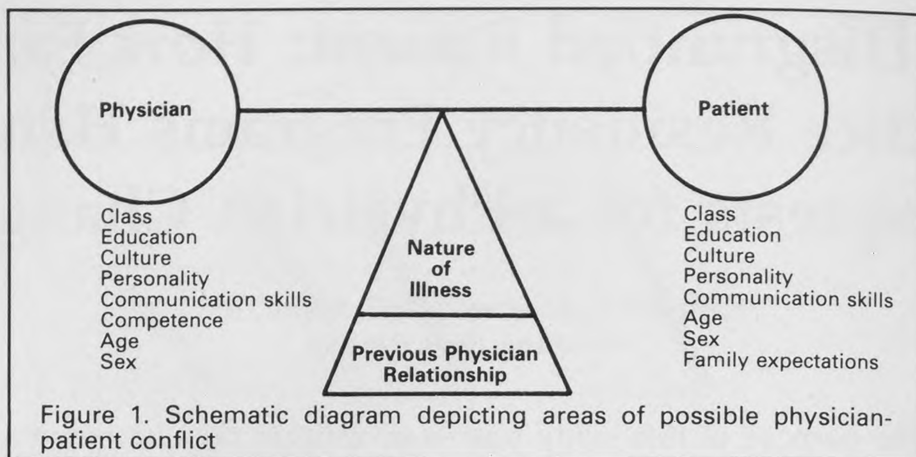

Figure 1. Schematic diagram depicting areas of possible physician-patient conflict

He emphasizes that the physician must maintain his perspective and that his role and contact with the patient should be limited.[3]

Balint, in his book *The Doctor, His Patient and the Illness,* noted that in the National Health Service of the United Kingdom, ten percent of patients abandon physicians' lists in a single year for various reasons.[4] Koos, in his study of rural Americans, found that 13 percent have dropped a physician.[5]

In their extensive review of illness and behavior, Kasl and Cobb analyzed the various economic, social, and cultural factors that resulted in unsatisfactory or discontinuous relationships between health providers and patients.[6]

Finally, there is the question of physician competence. Whether perceived or real, a patient who does not think that his care is correct or proper will not return to that provider.

In summary, it appears that this problem is numerically significant and that myriad reasons can prompt a patient or physician to desire a change. There seems to be a delicate balance of contributing factors as shown schematically in Figure 1.

It therefore seemed appropriate to survey family practice residency programs to see what methods they used to deal with this problem and its various origins.

Methods

One hundred fifty family practice residency programs in the United States were chosen at random from a 1978 list of programs accredited by the American Association of Family Practice, and letters were sent to their directors between June and October 1978. They were asked to describe the method used to handle patients who wished to change physicians. If there were no written guidelines, they were asked to provide the way it was informally managed.

Results

Of the letters sent (N=150), there were 51 responses (34 percent). These results were easily divisible into four categories (Table 1).

1. *Automatic transfer*: 23/51 (45 percent). This represents the most common procedure. These rationales were given: (A) fear of losing the patient, (B) innate right to change, (C) mimicry of public sector as closely as possible, (D) observation of real patient behavior by residents, (E) inability of one person to meet the needs of all types of patients. Eleven of the programs in this category had written guidelines and 12 did not.

An analysis of the written responses indicated that only 7 of the 23 programs using this procedure attempted to investigate the reason for the request for change, although they granted all requests. Those that did ask for a reason did so to give feedback to the resident and program as well as for resident correction where indicated. The programs not investigating the reasons usually were concerned with retaining patients or recognizing that no physician can meet every patient's expecta-

tions. Incidentally, several respondents mentioned that such requests occurred rarely, with estimates from one per two to three months to never in four to five years.

2. *Referred to original physician*: 14/51 (27.5 percent). This procedure involved referring the patient who requested a change to his current physician to discuss the reason for the request. Ten programs had written guidelines and four did not.

The programs which used this method stated that most patient-physician problems arise from misunderstanding and that the problems for the most part ceased after this encounter. Whether many people would rather leave a program than face a physician in such a situation is not clear. Several letters stressed that there was great educational benefit to be gained by the resident, ie, important feedback. Of interest is the fact that six of eight military programs responding used this method. The degree of faith in this system by the people using it varied from "most patients comply" to "most won't do this."

This particular system places heavy responsibility on the resident to be objective and to listen. These two qualities are difficult at best for the practicing physician and more difficult for the beginning resident. This system also requires a great deal of courage on the part of a patient in confronting a physician with a perceived deficiency.

3. *Designated authority*: 13/51 (25.5 percent). Programs using this procedure have either a committee or an individual who determined the appropriate action to be taken. Nine of these programs had guidelines and four did not.

Respondents using this type of system stated that the reasons for dissatisfaction were so varied that an informal inquiry was necessary to determine appropriate management. One half of this group indicated that they reacted favorably to most of these requests. However, four specifically were concerned with "doctor shopping" and attempted to control these types of patients.

4. Finally, one program *dropped the requestee* from the program automatically.

Table 1. Methods Used to Handle Requests for Physician Change

Type of Response	%	Number (N=51)
Automatic transfer	45	23
Referred to original physician	27.5	14
Referred to designated authority	25.5	13
Dropped from program	2	1

Discussion

Although the total number of respondents (51) was low (34 percent), certain broad trends are discernible and resulted in three easily recognizable methods of dealing with requests by a patient for change of physician. These methods probably reflect different priorities. Group 1, automatic transfer, was the most common method selected. A director desiring to maintain a patient population would cooperate with the patient's desire as much as possible. Likewise, a director wishing to limit conflict and confrontation would choose this alternative. If time expended is a primary consideration or if the problem is judged unimportant, this method will quickly deal with it. Finally, as stated earlier, this avenue mimics the free selection nature of our private health care system.

Those choosing the second method, referring to original physician, may have a different set of priorities. This system delegates most of the responsibility for settlement with the patient and the resident. It takes advantage of the already existing patient-physician relationship, if it is viable. The educational value for the resident of having to deal with the problem himself and possibly growing from the experience is greater with this method than with the previous one discussed. However, it would be difficult to determine the degree of success of this method. Was the problem legitimate? Was the patient satisfied? In addition, some patients would feel too threatened to bring the matter up with the resident concerned. Others may not state or even *know* the real reason they wish to change. This system assumes that both the resident and the patient have enough maturity to deal with the conflict, the confrontation, and a compromise. Who decides what is reasonable? Vanderpool[3] implies that the patients with more serious psychological problems most often cause con-

flict. Will a resident, in particular a new one, be equipped to handle such a challenge? On the other hand, a resident with a significant problem, be it psychological or competency related, may have trouble deciding that the patient is correct and then indicating to his director that the change request is reasonable. He may, in turn, handle the problem by overcompensating or overextending himself.

The third option, the designated authority, is cumbersome because it requires more time and probably several individual and group meetings. The patient complaining may not want to involve yet another person. That the arbitrator is a health care provider (eg, psychologist, social worker, physician) and therefore already perceived as being biased, may be another stumbling block. But this method also has several important advantages. There is a third person whose disinterested judgment and negotiating abilities can be utilized to resolve the conflict. Significant problems with residents and with patients will come to the attention of, and can be dealt with by, the staff. Directors choosing this method may be motivated by a sense of "fair play" or may recognize this as an opportunity to learn about the residents and patients. Half of programs using the designated authority method (7/13) granted most of the requests, although none of the respondents stated their reasons. As with the automatic transfer method, patient-physician conflicts will be kept to a minimum; however, those residencies desiring the bonus of learning from the conflict might find this method both expedient and educational.

The stated wide range of frequency of requests for change (from one per two to three months to never in four to five years) brings up several considerations. Certainly, size of program and volume of patients is a factor. If there is such a thing as average number of complaints per standard population, then larger programs can expect more complaints. The type of population served also appears to be important. There might be a fundamental difference between a military program and private practice. Patients who are discontented with a private physician leave his practice and seek medical care elsewhere in the community. In the military setting, patients are, relatively, a captive population and a dissatisfied patient more often seeks reassignment to another physician in the same practice.

The prevalence of episodic care (as opposed to continuous care by the same physician) might also be expected to make a difference. If episodic care is common, the patient might be less likely to complain, knowing he will probably get a different physician the next time he is ill. Finally, the wide range in difference may reflect varying degrees of interest in the diagnosis of physician-patient conflict.

Twenty programs did not have written guidelines and 31 did. Because of the nature of the survey, it could not be determined whether those programs without written guidelines had infrequent requests for a change of a physician and therefore had not developed guidelines, or the approach to this problem was so well understood that guidelines were unnecessary.

In summary, selection of a method to deal with a patient's request for physician change reflects an unspoken agenda that revolves around six basic questions: (1) Is it important to keep as many patients as possible? (2) Is it important to monitor physician-patient conflict that results in request for change of physician? (3) Is there enough time to devote to each individual conflict and its resolution? (4) Is it important for resident evaluation to know why some of a resident's patients are unhappy? (5) Is it an educational process for the resident to deal with his/her unhappy patients directly? (6) Is it a patient's right to freely change physicians regardless of the reason? The answers to these questions by a program director will determine the basic form of the solution selected.

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