Deliberate departures from good general practice: a study of motives among Dutch general practitioners

MARJAN VELDHUIS

LODE WIGERSMA

INGE OKKES

SUMMARY

Background. *When general practitioners (GPs) act contrary to their own standards of good practice, they usually cite patient demands as the main reason. However, up until now, studies have relied on doctors' recollections of departures from their own norms, which may be unreliable.*

Aim. *To systematically explore GPs' motives for deliberate departures from their own conception of good practice.*

Method. *Forty-nine GPs, over five days, registered to what extent they had deviated from their own norms, and recorded the motives underlying any deviation.*

Results. *Of the 6087 consultations registered, 10% contained some departure from 'good' general practice, the majority (75%) of which was perceived by the doctor concerned as 'slight'. Doctors underpinned their departures mostly by referring to the doctor–patient relationship: the wish to be nice was used, on average, in 42% of deviations, and the wish to prevent a conflict in 30%. The most important non-relational motive was clinical uncertainty, which doctors used in 11% of their cases.*

Discussion. *Contrary to common belief, GPs often comply with patient requests because they wish to, and not because they feel forced to. Whether or not this behaviour affects the quality of care is largely dependent on the model of 'good' general practice used.*

Keywords: general practitioners; quality of care; patients.

Introduction

OVER the past decade, decision-making in general practice has become increasingly rooted in scientific clinical knowledge. This gradual transformation shows itself most clearly in the recent development of clinical standards and guidelines, and their introduction and implementation in general practice. In the process, it has become clear that GPs often do not comply with these scientifically-based standards.[1] To some extent this is caused by problems with knowledge and acceptance, but research in The Netherlands has shown that, even when doctors know and accept clinical guidelines, they do not always follow them.[2,3] This is in line with more general evidence showing that GPs do not always act according to their own standards of good practice.[4-7]

When asked why they deviate from their own rules of good practice, doctors generally point at patient demand as the main cause,[3-7] while fear of litigation[4,5,7] and clinical uncertainty[4,7] are also frequently mentioned. Apparently, GPs feel pressurized by their patients, which results in a departure from their own norms. However, while the view that patients are to blame is not uncommon,[8] it is by no means clear what exactly is happening. Although there is ample evidence that both the patients' expectations and the doctors' perceptions of pressures influence the clinical process,[9-14] we do not, as yet, know how this is related to departures from good practice. Up until now, no study has looked directly at situations in which doctors decided to deviate from their own rules. All studies on this subject had a retrospective design, in which the heavy reliance on doctors' memories forms a source of unreliability.

The aim of the study reported here was to provide more reliable evidence about GPs' reasons to make decisions that run counter to their own norms. This study was conducted as part of a wider project to unravel the various influences contributing to this phenomenon.

Method

Developing the list of motives for the consultation registration form

The list was developed as part of a study aimed at clarification of the concept of 'defensive behaviour', as used by Dutch GPs. To begin, 23 GPs working in the Department of General Practice, University of Amsterdam, described their own reasons for defensive behaviour. This was defined somewhat more broadly than usual as 'deviation from the doctor's own conception of good general practice, induced by the fear of complaints or reproaches from patients or their relatives'.[15,16] On the basis of these descriptions, we developed a questionnaire with a preliminary list of motives. Subsequently, 114 GPs, who were also asked to add any missing motives, filled in this questionnaire, which examined the perceived contribution of the identified motives to personal defensive behaviour. The final list consisted of 22 motives. Factor analysis revealed that a large number of these could be summarized in three dimensions of the doctor–patient relationship. The motives underlying defensive behaviour turned out to be so similar to those underlying uncomfortable prescribing decisions[7] that we consider them to be applicable to a more general registration of departures from good practice.[16]

Subjects

A total of 49 GPs volunteered for this project, 16 of whom were departmental staff-members, while the other 33 were working in training practices. The participating doctors were instructed to record deviations from their own norms of good general practice and the motives underlying these. The departmental staff, all of whom worked in general practice part-time, were asked to do this during two weeks in April–May 1993, while the (mostly full-time working) trainers were asked to register for six days in February 1995.

A consultation registration form was designed to allow registration of all consecutive consultations of a morning or afternoon. After each consultation, the GP filled in, on a four-point scale, to what extent (not at all, slightly, clearly, strongly) he or

M Veldhuis, MA, medical sociologist; L Wigersma, PhD, general practitioner; I Okkes, PhD, linguist, Department of General Practice, Academic Medical Centre, Amsterdam.

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she had deviated from 'usual behaviour and from what you regard as good general practice'. In case of deviation, putting a cross against any applicable motive stated the reason(s) for this. The motives were arranged to form columns (A–V), while the consultations were registered on consecutive lines. The registration form itself contained a full list of abbreviated motives. A non-abbreviated list was added for reference. The participants were allowed to use motives not on the list and to describe these on the back of the form.

Data analysis

Our units of analysis were the GPs. First, we assessed whether differences existed between departmental staff and trainers in the use they made of individual motives and groups of motives (factors). We calculated, for all doctors, the proportion of the departures from the norms for which they used the different motives and factors to underpin. Student *t*-tests showed no significant ($P<0.05$) differences between the sub-groups, with the exception of one motive ('I do not know this patient well'). On the basis of this finding, we decided to analyse the results of both sub-groups together.

In addition to the data on average use of motives, presented in Table 1, forward stepwise logistic regression was performed to determine the association between motives and degree of departure. The severity of deviations was dichotomized into 'light' (0) and 'clear/strong' (1), and used as outcome variables, and the three relational factors, and all other remaining motives, as covariates. A random effect adjustment was used to control for differences between GPs.

The analyses were done with SPSS and Egret.

Results

The 49 participating GPs returned forms representing an average of almost five whole days (one full week) of consultation contacts. A total of 6087 consultations were registered, giving an average of 124 consultations (SD = 40) per doctor.

Of the 6087 registered consultations, 599 (10%) contained some violation of the doctor's own conception of good general practice. However, there were large differences between doctors: the individual rate of deviance ranged from 3% up to 42% of consultations.

In most cases, the behaviour concerned deviated only slightly from the doctor's norms: in 447 consultations (75%) there was 'slight' deviation, in 122 consultations (20%) the deviation was 'clear', and 30 consultations (5%) involved 'strong' deviation.

Table 1 shows the average use of motives by the GPs, and the number of doctors using each motive. To facilitate interpretation, we have grouped the motives belonging to the three relational factors found during the development of the list of motives, and we summarize for each factor the proportion of deviations in which at least one of the constituting motives was used. As deviations could be underpinned by more than one motive, the rates of use of the single motives add up to more than 100, and the average use of any one factor is less than the total of its constitut-

Table 1. Use of motives to underline deviations from good general practice.

Motives	Mean proportion of deviations in which GPs need motive	Number (proportion) of GPs using motive (n = 49)
Factor 1. Conflict with patient		
I do not want a conflict	11.0	30 (61.2)
I do not want to negotiate now	8.2	24 (49.0)
I want to get rid of this patient now	10.3	27 (55.1)
This patient is demanding	9.4	29 (59.2)
Any of these motives	30.4	44 (89.8)
Factor 2. Problems of mutual trust		
I do not like this patient	6.3	18 (36.7)
This patient does not like me	1.0	4 (8.2)
I want to protect myself against a complaint	1.5	6 (12.2)
In the past, I have made a mistake with patient/relative	1.4	9 (18.9)
This patient does not trust me	2.6	11 (22.4)
Any of these motives	10.3	25 (51.0)
Factor 3. Wish to be nice to patient		
I have a special relationship with this patient	4.7	19 (38.8)
I want to be able to offer something to this patient	15.2	36 (73.5)
I want to please this patient	25.9	38 (75.5)
I want to shield this patient[a]	2.0	6 (18.2)
Any of these motives	42.3	47 (95.5)
Other relational motives		
I want to get this patient on another track	3.1	14 (28.6)
I see this as a matter of give and take	6.1	17 (34.7)
I want to preserve a working relationship	12.7	28 (57.1)
I do not know this patient well	4.2	13 (26.5)
This patient is passive or dependent	6.0	20 (40.8)
This patient is anxious	10.7	29 (59.2)
Other non-relational motives		
I am working under time pressure	7.3	20 (40.8)
I am uncertain about the diagnosis	11.3	26 (53.1)
I am having language problems	3.3	11 (22.4)

[a]Not on the list of university staff; proportions calculated over 33 GP trainers.

ing motives.

Overall, the relational motives were of much greater importance than the non-relational ones. Those associated with the wish to be nice to the patient were most frequently used, underlying deviations from good general practice in an average of 42% of cases. Motives arising out of a conflict with the patient, either overt or covert, were mentioned in 30% of deviations. In contrast, the motives summarized as 'problems of mutual trust' did not play a large role. Of the non-relational motives, diagnostic uncertainty was by far the most important.

Table 2 shows the relationship between the use of motives and the severity of departures from good practice. All factors and the remaining single motives were entered into a forward stepwise regression procedure, but only four attained significance. The probability of a more severe deviation turned out to be considerably higher when conflict (OR = 3.4), a problem of trust (OR = 4.5) or the wish to preserve a workable relationship (OR = 2.2), was an underlying motive, and much lower (OR = 0.5) when the doctor wanted to be nice to a patient.

It can already be inferred from Table 1 that there was considerable variation between the GPs in the use they made of the different motives. Figure I shows this in more detail for the relational factors. The variation in the use of motives related to the wish to be nice to patients, and to the wish to avoid conflict, is particularly high, with some doctors using these in (almost) none of their deviations from good practice, and others in (almost) all.

Eighteen GPs used motives not on the list, generating a total of 21 expressions. The most important additional motive, encountered six times in different formulations, was that a procedure that the GP did not agree with had been initiated or recommended by a colleague. Most of the other motives were variations on an already existing one.

Discussion

When the GPs participating in this study acted in disagreement with their own norms of good practice, which on average occurred in 10% of their consultations, they largely underpinned these actions by two relational motives. Like their British colleagues,[7] Dutch doctors turned out to be motivated by a strong concern for the doctor–patient relationship. Equally striking, however, is their wish to be nice to their patients, which, on average, played a role in over 40% of the deviations. In addition, diagnostic uncertainty again stands out as an important non-relational motive.

That the importance of 'being nice' has not clearly emerged from previous research may well be due to the longer time gap between GP behaviour and the registration of motivation in these studies. The much greater emotional impact of situations of conflict, distrust, and uncertainty[17,18] can easily lead to a distortion of the memory, and thus to the over-reporting of these more dramatic experiences with problematic decision making, at the cost of more 'ordinary' ones. Also, the fact that the wish to be nice is associated with less severe deviation may lead to poorer recollection.

The results of this study have, of course, limited generalizability. One caveat arises from the fact that the participating GPs are a self-selected group of doctors with regular academic contacts. Among a more diverse group, the motivational pattern might be different. Another limitation is caused by the short registration period. It is impossible to estimate from one week's registration how often relatively rare events, like being afraid of a complaint, or being distrusted, really occur. To find out, one would need to collate data over a longer period.

It has repeatedly been found that patients' expectations of care are a major determinant of the care they get.[9-11,13,14] Our results suggest that patient preferences can influence doctors' decisions in different ways. Even when expectations and wishes not coinciding with the GP's own judgment are fulfilled, this does not necessarily mean that the doctor has felt forced to comply. Two distinctly different situations may occur: one in which the GP chooses to deviate a little from his/her own norms of good practice out of positive feelings towards the patient; and one in which (often) more serious deviation is indeed seen as the only way to avoid negative consequences in the relationship with the patient. Therefore, if any blame has to be attributed, it should at least be shared between doctor and patient. Recent research showing that GPs' perceptions of patient expectations are even more important than the expectations themselves,[9-11] and that doctors 'comply' with perceived patient expectation for a prescription even when this expectation is non-existent,[11] also suggests that GPs play a more active role than is commonly assumed.

Although our study has made a contribution toward a better understanding of doctors' departures from their normal standards of care, some questions remain. By focusing on GPs' conscious

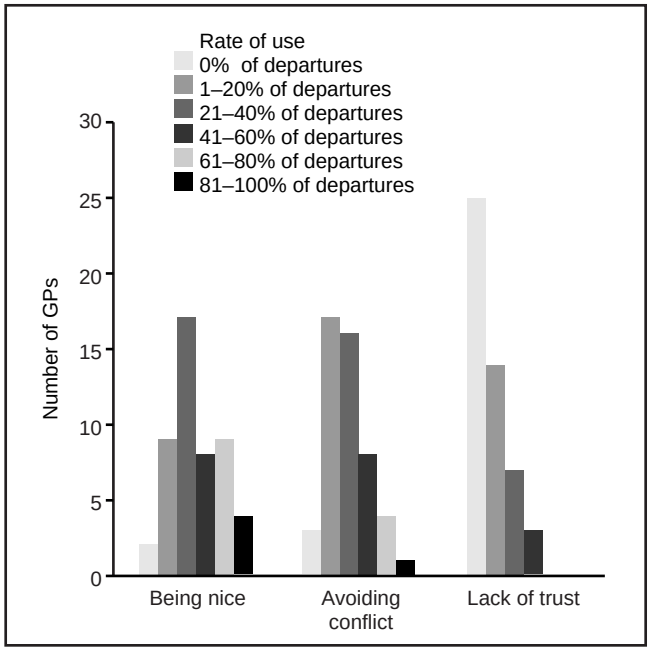

Figure 1. Variation in the use of relational factors to underpin departures from good general practice. Bars represent numbers of general practitioners (n = 49).

Table 2. Stepwise logistic regression analysis of motives associated with more severe departure from good general practice (n = 599).

Motive or factor	P-value	Odds ratio (95% CI)
Conflict with patient (factor 1)	<0.001	3.412 (2.103 – 5.535)
Problems of mutual trust (factor 2)	<0.001	4.452 (2.272 – 8.722)
Wish to be nice to patient (factor 3)	0.014	0.532 (0.321 – 0.881)
Wish to preserve working relationship	0.015	2.178 (1.163 – 4.079)

motives, we may not have captured all influences on their behaviour, but only those they are able and willing to reveal. Further research will provide more objective data on determinants of departure from good practice, including the clinical and demographic characteristics of patients, and on the contents of deviations.

The aim of this study was to find out why GPs make decisions that run counter to their own conception of good care. For this reason, the deviations concerned had to be subjective ones, independent from any objective standard or guideline. However, the fact that they appear to be quite common, naturally raises an interest in their implications for the quality of care. This is a difficult point to get a grip on. That individual doctors see some decisions as being in conflict with their own norms of good practice does not necessarily mean the care is 'substandard' in a more general sense. As yet, there is no comprehensive concept of quality in general practice. Different models of 'good' practice, with potentially conflicting sets of norms, exist side by side.[19] In cases of conflict, individual preferences may legitimately determine which set of norms will prevail over the other.[20] Our results suggest that the tension between the science and art of patient care, in particular, provides the background for many departures from individual norms. Thus, not following a clinical standard out of concern for a patient's feelings could be either normal behaviour or a departure from good practice, depending on the particular balance of norms of the observer. This makes it impossible to pass a priori judgement on many of these subjective deviations.

Nonetheless, GPs should be supported in either coming to terms with or changing behaviour they are not happy with. Our study has shown that doctors can be made aware of a fuller range of motives underlying their actions than merely the stereotypical 'patient pressure', even if they were not aware before. This finding can be used in an educational context to provide doctors with an insight into their own habits that could be a first step towards both acceptance and change.

References

1. Conroy M, Shannon S. Clinical guidelines: their implementation in general practice. *Br J Gen Pract* 1995; **45:** 371-375.
2. Grol R. National standard setting for quality of care in general practice: attitudes of general practitioners and response to a set of standards. *Br J Gen Pract* 1990; **40:** 361-364.
3. Fleuren M, Grol R, De Haan M, Wijkel D. Care for the imminent miscarriage by midwives and GPs. *Fam Pract* 1994; **11:** 275-281.
4. Newton J, Hayes V, Hutchinson A. Factors influencing general practitioners' referral decisions. *Fam Pract* 1991; **8:** 308-313.
5. De Marco P, Dain C, Lockwood T, Roland M. How valuable is feedback of information on hospital referral patterns? *BMJ* 1993; **307:** 1465-1466.
6. Schwartz SK, Soumerai SB, Avorn J. Physician motivation for non-scientific drug prescribing. *Soc Sci Med* 1989; **28:** 577-582.
7. Bradley CP. Factors which influence the decision whether or not to prescribe: the dilemma facing general practitioners. *Br J Gen Pract* 1992; **42:** 454-458.
8. Britten N. Patients' demands for prescriptions in primary care: patients cannot take all the blame for overprescribing. [Editorial.] *BMJ* 1995; **310:** 1084-1085.
9. Cockburn J, Pitt S. Prescribing behaviour in clinical practice: patients' expectations and doctors' perceptions of patients' expectations - a questionnaire study. *BMJ* 1997; **315:** 520-523.
10. Macfarlane J, Holmes W, Macfarlane R, Britten N. Influence of patients' expectations on antibiotic management of acute lower respiratory tract illness in general practice: questionnaire study. *BMJ* 1997; **315:** 1211-1214.
11. Britten N, Ukoumunne O. The influence of patients' hopes of receiving a prescription on doctors' perceptions and the decision to prescribe: a questionnaire study. *BMJ* 1997; **315:** 1506-1510.
12. Armstrong D, Fry J, Armstrong P. Doctors' perceptions of pressure from patients for referral. *BMJ* 1991; **302:** 1186-1188.
13. Webb S, Lloyd M. Prescribing and referral in general practice: a study of patients' expectations and doctors' actions. *Br J Gen Pract* 1994; **44:** 165-169.
14. Virji A, Britten N. A study of the relationship between patients' attitudes and doctors' prescribing. *Fam Pract* 1991; **8:** 314-319.
15. Lamberts H, Janssens PMH. Defensief handelen door huisartsen. *Ned Tijdschr Geneeskd* 1984; **128:** 598-602.
16. Veldhuis M. Defensive behavior of Dutch family physicians. Widening the concept. *Fam Med* 1994; **26:** 27-29.
17. Bredtfeldt RC, Ripani A, Cuddeback GL. Emotional responses to malpractice suits: should residents be prepared? *Fam Med* 1987; **19:** 465-467.
18. Levinson W, Stiles WB, Inui TS, Engle R. Physician frustration in communicating with patients. *Med Care* 1993; **31:** 285-295.
19. Toon PD. *What is good general practice? A philosophical study of the concept of high quality medical care.* [Occasional paper 65.] London: Royal College of General Practitioners, 1994.
20. Lamberts H, Hofmans-Okkes IM. Values and roles in primary care. *J Fam Pract* 1996; **42:** 178-180.

Address for correspondence

Ms M Veldhuis, Department of General Practice, Academic Medical Centre, Meibergdreef 15, 1105 AZ Amsterdam, The Netherlands.

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