THE DISCONTENTED PATIENT

Leaving by Notification

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This paper represents part of a study of the psychological involvements incurred when patients leave their doctor. The investigation was carried out by a research group of general practitioners directed by Dr Michael Balint, then consultant psychiatrist at the Tavistock Clinic, London.

In Great Britain under National Health Service regulations the processes of choosing a family doctor and changing for another have become somewhat formalized. People may "register" with a doctor of their choice and thereby become patients "on his list". If they wish to leave him to register with another doctor they must fulfil certain requirements: if they have changed their address they may change their doctor without further formality; otherwise, they may ask for their doctor's written permission to change, or (if they feel disinclined to approach their doctor) they may obtain this permission from the executive council, the local body administering the National Health Service in a particular area.

The total number of people who leave their doctors is considerable.* This is bound to have certain disadvantages for the patients, the doctors, and the authorities administering the National Health Service.

*In the area of the Middlesex Executive Council (identical with the County of Middlesex and comprising parts of Greater London) out of a total population of 2¼ million 259,000 (11.5 per cent) left their doctors' lists in 1956 (*Statistical Review*, 1957). This proportion has remained approximately the same over the years and is likely to remain so. In rural areas fewer people change their doctor, perhaps only 2—4 per cent. We may assume that altogether 2 to 3 million people annually change their doctors.

The *patient* who changes his doctor loses the continuity of both service and relationship, the most valuable asset of general practice. The *doctor* also loses when his patient leaves him. Obviously, under the present system of remuneration in the National Health Service, whereby the doctor is paid a fixed annual fee per patient registered with him, each patient that leaves constitutes a financial loss. However, well established practices either remain stable or even increase their numbers, as the amount lost is counterbalanced by new intakes. Yet we found in the course of our study that doctors were quite disproportionately upset when their patients left them, not because their livelihood seemed endangered, but because it constituted a threat to their self-esteem. The *administration* is charged with considerable expense owing to the clerical work involved, and there are upheavals because documents and medical records of permanent value have a habit of disappearing in transit, especially in the Greater London area.

Executive councils classify " leavers " (this was the name which we gave to patients who had left their doctor's list) for administrative reasons and give each class a code letter. Some people die ("D"), emigrate ("E"), or enlist in the armed forces ("S"), and thus remove themselves from their doctors' lists. Others may move out of their executive council area into the area of another executive council ("R"). In Middlesex, for example, 88,000 people or 4 per cent of all residents moved out of the county in 1956 and accordingly changed their doctor. Others may move within the council area and are then able to change their doctors without further formality ("X"): 90,000 or 4 per cent of the population of Middlesex did so in 1956. In the same year 36,000 people (1.5 per cent of the population of Middlesex), i.e. 17 per cent of the leavers, changed their doctor by notification, a procedure that in executive council statistics bears the code "N". This means that the patient, not having changed his address and unwilling to ask for his doctor's written permission,* had written to the executive council and had asked for leave to change his doctor. The executive council would then endorse the patient's medical card, return it to him, and after a waiting period of a fortnight the patient could change to a new doctor. This is a tedious and complicated business. People who want to change their doctors under code "N" have to go to a lot of trouble, yet, according to the figures given above, a large number of people determinedly did so. The reasons for this classification and coding are purely administrative as each class needs different

*This would be code "C" (= consent) which we treated as "N" changes for purposes of our research.

handling by the executive council offices. Medical or psychological considerations have nothing to do with the various code letters. This was amply proved by our survey which showed that many changes under codes "X" and "R" were not simply determined by geographical necessity, but by pressure of disturbed relationships.

Changes under codes "N" and "C" obviously indicate disatisfaction between doctor and patient. However much hostility between doctor and patient may be hidden in moves in other categories, it is clearly in the open in the "N" and "C" changes. We concentrated therefore in this paper on these classes alone.

Judging by our own experiences and feelings and by what we heard from other doctors with whom we discussed the subject, doctors feel especially dismayed about patients who leave under code "N". When we discussed these "N" leavers, we could often discern strong feelings of guilt or anger beneath the doctor's defences ("I could not care less"; "I am glad he is off my list "; "Good riddance"). We also found that in the majority of cases we had been taken completely by surprise by our patients' leaving and that we, at first, had no obvious explanation for their leaving. On the contrary, we thought that most of these patients should have clung to us, as we had done so much for them.

We formulated a number of hypotheses about the reasons for patients' leaving and the excessively strong emotional reactions of the doctors to it, especially in the case of "N" leavers. We tested these hypotheses partly statistically, partly by case-descriptive, psychological methods. We examined during 1957 altogether the cases of 1,015 consecutive leavers from our practices, many of them in great detail. This was done by the doctor concerned describing his patient, the history, why he thought the patient had left him, his reactions to this, and by the other participants discussing the statements made and questioning and criticising the doctor. Out of 685 adults in this series of leavers, 85 (12.5 per cent) had left under code "N" procedure.* In addition, when we had reached the 1,015th leaver, we examined similarly 2 per cent randomly chosen patients who had not left our practices. The proceedings were taken down in shorthand, and our case reports are taken from these notes. The results of this investigation will appear in book-form. This paper deals only with some of our findings regarding "N" leavers.

A brief description of the practices of the participating doctors with the numbers of " leavers " is given in table I.

*We left children under 15 out of our investigation of "N" leavers as the parents would usually remove their children from the doctor's list when they transferred.

TABLE I

TYPE OF PRACTICE AND NUMBER LEAVING

Participant doctor	*Single-handed (S) or number of partners in practice*	*Total number of patients in practice at end of survey*	*Leaving rate of "N", "X", "R". (Total "N", "X", "R" leavers per 1,000 patients in practice)*	*Number of "N" and "C" leavers*	*Number of "X" and "R" leavers*	*Description of practice*
A	3	9,148	56	44	213	Suburban; industrial
B	S	2,137	123	13	118	Town; middle and working-class, a good deal of shifting population with a large foreign element
C	3	9,985	61	46	255	Suburban; industrial; a good deal of slum population
D	2	3,121	74	7	108	Suburban; industrial
E	3	6,351	65	18	188	Suburban; industrial; one part of practice in large new council estate; the other, smaller part in working-class residential district
		30,742	—	128	882	

Some might think, of course, that there is no problem at all; that patients leave their doctors under code "N" because they are dissatisfied, perhaps with the doctor's medical knowledge, treatment, or manner. This was, however, not common. The curious fact emerged from our study that the patients had often received what the doctor thought was the best treatment available. Frequently the doctor had taken a good deal of trouble with the patient who had subsequently left him under code "N"; and he had no inkling that the particular patient was likely to leave him; he was thus greatly upset when he found that this had happened. On the other hand, there were patients who had remained with us, although we felt that they would have been justified in leaving us, because our treatment had been perfunctory, hasty, or unskilful.

The only other investigation of " leavers " which we could trace was by Gray and Cartwright (1953), who had questioned 7,027 randomly selected adults in England and Wales. As regards choosing a doctor, they discovered that 45 per cent of the people had inherited their family doctor or accepted the successor of a practice, 15 per cent chose the nearest doctor, 14 per cent had selected their doctor on recommendation, 9 per cent had taken on the spouse's doctor. The rest (17 per cent) chose the only doctor available in their district, or had registered with a doctor they had called in an emergency, or could not remember how they chose, or chose a doctor of a specific sex, religion, or nationality.

The authors found an adult changing rate of 7 per cent per annum, of which four-fifths were due to movements of the doctor or the patient, and one-tenth (i.e., 7 per 1,000 adults per annum) due to dissatisfaction of the patient.

We tried to classify our "N" leavers in groups, according to what we thought were the main reasons for the patients' leaving. Underlying our classification was a spectrum of the doctor-patient relationship which ranged from complete lack of contact between doctor and patient to a state of over-involvement in which both became dissatisfied: the patient because his excessive (unconscious) expectations, which were quite irrational, could not be fulfilled, and the doctor because he could not fulfil the demands of the patient. We shall describe these groups and illustrate them with short case reports.

Group I: no contact between doctor and patient

One-eighth of our "N" leavers constituted an apparently insoluble puzzle: they had never attended their doctor; their records were a complete blank; and the doctor could not remember them at all. They thus had had no contact with the doctor, and yet they had left

him under code "N". We could not understand this, and we were unable to find a cause for such changes, as we had no opportunity to follow up these patients. In two such cases it turned out that the patients' change to another doctor was really based on a clerical error. The patients had attended the other doctor all the time, but, by some mistake had been registered with the doctor in our group. When the error had been discovered, the patients then transferred to the appropriate doctor.

However, this could not have been the case with all the mysterious unknowns. From our experience of patients who changed doctors under other codes, we stipulated the existence of people who could make only very slight emotional contact with others and then had to run away from them. Why this kind of person should register with a doctor, *never* contact him, and then change to another doctor under code "N" is still not explained.

Case 1—Mr and Mrs H., a young couple, registered with us two or three years ago. Neither I nor my partners have ever seen or known anything about them; there are no entries on their record card; they are complete strangers. We received notification that they had been removed from our list and placed with another doctor under "N" procedure.

Group II: professional contact only

Somewhat related to the first group were a number of patients (one-tenth of the total) who had consulted their doctors chiefly about minor illnesses and only briefly at that. They had left no deep impression, had given away very few, if any, of the details of their lives and feelings, and just treated the doctor as someone who supplies technical advice, medicines, or certificates. We called this kind of contact between doctor and patient "professional", in the sense that no strong emotional bond or knowledge of the patient's emotional life were involved.

A typical example of group II was:

Case 2—Miss or Mrs B lives near my surgery, but I do not even remember whether she is married or single. In fact, I cannot remember her at all. She has been on my list for 5 years and, according to my records, has attended a few times for colds. She has now changed under "N" code to another local doctor.

We thought that in many of these cases the changing must have been due to geographical distance or some other extraneous circumstance. As we did not feel emotionally involved with these patients, we were not particularly annoyed with or depressed about this kind of "N" leaver.

How far the extraneous reasons surmised were true we do not know. Nevertheless, geographical distance may play a part and lead to what one might call a "friendly" "N" change.

Case 3—An elderly retired couple were good friends of one of the doctors of our

group. They had become patients on his list when he commenced practice, although they lived a good distance away from him. As they were getting older, they felt it a burden to visit him and an imposition to ask him to visit them for minor troubles. They asked their doctor friend if he would mind their registering with a doctor who lived much nearer to them, and they changed to this doctor under code "N".

Group III: reasons not known

There were a number of patients who had been on their doctors' lists for years. They had usually not been seen for a year or two; the doctor received notification that the patient had transferred under code "N". These represented about one-quarter of our "N" leavers. As in these cases the relationship had been satisfactory, the doctors were surprised and felt hurt. Usually, they had no explanation for the patient's leaving. Occasionally we learned from relatives that the patient had married and gone over to the spouse's doctor. We still could not understand why the pull of one spouse should have been stronger than the pull of the other. It was clear, that in spite of a good relationship, we knew surprisingly little about the patient.

Case 4—A secretary, aged 35, lived in a hostel. I got on fairly well with her. She had left home recently, was homesick, and had a vague sort of illness. She returned home to her parents to convalesce. She saw her old doctor, who wrote me a nice letter about her. When she returned after three months she changed to another doctor in the locality under code "N", without even having come to see me again.

Here, the doctor had been on good terms with his patient, yet he himself was surprised to see how little he really knew about her. He just could not understand why she had left him. In a few of these cases there had been a relationship where the patient had discussed his emotional and intimate personal problems with the doctor, and where the doctor thought he knew his patient very well indeed. Yet, even after full discussion we could not explain the possible reason for the patient leaving.

To the same group belonged a number of "N" changes that occurred chiefly in two practices. In the localities of these doctors a newcomer had set up practice in competition and a number of patients had changed to the new doctor. Nothing had happened between doctor and patient that could have made the doctor suspect that his patient wished to change to a newcomer. Yet, some need of these patients that the doctor did not recognize must have remained unfulfilled. So at the first opportunity they switched to a new family doctor, in search of something which we could not identify. We called this " a search for a better doctor," although we did not really know what the true reason for the change had been.

It happened in ten per cent of our "N" cases.

Case 5—Mr and Mrs M. with their 14 year old daughter changed to the newcomer in our district. They had been old patients of our practice. I do not know them very well, but my partner used to see a great deal of them. Mrs. M. suffered from dyspepsia and my partner tried his best with her. But they left us without a word of complaint or explanation.

This was fairly typical of the kind of family " in search for a better doctor "; it surprised and dismayed the doctors greatly, and we could find no reason for the patient changing. Only in one case were we able to reach a tentative conclusion.

Case 12—This married couple had been in our practice for about 3 years. The wife was 38 when she had her first baby. She was a neurotic woman with many anxieties which she used to discuss with me at great length. Before joining our practice she had made numerous enquiries about doctors in our district with a consultant with whom she was friendly. She finally decided to come to me on his recommendation. We were on very good and " intimate " terms. She wrote me a letter recently to say that, as a doctor friend of hers was starting a practice in our district, she was going to join him. I do not think she was dissatisfied with me.

This woman probably needed a professional relationship with her doctor integrated with personal friendship. This particular need our doctor had not been able to satisfy.

Group IV: unsuitable treatment

In this, our largest group (one-third of all "N" leavers) the doctor's treatment was unsuitable in so far as the patient's *reasonable* expectations were not fulfilled by the doctor. In some of these cases the doctor's treatment seemed to have been wrong or, at least, inappropriate. An example was:

Case 6—A middle-aged man, single, had been on my list since 1949. I had never seen much of him. Recently he wrote me a very polite letter saying that purely on account of distance he found it necessary to change his doctor. He lives about a mile away from me.

He came to see me two years ago and said that he thought he needed circumcision. I knew that he had had some sexual difficulties. I examined his penis and thought it would be good idea to stretch his foreskin under a local anaesthetic. I did so, and he went away apparently quite contented. He telephoned me a couple of days later saying that something had happened, his penis had swollen to the size of a fist. I told him that it would go down all right and that there was nothing to be afraid of. He came to see me and evidently had phimosis. After my reassurance he left looking rather doubtful and did not consult me any more for his sexual complaints. Since then I have seen him only a few times. He seemed fearful and appeared to look on me as a dangerous eccentric. I think if I had not done the stretching of the foreskin he would have managed the distance from his home to my surgery.

We discussed this case in our research group and the doctor told us about the patient's sexual difficulties which were connected with phantasies of danger to his penis. The patient had always

been frightened of paraphimosis. We were somewhat surprised that the doctor, who reported this case, had acted out of character. He had not enquired of this man, who obviously suffered from a neurotic sexual difficulty, about this problem and had dismissed him rather easily. We were also surprised that he had not asked him to return daily until the phimosis had subsided, thus taking that opportunity of getting to know the man's emotional problems.

When the patient returned at a later date he complained of a sore throat. We thought that the doctor could then have referred to the matter again and enquired about the patient's penis. The doctor, however, said that he felt that the patient might have consulted another doctor and that he did not want to embarrass him. The general opinion was that by not going into the matter the doctor appeared to be disinterested and that the patient probably had interpreted this as indifference. The doctor finally admitted that he felt rather guilty about the whole affair, and that was why he had not broached the subject when the patient turned up.

The treatment given was undoubtedly not the best. The patient had presented a sexual problem, and the doctor had somewhat brutally added to his anxiety by causing a penile swelling. In addition, the doctor had not asked the patient to return to him, and when the patient came back after a long interval, the doctor had not bothered to enquire about the important previous event. We were not really surprised that the patient had left the doctor.

The reverse of this kind of case may at times force the patient to change his doctor. It is perhaps one of the most difficult tasks to know when to treat a patient physically and when psychologically. In the above case the doctor erroneously remained on a physical level, instead of dealing with the patient's emotional problems. In the next case the doctor, quite rightly by superficial appearances, tried a psychological approach, but was rejected.

Case 7—A young, married woman came to see me some years ago. She was severely depressed and suffered from a number of anxiety symptoms. I sent her to see a psychiatrist who, however, could not persuade her to accept psychological treatment. She did not return to me, but went to my partner who is more organically-minded. In the end she slowly withdrew and has now changed to another doctor under code "N".

The reporting doctor had tried to deal with the patient wholly psychologically. He had not examined her physically, as in his view there was no need for it. That was quite right, so far as it went. But we had found that there are certain phases in illness when patients want to be left alone with their problem and desire just to be treated physically; there are other phases when patients really want something done about their true illness, the underlying

problem. It is not at all easy to judge the right moment for an active psychological approach. In those cases, however, where we probed too soon, inopportunely, or too forcefully, some patients would flee and change to other doctors.

The same would happen when a doctor insisted on curing a physical ailment, the retention of which was necessary for the patient. General practitioners know only too well that the cure of one physical illness may lead to another illness. We found that it could also lead to a complete breakdown of the doctor-patient relationsihp. The doctors who reported "N" leavers of this kind had taken special trouble with them. After all, curing a patient of his physical illness is not always an easy task and may demand a good deal of medical skill. In consequence, the doctor's disappointment at the patient's ingratitude, when the patient left under code "N", was therefore great.

Case 8—A drab and unattractive middle-aged woman had a chronic varicose ulcer. She complained bitterly about this to the doctor and even brought her husband to the doctor's consulting room to call on him as a witness of her suffering. The doctor sensed much emotional dissatisfaction beneath the dreary, joyless appearance of the woman. He tried hard to get on sufficiently good terms with her to understand the underlying emotional disturbance. However, she rejected all his attempts and would talk of nothing but her bad leg. The doctor felt that he had failed to help her with her emotional problem. He gave up trying and concentrated on curing her varicose ulcer. Using much effort, patience, and skill, he succeeded in getting the ulcer to heal. However, she did not rejoice when the apparent cause of her complaints had disappeared. On the contrary, she came to him complaining of pains in her leg. The doctor, his curative zeal now being aroused, assured her optimistically that he would be able to cure her of her pains, as he had cured her of her ulcer. But she gave him no chance. She changed under code "N" to another doctor, to the great annoyance of our doctor who thought that he had done so well.

The members of our study group were not slow in pointing out that the doctor—with all his goodwill and treatment—had in fact rejected the kind of relationship that the patient evidently needed, namely a doctor who would allow and help her to live with her gravitational ulcer and so enable her to have a good cause for complaining. The doctor, however, imposed his own therapeutic ideal upon her, his idea that illness must be cured and complaints silenced, regardless of what the ailment or complaint may have meant to the patient. The patient promptly told him, by leaving him, that in her eyes he had been a bad doctor.

A similar attitude was taken by those patients whom the doctor disliked. It is not to be expected that doctors could possibly like all their patients. However, two important psychotherapeutic tools in the doctor's possession are sympathy, or his feeling *for* the patient and his suffering, which give him the motive power for his efforts to understand, and empathy, or his feeling *with* the patient

through his own life experiences, which is his method of understanding. These tools are not available if the doctor actively dislikes his patient.

Case 9—In this week's list of removals I noticed Mrs N. and her 6 year old son. She has been my patient for 3 or 4 years. When I saw her first she was pregnant, and her children were getting on her nerves. She was fed up with being pregnant and did not want the baby. She impressed me as a disgruntled and unfriendly person. It was obvious that she did not like me very much; apparently she did not like any one very much just then. She was depressed, complained of nausea and a number of indeterminate symptoms.

About 2 months ago she presented her 6 year old son saying that he was deaf, and she asked me what I was going to do about it. She wanted to take him to hospital for a specialist opinion. She also wanted a certificate for school, as he had been away for 2 weeks. Obviously the school attendance officer had come to her house, and she needed the certificate. I refused to give it to her, as I had not seen the child before. She is the sort of woman whom I felt I could never satisfy. Obviously my justifiable refusal to give her the ante-dated certificate was the last straw.

In our discussion it was pointed out that the doctor had neither investigated the child's deafness, nor the reason for the child's absence from school. It was fairly obvious that the doctor disliked the patient, and that he did not care to go into the problem. The doctor admitted this; the patient evidently felt it; and in due course the relationship between the two broke up.

We had several such "N" changes of patients whom the doctor disliked. This is probably quite a good solution of how to terminate a mutually unsatifactory relationship. On the other hand, it would have been an interesting problem for the doctor, although possibly too difficult, to find out why he disliked the patient so much. Perhaps he might then have found out whether the dislike aroused by the patient's demeanour was a symptom of the patient's illness, and, if so, whether the doctor's understanding could not have been used therapeutically. None of our "N" cases, however, were so examined.

This present group has so far consisted of cases where inappropriate or wrong treatment was applied. The patient's change of doctor seemed, if not always justified, at least understandable.

The following sub-group of patients, are people where the doctors were probably not at fault at all. These patients were women whose husbands had died whilst under the care of their doctor and who had blamed the doctors for their husbands' death. We called this " widows' paranoia ".

Case 10—For the last 6 or 7 years we had treated a man who suffered from severe attacks of auricular fibrillation. We had visited him faithfully and immediately

at all times, whenever his wife, who was an anxious woman, called us, which was probably every time he had an attack.

About 2 years ago they moved to a more distant estate, and although inconvenient for us, we still went to visit him there. Two months ago the husband had an attack; they called us, and my partner arrived about half an hour later, but the man was dead. Shortly afterwards the wife left us under code "N". I recently learned that the widow had told another patient of ours: "You should not remain with those doctors; they are horrible; they did not come when my husband had an attack, and he died". We were resentful about this, because we had gone to visit the man unstintingly day or night and had even kept him on our list when he moved a distance away, because we did not want to deprive this very ill man of the doctors he knew so well.

The treatment of the actual patient (the husband) had not been wrong. The doctors concerned had given him a great deal of attention and could certainly not be blamed for his death. The widow's feelings of guilt (which most people have when a beloved one dies) must have been greatly relieved by her placing the responsibility for her husband's death on the doctors. This may be a remedy for an unbearable pain, but it is not a realistic solution. It seems a pity that a break in the widow's relationship with her doctor should happen just at a time when she might need him most. One wonders whether this damage to the doctor-patient relationship could not have been prevented by free discussion with the wife, whilst the husband was still alive, of her feelings (especially those of an aggressive and hostile nature) towards her husband.

"Widows' paranoia" seems to be fairly common. Those of us who work in partnerships could recall similar cases where the widow did not actually change to another practice, but changed within the partnership to the exclusion of the first doctor.

Group V: over-demanding patients

These patients (approximately one-sixth of our "N" leavers) made what the doctors considered excessive demands on them. They did the same to everybody in their environment; and often people around them, therefore, rejected or avoided them. Such persons are commonly rather immature and dependent: they need a relationship with others reminiscent of that of the infant with his parents. They would demand from the doctor that he settle all their problems; that he be a never-failing source of comfort and protection; and that he be available to them at all times. Many of these people fell ill in a rather dramatic way, they suffered whatever illness they had in frequent crises or attacks. Whenever this happened the doctor had to be present. In time the doctor became tired of the patient's ever-recurring and increasing demands, in the fulfilment of which he was bound to fail in the end. That was the time when

the patient left him with a grievance and grudge. The doctors would commonly, after these patients had left, feel greatly relieved, although, at the same time, they might be angry over the ingratitude shown and feel regret at the failure to help. These were the people doctors generally call "psychoneurotic" patients. The overt reasons for the change might be quite trivial: the patients angrily changed because their present doctor had gone on holiday, or had not been availabe at a particular surgery session which they had attended.

Case 11—Mrs B., an elderly widow, is grossly hysterical. I used to see her at frequent intervals with attacks of intense anxiety, globus hystericus, tremor, and inability to breathe. She had all sorts of investigations in hospitals, but nothing abnormal was ever found. I saw her in quite a number of these acute crises, and I tried unsuccessfully to get somewhere with her. This woman bothered me very much. I have not seen her for some time, but she has changed under "N" code.

We found in the case of patients who made excessive demands that, although the patient formally changed his doctor, very often the doctor had pushed the patient out of his practice. Sometimes the doctor was not fully aware of the fact that his attitude to the patient had clearly said " I do not wish to attend you any longer ". Occasionally, the doctors quite openly said that they had made the patient change to another doctor.

Not all our demanding patients left us, however. On the contrary, some arrived at a form of symbiosis with their doctors, a common experience that we shall discuss below. The doctor will only edge the patient out of his practice if the demands become unbearable, and similarly the patient will only leave if the doctor cannot satisfy a vital need.

Doctors' reactions

In the discussion of our cases we made a special point of stating our feelings about the change. In the majority of cases this was given as " indifference ". During the discussion, especially that concerned with "N" leavers, it became clear that " leaving " aroused feelings ranging from vague uneasiness to deep disquiet in most doctors. No doctor was completely indifferent to an "N" leaver; his feelings were often mixed; there was annoyance at the patient's leaving, mingled with relief in the case of those patients who had been troublesome.

The major and first emotion that normally occurred was one of surprise. At first sight hardly any doctor of our group could explain why the particular patient under discussion should have left him under code "N". When after some thought and discussion we considered we had found a suitable reason the doctor would accept

it, but the event remained painful. We noted a number of psychic defences against this pain or anxiety. One defence was a kind of mental annulment (repression). The doctor had forgotten all about the particular "N" leaver, and he could remember details only after some prodding. Another defence was that of projection. The doctor felt guilty about the patient's leaving and blamed his partner, assistant, or a doctor in a rota group. In retrospect the number of cases that the reporting doctors' partners were presumed to have mishandled was certainly larger than probability allowed. The same defence mechanism was also used with respect to the patient. "N" leavers were sometimes referred to with scarcely veiled contempt. They were described as " stupid ", or " dirty people ", or people of a low social group, and " it was a relief to be rid of them ". Occasionally the reaction of the doctor was one of depression. He would say that it was useless to expect gratitude or loyalty from patients; these qualities did not exist and to look for them was asking for disappointment; the better one treated the patient, the more devotedly one looked after him, the more likely he was to " stab you in the back "; so if you were prepared for this, it would be less painful.

"N" leavers who never were

The surprise that we felt, when patients left us, may have given the impression that we did not expect anyone to leave us under "N" code. This was not so: we guiltily expected some people to leave us, and we were surprised at their staying on. They were, we felt, dissatisfied with us and might have left quite justifiably under "N" procedure. Strangely enough, the overwhelming majority of these did not leave. We had on our files cases where patients had openly quarrelled with the doctor, or frankly expressed their dissatisfaction over treatment, or where the doctor had become very angry with and even abusive towards the patients. Yet these disagreements did not seem to drive patients away. A study of the cases showed that the quarrels and dissatisfaction somehow fulfilled a need of the patient.

Another type of patient who should have been a leaver belonged to the group of incurable grousers, so well-known to general practitioners. In the beginning of our research we thought that we should find many among our "N" leavers. In fact, there was not one among them. They are the kind of people who arouse none of the sympathy that suffering normally evokes. Their relationship with their doctor is not happy. The patients torture themselves and the doctor with their infinite list of complaints; they never get better; and the doctor feels that he is made ineffective. Evidently,

the doctor-patient relationship need not necessarily be smooth and amicable to be successful. The situation reminds one of some married couples who constantly fight, yet cannot bear to be parted. We concluded that openly expressed hostility, tolerated and understood by the doctor may make for a better relationship than repressed resentment.

Is "N" leaving a measurment of good practice?

One might think that in an ideal general practice there would be no "N" leavers. But case discussion showed this view to be wrong. Not only is the patient's freedom of choice of doctor important in our society, but some doctors may be unsuitable for certain patients, and *vice versa*. Without this free choice, emotional tension might rise to pathological heights, and this would lead to practical difficulties.

Furthermore, there are people who are moved by a pattern of the recurring need to prove that paternal relationships are bad and dangerous. They have to break such relationships after a while. A " good " doctor threatens to disrupt this neurotic way of life, and they have to prove him " bad ". Unless he can interpret this pattern the doctor will be quite helpless; the patient will eventually find fault with him and leave.

There are also patients who constantly seek pain and suffering as a just punishment to assuage their unconscious feelings of guilt. These people need to suffer, and this need clashes with the doctor's professional duty (or need) to mitigate pain and suffering. " Why did you not let me die? " is a not unknown response by deeply depressed people to the doctor's effort to save their life. If the doctor deprives such patients by his therapeutic zeal of their only solace, they may, as we have seen, become " medically " better, but may have to leave the doctor.

Thus changes of doctors under code "N" may help the doctor in limiting the field of his practice to those patients whom he feels that he can help. He is thus relieved of unnecessary frustrations and distress, to the benefit of his practice population in general.

The numbers of "N" leavers are therefore no true measure of good practice. If one wished to judge a doctor by his "N" leavers, one would have to consider not only the number of patients, but also the reasons for which they leave him. If large numbers of patients were disappointed in their doctor, either because he was not able to give them what they needed or because he did not understand what they wanted, he could be called a bad doctor. On the other hand, if a large number of patients left because he

refused to be imposed upon, this might well be a sign of good medical practice. It has to be recognized that there will always be a certain number of "N" leavers for the reasons which we have given, whatever the inconvenience and difficulties for patients, doctors, or administration. The doctor who is able to maintain a satisfactory relationship with his patients might possibly have more "N" leavers than the doctor who suffers by tolerating the excessive pressure of unreasonable demands of his neurotic patients. The doctor and his practice will benefit by accepting the inevitability of the "N" leavers.

Summary

As part of an investigation (in 5 practices) of 1,015 patients who had changed their general practitioners (" leavers ") we studied 85 adults who had left " by notification " (code "N"). They were classified according to the likely reasons for leaving. We found that the discontent which leads to breakdown of the doctor-patient relationship, expressed by leaving " by notification ", might be due to the inability either of the doctor or of the patient to sustain the relationship.

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