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General practitioners' reasons for removing patients from their lists: postal survey in England and Wales

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The removal of patients from doctors' lists causes considerable public and political concern, with speculation that patients are removed for inappropriate, including financial, reasons.¹ In 1999 the House of Commons Select Committee on Public Administration noted that little evidence was available on either the frequency of, or the reasons for, removal of patients.² National statistics do not distinguish between patients removed after moving out of a practice area and those removed for other reasons. Two postal surveys have reported why general practitioners might, in general, remove patients,^{3,4} and one small study has described the reasons doctors give for particular removals.⁵ We therefore determined the current scale of, and doctors' reasons for, removal of patients from their lists in England and Wales.

Participants, methods, and results

In April 2000 we sent a questionnaire to 1000 general practitioners in a random sample of practices, but to no more than one doctor per practice. Up to two reminders were sent to non-respondents at fortnightly intervals.

The questionnaire asked for the number of patients removed from the practice list in the previous six

months (for reasons other than living outside the practice area), the reasons contributing to the most recent removal, and whether that removed patient was given a reason. A list of suggested reasons for removal was included (having been compiled in the light of published opinions^{3,5}), and respondents were asked to indicate which of these were "primary" reasons and which others were "contributory."

The questionnaire also asked whether target payment systems (for childhood immunisation and cervical smear testing) and financial arrangements for drug budgets and out of hours care created financial incentives for removing patients.

Of the 1000 doctors surveyed, 14 replied that they were not working in general practice. Of the remaining 986, 748 (76%) responded. In the previous six months 300 out of 745 practices (40% (95% confidence interval 37% to 44%)) had removed one or more patients. When 21 practices whose list size was not stated were excluded, 988 patients had been removed during this period from a registered population of 4.6 million, (removal rate of 4.3 (4.1 to 4.6) per 10 000 patients a year).

The primary and contributory reasons given for the most recent removal by each of these 300 practices are shown in the table. Violent, threatening, or abusive behaviour was given as a primary reason in 176 of

300 removals (59% (53% to 64%)) and as a contributory reason in a further 24 (8%). Other primary reasons given were complaint by a patient (5 (2%) cases), non-compliance with childhood immunisation (4 (1%)), and non-compliance with cervical smear testing (2 (7%)).

In 238 of 288 (83% (78% to 87%)) most recent removals, the practice had given the patient a reason for the removal, either in writing (55% (157)) or in person (28% (81)).

About half of general practitioners believed that the target payment systems for childhood immunisation (370/732) and cervical smear testing (360/732) had created financial incentives to remove patients. Smaller, but still substantial, proportions of respondents considered that financial arrangements for practice drug budgets (295/728) and out of hours care (321/733) also created such incentives.

Comment

General practitioners report that violent, threatening, or abusive behaviour by patients is their most common reason for removing a patient from their list. Non-compliance with childhood immunisation or cervical smear testing was rarely reported as a reason, and never as the sole reason, for removal despite the perceived financial incentives for removal.

The validity of our findings depends on doctors being able and willing to identify and report the number of removals and their reasons for them. If our respondents were unaware of all removals from the practice or were not truthful about why they removed patients, our findings will misrepresent the situation. Moreover, patients may have different views of the events leading to removal, which future research should seek to understand.

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Contributors: MP contributed to the study design, helped to write the paper, supervised the survey, and analysed the data. FS administered the survey, contributed to data analysis, and

Primary and contributory reasons given by 300 practices for most recent removal of a patient from their list. Values are numbers (percentages) of practices citing each reason

Reason	Primary	Contributory
Violence, threats, or abuse	176 (59)	24 (8)
Drug or substance misuse	36 (12)	51 (17)
Inappropriate demand:		
In normal hours	38 (13)	47 (16)
Out of hours	24 (8)	31 (10)
Inappropriate demand for medication	31 (10)	54 (18)
Non-compliance with:		
Appointments	38 (13)	39 (13)
Treatment	25 (8)	44 (15)
Childhood immunisation	4 (1)	5 (2)
Cervical smear testing	2 (1)	5 (2)
Deception or crime	44 (15)	26 (9)
Complaint or litigation by patient	5 (2)	14 (5)
Inappropriate sexual behaviour	7 (2)	6 (2)
Request for unconventional treatment	3 (1)	6 (2)
Cultural differences	3 (1)	3 (1)
Request for particular kind of general practitioner	2 (1)	4 (1)
Other	11 (4)	3 (1)

Some respondents gave more than one primary reason or more than one contributory reason per removal.

helped to write the paper. JM designed the study, contributed to the analysis, and wrote the paper. JN contributed to the study design, data analysis, and helped to write the paper. MP is the guarantor for the paper.

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- 2 House of Commons Select Committee on Public Administration. *2nd report. Annual report of the Health Service Ombudsman for 1997-98 [session 1998-99]*. Norwich: Stationery Office, 1999. www.parliament.the-stationery-office.co.uk/pa/cm199899/cmselect/cmpublicadm/54/5402.htm
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One hundred years ago After-dinner speeches

After-dinner speaking out of the mouths of some few practitioners becomes a science, and nothing can better promote digestion than to set back "serenely full" and listen to the founded periods and elaborate impromptus of someone whose natural gifts have been cultivated by art. Genius has been defined, wrongly we think, as the faculty of taking pains, but there is no doubt that whoever wishes to excel in post-prandial oratory must adopt this course, the absence of which caused the failure of the Vicar of Wakefield's family portrait. On minor occasions anyone possessing a fluent tongue, and knowledge and nerve, and a pinch of the Attic salt of humour will probably speak best on the spur of the moment, but trusting to inspiration may sometimes prove a broken reed, and those who have to obey the orders of the

toast master when important issues are at stake may be advised to make more or less careful preparation. When the late Sir James Paget had to deliver an important speech he might be met in the Regent's Park pacing round and round, and rehearsing his performance; and Charles Dickens, *facile princeps* with his tongue as with his pen, would walk miles over Hampstead Heath declaiming and gesticulating when he had to take the chair at a public dinner. On the other hand, over-elaboration becomes a positive evil when it leads to the production and infliction of long dreary harangues which must be continued to their bitter end, with scanty regard to the comfort of the long-suffering audience.

(*BMJ* 1901;ii:910)