

## Qualitative Research

# Conditions for gatekeeping when GPs consider patient requests unreasonable: a focus group study

Jørgen Breivold<sup>a,\*</sup>, Karin Isaksson Rø<sup>b</sup> and Stefán Hjörleifsson<sup>a,c</sup>

<sup>a</sup>Department of Global Public Health and Primary Care, University of Bergen, Bergen, Norway, <sup>b</sup>Institute for studies of the Medical Profession, The Norwegian Medical Association, Oslo, Norway and <sup>c</sup>Research Unit for General Practice NORCE, Bergen, Norway

\*Correspondence to Jørgen Breivold, Department of Global Public Health and Primary Care, University of Bergen, PO Box 7804, Bergen N-5020, Norway; E-mail: [Jorgen.Breivold@uib.no](mailto:Jorgen.Breivold@uib.no)

### Abstract

**Background:** Requests from patients that are regarded by GPs as unreasonable are a source of conflict between GPs and patients. This makes gatekeeping challenging, as GPs negotiate a struggle between maintaining the doctor–patient relationship, protecting patients from the harms of medical overuse and acting as stewards of limited health care resources. More knowledge of how GPs can succeed in these difficult consultations is needed.

**Objective:** To explore Norwegian GPs' perceptions of conditions that can promote their ability to act as gatekeepers when facing patient requests which they consider 'unreasonable'.

**Methods:** A qualitative study based on three focus groups with Norwegian GPs conducted in 2019, exploring consultations in which the patient made a seemingly unreasonable request, but the GP was able to navigate the consultation in a clinically appropriate manner. Thematic cross-case analysis of verbatim transcripts from the focus groups was carried out using Systematic Text Condensation.

**Results:** The analysis revealed three major themes among the conditions that the GPs considered helpful when faced with an 'unreasonable' patient request: (i) professional communication skills; (ii) a long-term perspective; (iii) acknowledgement and support of GPs' gatekeeping role among peers and from authorities.

**Conclusion:** Professional communication skills and relational continuity need to be prioritized for GPs to maintain their role as gatekeepers. However, support for the gatekeeping role within the profession as well as from society is also required.

**Key words:** Family practice, focus groups, gatekeeping, medical overuse, professional autonomy, qualitative research

### Introduction

Patient requests that GPs regard as 'unreasonable' are common and can be a source of conflict in general practice (1–4). Nilsen and Malterud have previously demonstrated that outright refusals of patient requests can carry a heavy price for GPs and end long-standing patient–doctor relationships, and they conclude that GPs' skills in negotiating potential conflicts should be bolstered (1). This and

other research have addressed consultations involving requests from patients that GPs find it necessary to refuse (1,5) and dilemmas regarding specific topics such as sickness certificates and prescriptions (6,7). However, in clinical practice, a broad range of situations can arise where neither denying nor accepting the patient's request appears to be a good strategy, e.g., continuing prescriptions of opioid drugs for non-malignant chronic pain or referral to diagnostic

## Key Messages

- Patient-centred communication skills are relevant for GPs' gatekeeping.
- Deprofessionalization undermines the gatekeeping role.
- Gatekeeping requires support among peers and from society.

imaging based on vague and non-alarming symptoms. To achieve good practice in such situations, GPs must negotiate a struggle between maintaining the doctor–patient relationship, following scientific evidence and safeguarding the interests and integrity of their patients, including protecting them from the harms of medical overuse, and acting as stewards of health care resources (8). In Norway, patients are registered with individual GPs who function as gatekeepers for the expenditure of common welfare and health care resources including access to specialist services (9). This arrangement accentuates the gatekeeping role and makes the balancing of the different considerations described above particularly challenging.

Studies indicate that GPs often choose to grant patient requests for testing and treatment even when they consider these to be inappropriate (10,11), risking over-detection and over-treatment (12). This seems in part to be related to an intolerance of errors of omission that can lead to defensive medicine (13–15). Another main reason is that it can be more expedient to accommodate patient requests than to try to advocate for a more suitable course of action (16), especially since turning down a patient's request can have severe relational and emotional consequences for the GP (1). More knowledge is needed of how GPs can succeed as gatekeepers in consultations that involve these difficulties.

The aim of this study was to explore Norwegian GPs' perceptions of conditions that can facilitate their ability to act as gatekeepers when facing patient requests that they consider 'unreasonable'.

## Methods

### Sampling and recruitment

We conducted a qualitative study in 2019, obtaining data through three focus groups with a total of 17 GPs recruited from continuing medical education groups in the county of Rogaland, Norway. GPs practicing in urban (59%) and rural (41%) counties were represented. Eight of the participants (47%) were male. The length of experience as a GP varied between 6 and 32 years with a mean of 19 years.

### Data collection

JB, who is a GP and a PhD student, conducted the focus groups using a semi-structured interview guide (Box 1). The focus groups, lasting 72–98 minutes, were audio recorded and transcribed verbatim. In the focus groups, we emphasized that by 'unreasonable request' we meant any requests from patients that the GPs themselves had

perceived as unreasonable from a professional point of view, and we did not strictly define 'good clinical practice'. KIR is a specialist in occupational health, and SH is a GP; both are senior researchers with training and experience in qualitative methods.

### Data analysis

Analysis was carried out using systematic text condensation, a method for thematic cross-case analysis (17) in four iterative steps, where JB and SH performed steps (i)–(iii), while KIR also participated in the last stage: (i) read all transcripts to get an overall impression and elicit preliminary themes; (ii) develop code groups based on preliminary themes, identify meaning units describing consultations with unreasonable patient requests and code for these; (iii) establish subgroups exemplifying vital aspects of each code group, condense the contents of each group and identify illustrative quotes; and (iv) finally synthesize the results from each code group and present a reconceptualized description of each category concerning conditions for gatekeeping.

## Results

The GPs participating in the focus groups shared different examples of consultations where the patient had requested investigations, referrals or treatments that were 'unreasonable' when regarded from the GP's professional perspective. The analysis revealed three main themes among the perspectives provided by the participants on the conditions that can facilitate GPs' gatekeeper role in such consultations, i.e., professional communication skills, relational continuity of care and support for the gatekeeping role from peers and society. The results are presented below according to these three themes.

### Communication skills for mutual understanding and trust

The participants pointed out that, strictly speaking, when a GP experiences a request as unreasonable, the GP has not fully understood why the patient is making the request. From the patient's point of view, the request might be completely reasonable. For instance, there can be a gap between how the doctor and the patient perceive the problem at hand. As one of the informants put it:

The unreasonable request is almost always a concern that you have not yet understood. If you start by refusing their requests, you will not find out anything at all. (#9)

#### Box 1: Main questions from the interview guide

Can you recollect and describe a consultation during which you experienced that, although the patient made an unreasonable request, which was difficult both to refuse and to fulfil, you were still able to conduct the consultation in a clinically appropriate manner?

Why do you think your management of this consultation can be characterized as good clinical practice?

What were the consequences of your being able to conduct the consultation in a clinically appropriate manner?

Accordingly, the GP must explore the reasons for the patient's request. Awareness of differences in language, culture and level of education could be of great help to understand the rationale behind a patient's request. Furthermore, the participants argued that understanding a patient's request would not be sufficient in itself. They shared a broad agreement that the patient needs to know that their doctor has understood the concern behind the request. Accordingly, the GP should express respect for the patient's perspective and encourage the patient's contribution to the dialogue.

The participants described different ways in which their medical competence and behaviour could make patients trust their professional judgement. Some of the participants would emphasize their own medical experience to create a sense of trust. Also, sometimes they would purposefully do a thorough physical examination to give credibility to their subsequent arguments. One participant mentioned that it would help if he came across as being up to date on the subject or made an effort to obtain information if he did not know the answer himself. Generally, the participants emphasized the importance of being sensitive to each patient's individual need for care. One participant shared an example from a consultation with an infant and her mother, who was not satisfied with the verdict given by several doctors that her daughter's symptoms were nothing more than a common cold. The mother was still anxious and requested further investigations of her daughter:

Then I told her that everything was fine, and I am your GP; you can come to my office for a brief check every day if you want. It made her relax completely. (#6)

The participants shared their experience of educating patients, often on basic topics. Sometimes they had to confront misconceptions and unrealistic expectations, as for example when explaining to a patient that the only effective treatment would be for the patient herself to change her lifestyle. If they met the patient with accurate explanation while remaining empathetic and clarifying any misunderstandings, the chances would be better that the patient could accept a different outcome of the consultation than they had expected. One focus group discussed how a sense of humour sometimes could be helpful in reaching agreement with their patients. However, this strategy would have to be applied with care, as an anxious patient could be susceptible to feeling that the doctor was not taking the situation seriously enough, making it even more difficult to solve.

### Long-term perspective

The participants described how they would develop an alliance with their patients over time, with each party becoming more tolerant of the other. They described how trust can be developed over time, as, for example, when a patient experiences that the GP does a thorough job and is available for follow-up. Being familiar with the particularities of the patient's situation could enable the doctor to deal with requests that might initially appear unreasonable. This sometimes involved gradually educating patients:

I have taught them a more adequate understanding of their symptoms and coping in spite of suffering. [...] It was difficult in the beginning, but then it gradually improved as they came to understand part of my message. (#4)

One participant expressed that he would prepare patients for refusals that he would make in the future. A long-term perspective would also allow the GP to make compromises:

Sometimes you may have to make a small concession in order to do what is more reasonable later. At least this is what I often think to myself when I do something that is questionable. (#9)

While the participants expressed that one would not have any integrity as a doctor if one never took any disputes with patients, they also accepted that they could not achieve the most favourable outcome from a medical point of view in every consultation. Taking a flexible approach to problem solving would contribute to trust, whereas rigidity could lead to conflicts with patients. The room for bargaining would differ from case to case. Sometimes an acceptable compromise might involve, e.g., referring the patient for physiotherapy instead of surgery.

### Support of the gatekeeper function

In the participants' experience, the gatekeeping role has become increasingly challenging because of societal forces that increase demand for medical services and promote a consumerist attitude among patients. They found that under these circumstances it has become hard for individual GPs to turn down patients' requests on their own:

I think general practitioners often stand alone in difficult consultations. We see the patients alone, and somehow it is us against the rest. (#8)

As a partial remedy for this, they called for better ways to enable mutual support among colleagues. Support from other health care professionals could also be helpful, and some participants shared examples of how it might be easier to convince patients if they were able to refer to support from other doctors. Thus, one participant gave an example of a consultation with the parents of a child with a viral gastroenteritis who at first did not accept the management she had suggested, but became very satisfied after the GP called a paediatrician for advice.

The participants also argued that patients needed to be aware of the gatekeeping role and accept on a general level that this is something GPs are required to do:

It would help if we had more external support. Not necessarily more guidelines, but a sort of understanding among the patients. (#8)

In part, the participants argued, this might be seen as the responsibility of GPs themselves. GPs should participate in public debate to inform patients about what to expect from their doctors, and the GP college should endeavour to ensure better alignment between GPs in controversial medical issues. However, the gatekeeping role of GPs should also be explained in official information from public authorities, as this would legitimize that the role of GPs includes protecting patients from medical overuse and acting as stewards of common resources. As a parallel example, some participants mentioned that extensive public campaigns about antimicrobial resistance and adverse effects of antibiotics have made it much easier to avoid the overuse of antibiotics.

## Discussion

### Summary

In this focus group study about conditions that facilitate adequate gatekeeping when patients make requests that the GP finds difficult to concede, the participants' answers centred around professional communication skills, relational continuity of care and support for the gatekeeping role from peers and society at large.

### Strengths and limitations

Using focus groups is appropriate when the aim is to describe and analyse the experiences, attitudes and viewpoints among a group

of individuals relating to common phenomena in depth (18). Being a GP and familiar with the situations experienced by the participants himself helped the first author facilitate and promote a comprehensive discussion, which strengthens the internal validity of the results. On the other hand, our preconceptions and medical background may also have prevented us from questioning common professional presuppositions. While we found that the data from three focus groups provided sufficient information power (19) for the purpose of this study, additional interviews could still have provided a broader range of perspectives.

We have sought to enhance the external validity of the study by sampling GPs with diverse backgrounds, providing important contextual information in the background section and applying theoretical perspectives to interpret the results below. While we have elicited knowledge based on the perspectives of the GPs themselves, other relevant sources of information about consultations in which GPs find patients requests 'unreasonable' should include interviews with patients or direct observation of consultations.

### Comparison with existing literature

The results of the current study corroborate and expand previous research (1), indicating that the ability to manage 'unreasonable' requests may hinge on specific communication skills for exploring and acknowledging patient perspectives and building trust. A previous study with simulated patients who made a standardized request for antidepressants points in a similar direction. The simulated patients who had their request rejected reported higher satisfaction if their primary care physician used an approach that specifically involved the patient perspective (11). Communication methods for engaging not only with patients' requests but also the broader emotional, cognitive and social context from which they arise are well known from the patient-centred clinical method (20). Our study adds weight to the argument that such methods can improve GPs' ability to deal with 'unreasonable' requests.

Our study also identified the importance of a flexible attitude on behalf of the GP and relational continuity of care, which aligns with previous research demonstrating that GPs often make compromises between competing factors to manage the gatekeeper role (3,6,8) and that relational continuity in primary medical care can reduce mortality (21) and specialist health care use (22), while increasing staff and patient satisfaction (23).

To the best of our knowledge, the current study is the first empirical inquiry into conditions for gatekeeping in general practice that are not confined to the patient–doctor relationship or to the skills of individual GPs. Based on their experience that they often feel left to themselves in consultations where patient make 'unreasonable' requests, our participants called for support for the gatekeeping role from peers and society. Nilsen has previously argued that GPs need political support and acknowledgement in their gatekeeping mission (24). The essence of Nilsen's argument and our finding is that for individual GPs to resolve disagreement with patients deriving from unrealistic expectations about what medicine can and should deliver, there must be a societal acknowledgement of their professional authority to do so. We find the theory of professionalism relevant to understand this claim. According to this theory, the authority of a profession relies on an agreement that its members should employ their skills to perform specific tasks for the common good as they are better equipped to manage these tasks than non-professionals (25). Furthermore, the legitimacy of a profession relies on the broad agreement on intersubjective norms on which its practice can be

based. Conversely, the legitimacy of a profession will be undermined in so far as such intersubjective norms are cast in doubt (26), and in some regards, the rise of the patient-centred approach in general practice has been accompanied by an erosion of the professional authority of the GP (27). Unsurprisingly, this seems to be borne out by reports that conflicts between GPs and patients are more frequent when the GP college disagrees on how to deal with specific conditions (28). On a more general level, the commodification and commercialization of medical services and the widespread availability of medical information and technologies seem to some extent to erode patients' trust in the doctor's judgement of what is likely to be in their best interest (29).

A prior study has found that one strategy GPs use to preserve long-standing patient–doctor relationships when negotiating refusals is to place the responsibility with distant third parties, such as the primary care organization or guidelines (28). The GPs' need to feel supported by, and to place some of the responsibility on a third party, demonstrates that gatekeeping should be understood in a societal context rather than as an issue that only pertains to individual clinical encounters.

It has previously been suggested that changing not only professional but also public attitudes towards uncertainty and error in medicine is essential to reduce medical overuse (30). In the current study, the participants pointed out that patients do not always have sufficient knowledge about the futility and risks associated with the excessive medical activity. In public debate about health care, there seems to be limited awareness of the dangers of medical overuse (31), and explaining such issues to patients from scratch in individual consultations can be a daunting task for GPs. While different professional initiatives have been launched internationally in recent years to address medical overuse (32–35), the effectiveness of such initiatives in supporting GPs in their capacity to protect patients from the harms of medical overuse has not yet been investigated.

### Implications for research and practice

Undergraduate and GP training should nurture specific patient-centred communication skills. However, professional bodies and authorities must also give their support to the gatekeeping role if GPs are to safeguard patients against investigations and interventions that are not in their best interests. Potentially, collective initiatives taken by the medical profession to minimize harm from medical overuse can legitimize gatekeeping. Such initiatives should be further implemented, and their effects on the ability of GPs to fulfil the gatekeeper role require investigation. Implementation and research should include the perspectives of patients and the general population.

### Conclusion

Professional communication skills and relational continuity need to be prioritized for GPs to maintain their role as gatekeepers. As predicted by the theory of professions, however, there also seems to be a need for mutual support of the gatekeeping role within the medical profession as well as from society and public authorities.

### Acknowledgements

The authors thank the GPs who participated in the focus groups and colleagues Stein Nilsen and Kirsti Malterud whose insights and research have been a crucial point of departure and inspiration for this study.

## Declaration

Funding: Norwegian Committee on Research in General Practice.  
 Ethical approval: Regional Committee for Ethics in Medical Research (reference 2018/2356); Norwegian Centre for Research Data (reference 125634); World Medical Association Declaration of Helsinki.  
 Conflict of interest: none.

## References

- Nilsen S, Malterud K. What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway. *Scand J Prim Health Care* 2017; 35(2): 201–7.
- Levinson W, Kao A, Kuby AM, Thisted RA. The effect of physician disclosure of financial incentives on trust. *Arch Intern Med* 2005; 165(6): 625–30.
- Carlsen B, Norheim OF. "Saying no is no easy matter" a qualitative study of competing concerns in rationing decisions in general practice. *BMC Health Serv Res* 2005; 5: 70.
- Smith S. Dealing with the difficult patient. *Postgrad Med J* 1995; 71(841): 653–7.
- Heath I. How medicine has exploited rationality at the expense of humanity: an essay by Iona Heath. *BMJ* 2016; 355: i5705.
- Nilsen S, Malterud K, Werner EL, Maeland S, Magnussen LH. GPs' negotiation strategies regarding sick leave for subjective health complaints. *Scand J Prim Health Care* 2015; 33(1): 40–6.
- Ekelin E, Hansson A. The dilemma of repeat weak opioid prescriptions - experiences from Swedish GPs. *Scand J Prim Health Care* 2018; 36(2): 180–8.
- Bringedal B, Isaksson RØK, Magelssen M, Førde R, Aasland OG. Between professional values, social regulations and patient preferences: medical doctors' perceptions of ethical dilemmas. *J Med Ethics* 2018; 44(4): 239–43.
- Mossialos E, Wenzl M, Osborn R, Anderson C. *International Profiles of Health Care Systems*. New York: The Commonwealth Fund, 2014.
- Kravitz RL, Bell RA, Azari R, Krupat E, Kelly-Reif S, Thom D. Request fulfillment in office practice: antecedents and relationship to outcomes. *Med Care* 2002; 40(1): 38–51.
- Paterniti DA, Fancher TL, Cipri CS, Timmermans S, Heritage J, Kravitz RL. Getting to "no": strategies primary care physicians use to deny patient requests. *Arch Intern Med* 2010; 170(4): 381–8.
- Little P, Dorward M, Warner G, Stephens K, Senior J, Moore M. Importance of patient pressure and perceived pressure and perceived medical need for investigations, referral, and prescribing in primary care: nested observational study. *BMJ* 2004; 328(7437): 444.
- Kanzaria HK, Hoffman JR, Probst MA, Caloyeras JP, Berry SH, Brook RH. Emergency physician perceptions of medically unnecessary advanced diagnostic imaging. *Acad Emerg Med* 2015; 22(4): 390–8.
- Nilsen S, Werner EL, Maeland S, Eriksen HR, Magnussen LH. Considerations made by the general practitioner when dealing with sick-listing of patients suffering from subjective and composite health complaints. *Scand J Prim Health Care* 2011; 29(1): 7–12.
- Studdert DM, Mello MM, Sage WM *et al*. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. *JAMA* 2005; 293(21): 2609–17.
- Casalino L, Crosson F. Physician satisfaction and physician well-being: should anyone care? *Prof. Prof.* 2015;5(1): 954–65.
- Malterud K. Systematic text condensation: a strategy for qualitative analysis. *Scand J Public Health* 2012; 40(8): 795–805.
- Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet* 2001; 358(9280): 483–8.
- Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. *Qual Health Res* 2016; 26(13): 1753–60.
- Stewart M, Brown JB, Weston W *et al*. *Patient-Centered Medicine: Transforming the Clinical Method*. London, UK: CRC Press, 2013.
- Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH. Primary medical care continuity and patient mortality: a systematic review. *Br J Gen Pract* 2020; 70(698): e600–11.
- Hansen AH, Halvorsen PA, Aaraas IJ, Førde OH. Continuity of GP care is related to reduced specialist healthcare use: a cross-sectional survey. *Br J Gen Pract* 2013; 63(612): 482–9.
- Freeman G, Hughes J. *Continuity of Care and the Patient Experience*. London: The King's Fund, 2010.
- Nilsen S. *Allmennlegrs Erfaringer som Portvakt*. PhD Thesis. Bergen, Norway: Universitetet i Bergen, 2018.
- Dzur AW. *Democratic Professionalism: Sharing Authority in Civic Life*, Vol. 13. The Good Society – PEGS (Organization), 2004, pp. 6–14.
- Rawls J. *Political Liberalism*, Vol. 4. New York, NY: Columbia University Press, 1993.
- Steinhart B. Patient autonomy: evolution of the doctor-patient relationship. *Haemophilia* 2002; 8(3): 441–6.
- Walter A, Chew-Graham C, Harrison S. Negotiating refusal in primary care consultations: a qualitative study. *Fam Pract* 2012; 29(4): 488–96.
- Ritzer G, Walczak D. Rationalization and the deprofessionalization of physicians. *Soc Forces* 1988;67(1):1–22.
- Hoffman JR, Kanzaria HK. Intolerance of error and culture of blame drive medical excess. *BMJ* 2014; 349: g5702.
- Ghanouni A, Meisel SF, Renzi C, Wardle J, Waller J. Survey of public definitions of the term 'overdiagnosis' in the UK. *BMJ Open* 2016; 6(4): e010723.
- Moynihan R, Smith R. Too much medicine? *BMJ* 2002; 324(7342): 859–60.
- Levinson W, Kallewaard M, Bhatia RS, Wolfson D, Shortt S, Kerr EA; Choosing Wisely International Working Group. 'Choosing Wisely': a growing international campaign. *BMJ Qual Saf* 2015; 24(2): 167–74.
- Grady D, Redberg RF. Less is more: how less health care can result in better health. *Arch Intern Med* 2010; 170(9): 749–50.
- Størdal K, Hjørleifsson S. Can we make wiser choices? *Tidsskr Nor Lægeforen* 2020; 2: 116.