

# General practitioners' perceptions of the appropriateness and inappropriateness of out-of-hours calls

Helen Smith, Val Lattimer and Steve George

## SUMMARY

**Background:** The number of out-of-hours calls to general practitioners (GPs) has increased steadily during the past 20 years. The proportion of inappropriate calls are reportedly increasing but we know very little about how GPs judge a call to be appropriate or inappropriate.

**Aim:** To determine the factors that influence GPs' perceptions of the appropriateness or inappropriateness of out-of-hours calls.

**Design of study:** Postal questionnaire survey.

**Setting:** GP members of the Wessex Primary Care Research Network (WReN) and the Northern Primary Care Research Network (NoReN).

**Method:** General Practitioners were asked to write down what they meant by an 'appropriate' and 'inappropriate' out-of-hours call. The free text was subjected to content analysis.

**Results:** Detailed responses were received from 146 (73%) GPs. General practitioners appear to have a well developed classification of the appropriateness of out-of-hours calls. Factors that make calls appropriate include not only the nature of patients' symptoms and illness but also non-medical factors such as patients' compliance and politeness.

**Conclusion:** The inclusion by GPs of non-medical factors in their conceptualisation of the appropriateness of out-of-hours calls may contribute to patients' confusion about what is and is not appropriate and also to the apparent failure of patient education initiatives designed to decrease inappropriate demand.

**Keywords:** GP perceptions; out-of-hours calls.

## Introduction

OVER the past 20 years there may have been as much as a fivefold increase in the number of out-of-hours calls to general practitioners (GPs) as judged from routine night visit data<sup>1-3</sup> and from studies in which the number of calls and night visits have been monitored in individual practices or in small areas.<sup>4</sup> This steep upward trend persists, even after adjusting for changes in the definition of out-of-hours calls over time.<sup>3</sup> Other studies have shown that between 41% and 60% of out-of-hours calls are judged by the GP as being medically unnecessary.<sup>5-11</sup> The proportion of inappropriate calls is reported to be increasing but, because of the difficulties comparing studies that utilise different methods, the evidence for this trend remains anecdotal.

To develop criteria for assessing the appropriateness of out-of-hours calls we need to understand more about doctors' perceptions of appropriateness. A criterion-based approach to measuring out-of-hours activity would allow us to move away from measures of total service utilisation and towards separate measures of appropriate and inappropriate use. Such a distinction could be used to monitor trends in the use of services and the data could be used to inform the reorientation of service provision. In this study we explored how GPs viewed the appropriateness or inappropriateness of the out-of-hours calls they received.

## Method

We obtained information on GPs' perceptions of the appropriateness and inappropriateness of out-of-hours calls as part of a survey of 199 GPs in two primary care research networks. The survey was conducted primarily to ascertain the views of GPs about the future provision of out-of-hours services.<sup>12</sup> The sample represented a broad spectrum of age, experience, practice characteristics, and patterns of out-of-hours care delivery.

The question on appropriateness (Box 3) was included as one of 26 questions in a postal questionnaire. The responses to this question were typed verbatim and we then undertook a content analysis of the text.<sup>13,14</sup> Two of the authors familiarised themselves with the data through reading and re-reading the transcripts. Research notes were made, listing ideas and themes. Once all the data had been reviewed we returned to our research notes to identify key issues, concepts, and themes, and to develop a framework within which to sort our data. The framework was applied to the transcripts from the northern network first and the categories refined before proceeding with the sorting of the dataset as a whole. Finally, we interpreted our findings and selected for presentation quotes that fully illustrated the breadth of our

H Smith, BMedSci, BM, BS, MSc, FFPHM, DM, senior lecturer, Primary Medical Care; V Lattimer, MA(Ed), RGN, DipN, DipNEd, RNT, PhD, MRC, research fellow; S George, MB BS, MSc, FFPHM, MD, senior lecturer, Health Care Research Unit, University of Southampton.

### Address for correspondence

Dr Helen Smith, Primary Medical Care, Aldermoor Health Centre, Aldermoor Close, Southampton SO16 5ST. E-mail: hes@soton.ac.uk  
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**Appropriateness is about:***Medical emergencies*

Life-threatening illness: 'Calls where the patient's life is at risk'. 'Clinical emergencies'. 'Life-threatening illness' (10).

Serious illness/acuteness: 'Unexpected acute onset or change in chronic condition'. 'Acute episodes; new symptoms' (14).

Not intervening would be detrimental: 'When medical intervention at that time will make a significant difference'. 'Will get worse if not treated'. 'Emergencies — where action may alter outcome'. 'Carry a threat to wellbeing and cannot wait until next day' (5).

Severe Symptoms: 'Chest pain'. 'Abdominal pain'. 'Shortness of breath'. 'Unacceptable pain'. 'Inconsolable or dopey babies or children'. 'Collapse'. 'Psychiatric crises'. 'Bleeding'. 'Persistent vomiting' (37).

Symptoms which could be serious: 'Problems that become worse'. 'Symptoms which could be serious'. 'Rapid onset'. 'Potentially severe'. 'Serious or possibly serious symptoms that need to be dealt with urgently'. 'Uncertainty regarding symptoms'. 'Threat of serious illness' (14).

Genuinely being unwell: 'Genuinely being unwell'. 'Real problems'. 'Real pathology'. 'Genuine illness'. 'Discomfort I would not like to be with without receiving help' (20).

Uniqueness: 'I don't like bothering you but I've never seen him/her like this before'. 'Requests for acute serious problem which an ordinary patient would not normally be able to cope with' (5).

Terminal illness: 'Palliative care'. 'Terminally ill patients'. 'Death' (8).

*Patient characteristics:*

Fear and anxiety: 'Genuine concern'. 'Genuine anxiety and illness'. 'Reasonable worry'. 'Genuine distress'. 'Not panicking'. 'Sick and frightened patients seeking help out of genuine fear of serious illness' (35).

Mobility: 'Isolation with lack of transport'. 'Patients whose medical care can be continued at home but would suffer severe distress/discomfort on travelling to see a GP' (9).

Age: 'Children with out-of-the-ordinary illnesses'. 'Young children'. 'Below six months old child'. 'Elderly, frail patient'. 'Elderly people with any problem' (9).

*Patient participation*

Self help: 'Patients having fully utilised self-help measures'. 'Self medicating appropriately'. 'Failure of self management'. 'Stopping to think'. 'Trying something first'. 'Taking responsibility'. 'Planning ahead a little' (14).

Reasonableness and receptiveness: 'Willingness to play a part, e.g. travelling to doctor'. 'Accepting telephone advice'. 'Sensible self care followed by reasonable decision to ask for further timely advice and/or face-to-face consultation'. 'Negotiating a solution' (23).

Respect for the GP: 'Valuing doctor's effort and advice'. 'Not making the GP feel awkward or that confrontation is required in order not to visit'. 'Being understanding and considerate of the hours worked by the GP'. 'The patient feeling appreciative'. 'I'm sorry to trouble you but'. 'Using a GP because of the skill he/she has'. 'Medical need, not patient convenience'. 'Simple good manners' (18).

Box 1. General practitioners' concepts of appropriateness in response to the question 'From your experience, please jot down some words and phrases which for you capture the meanings of appropriateness and inappropriateness'. Major headings correspond to the themes identified and subheadings correspond to the categories. Each category is illustrated with extracts from the data (the numbers in brackets at the end of the quotes relates to the number of GPs whose responses included something pertaining to this category).

**HOW THIS FITS IN***What do we know?*

The demand for out-of-hours care continues to increase and the proportion of inappropriate calls is reported to be increasing also. However, assessments of appropriateness are largely unstructured and subjective and the factors which influence GPs' perceptions of appropriateness not well understood.

*What does this paper add?*

This exploratory study identified substantial agreement about the medical urgencies thought to constitute appropriate out-of-hours calls. However, for some practitioners it was not the medical problem but the behaviour of the caller which determined whether the call was considered appropriate or inappropriate.

data. As a test of validity we presented our work at one of a series of workshops on qualitative methods for GPs. The course participants confirmed that our findings were a reasonable account of their own experiences.

**Results**

The questionnaire was returned by 148 (74%) of the GPs, of whom 146 completed the question on appropriateness. Most of the responders were male (84%), in full-time practice (87%), and aged 44 years or younger (70%), with a mean of 11 years as a principal in general practice. The responders from the Wessex Research Network were representative of GPs nationally with respect to age, sex, seniority within the practice, and professional qualifications. The Northern Research Network responders were slightly younger and included a higher proportion of women GPs.<sup>12</sup> Most responders gave multi-dimensional definitions of appropriateness (257 dimensions) which were not simply the converse of their definitions of inappropriateness (387). There was more conceptual diversity in the inappropriateness data than in the appropriateness data. The results of the qualitative analysis are summarised in Figures 1 and 2 in which the major headings correspond to the themes and the sub-headings correspond to the categories. These are further illustrated with original extracts from the responses in Boxes 1 and 2.

**Inappropriateness is about:**

*Non-urgent medical problems*

Minor illness: 'Minor conditions'. 'Trivial problems – colds and other minor self-limiting illnesses'. 'Minor discomfort, no changes'. 'Infections: sore throats, earaches, mild kidney infections'. 'Diarrhoea and vomiting'. 'Stuff of common knowledge or common sense'. 'Toothache'. 'Worried well'. 'Coughs and colds in otherwise well children'. 'Drunkenness' (60).

Chronicity: 'Ongoing chronic problems that are not really any worse'. 'Familiar ailments'. 'Panic attacks in regulars'. 'Chronic recurrent problems'. 'An ongoing problem with no change'. 'Longstanding conditions'. 'Problems days or weeks old' (34).

*Non-medical problems*

Social problems: 'Intervention in family disputes'. 'Poverty, lack of transport', 'Social needs'. 'Often being unable to help'. 'Something must be done, social needs, i.e. patient requires residential care or a relative to help out' (15).

Unavailability of other services: 'To cover deficiencies in other services, e.g. absent warden'. 'Calls that require a nurse (no nursing services available after midnight in this area)'. 'Having to carry out nursing duties, i.e. catheterising when there is no district nurse available'. 'Called because no other agency is available — social workers not available, to impossibility of finding NHS dentist at weekend or hospital decided to discharge to the community when patients unable to fend for themselves' (11).

*GP perception of patient convenience*

Regular users: 'Repeated feckless use of service'. 'The same old people time and time again'. 'Well known patient who frequently calls'. 'Repeated calls from individuals/families for similar problems' (9).

Working the system: 'Waiting until surgery closes before calling'. 'Using out-of-hours availability as a quick route to consultation'. 'Misleading description of symptoms'. 'Obtaining a second (third, fourth, fifth) opinion'. 'Deliberate manipulateness'. 'Being called out as more convenient than coming to surgery in open hours'. 'Calling out-of-hours because it is more convenient'. 'Wanting a visit as they have to go to work tomorrow'. 'Well we've both been at work all day doctor'. 'Nursery wouldn't take him tomorrow – conjunctivitis' (58).

Repeat prescriptions and routine care: 'Needs more pills as going on holiday tomorrow'. 'Using home visits to obtain a repeat prescription of a drug which could have been bought over the counter or ordered during the day'. 'Non-urgent or routine medical treatment'. 'New certificate' (21).

*GP perception of callers lack of knowledge*

Not knowing service organisation: 'Assumption that doctor on call is the same as a 24-hour service'. 'Are you the night-time doctor?' (5).

Unrealistic expectations: 'Expecting immediate care'. 'Just checking to make sure'. 'Regarding out-of-hours as a continuation of routine care but in the convenience of the patient's home'. 'Unrealistic expectations'. 'Expecting visits for minor illnesses'. 'Unrealistic expectations for instant treatments and cure' (19).

Calling too soon: 'Could wait without risk of deterioration'. 'Calling too soon (half an hour after sore throat begins)'. 'Problems which the man on the Clapham omnibus would regard as suitable for a consultation in normal working hours' (10).

*GP perception of callers unreasonableness*

Demanding care: 'Demanding a visit when advice is all that is needed'. 'Calling without following previous advice'. 'Calling as a first resort'. 'It's my right to have a doctor out'. 'Feeling forced into doing a visit by threatening/aggressive behaviour of the public rather than medical need'. 'Demanding visits – 'I want you here now' (30).

Third party calls: 'Virtuous third party calling on behalf of someone else'. 'Relative ringing from a distance to ask GP to visit mother'. 'Guilty weekend visiting relatives'. 'Nursing and residential home staff not taking responsibility' (12).

Thoughtlessness: 'Lack of regard for doctor's own time/privacy'. 'Lack of thought by patient'. 'Being out when doctor calls'. 'Knee-jerk calls, panic'. 'Forgetfulness'. 'Being casual about others'. 'Not thinking if the call would wait until morning'. 'Selfishness' (37).

*GP perception of callers irresponsibility*

Failure to take responsibility: 'Not using common sense — trying a proprietary over-the-counter medicine for simple complaints first'. 'Patients/parents not taking responsibility for more minor illness'. 'Excessive demand for service without acceptance of responsibility for health (poor locus of control by patient)' (35).

Not accepting telephone advice: 'Refused to accept sound telephone advice'. 'Inability to accept advice'. 'Not helpable'. 'Failing to relieve pre-anxiety by reassurance over the telephone' (14).

Calling too late: 'Problem having been present all day and then calls at night'. 'At 7 p.m. "He's been ill all day Doctor"'. 'Any symptoms which have been going on for more than one day and could have been sorted out in normal hours' (11).

Box 2. General practitioners' concepts of inappropriateness in response to the question: 'From your experience please jot down some words and phrases which for you capture the meanings of appropriateness and inappropriateness'. Major headings correspond to the themes identified and subheadings correspond to the categories. Each category is illustrated with extracts from the data (the numbers in brackets at the end of the quotes relates to the number of GPs whose responses included something pertaining to this category).

**Appropriate calls**

There was broad consensus about what constituted an appropriate call. Genuineness was a key concept and the word 'genuine' occurred frequently, as in 'genuine unwellness' and 'genuine anxiety'. Calls about potentially serious symptoms, severe symptoms or life-threatening conditions

were regarded as appropriate. Some doctors defined calls about patients who were terminally ill as always appropriate, others felt similarly about patients who were anxious, immobile or frail and elderly. Calls for young children with out-of-the-ordinary illnesses and for babies under six months were also cited as appropriate. General practitioners were willing to accept the best judgement of a carer where it was based

'Inappropriate' out-of-hours calls to GPs are reportedly increasing but we know very little about how GPs judge a call to be appropriate or inappropriate. From your experience, please jot down some words and phrases which for you capture the meanings of appropriateness and inappropriateness.

**Appropriateness is about**

**Inappropriateness is about**

Box 3. The question on appropriateness in the questionnaire.

		Life-threatening illness
		Serious illness/acute-ness
		Severe symptoms
	Medical emergencies	Symptoms which could be serious
		Genuinely being unwell
		Uniqueness
Appropriateness	Terminal illness	
		Fear and anxiety
	Patient characteristics	Mobility
		Age
		Self help
	Patient participation	Reasonableness and receptiveness
		Respect for the GP

Figure 1. Outline of themes and categories relating to the concept of appropriateness.

on previous experience of the patient's illness. An important characteristic of appropriateness was the patient or carer participating in the process of care; for example by trying self-help remedies first, by accepting telephone advice, or by being willing to travel to see the doctor. Six responders were of the view that out-of-hours calls were always appropriate, whatever the caller's concern. For some responders, respectfulness for the doctor was in itself sufficient to render a call appropriate.

### *Inappropriate calls*

The inappropriateness data were more extensive, more varied, and more difficult to code. Calls about minor, self-limiting illness and routine care, such as repeat prescriptions and medical certificates, were stated to be inappropriate. Patients with known chronic illnesses or who had health problems which, in the doctor's view, could have been dealt

		Minor illness
	Non-urgent problems	
		Chronicity
		Social problems
	Non-medical problems	
		Unavailability of other services
		Regular callers
	Patient convenience	Working the system
		Prescriptions and routine care
Inappropriateness		Not knowing service organisation
	Lack of Knowledge	Unrealistic expectations
		Calling too soon
		Demanding care
	Caller's unreasonableness	Third-party calls
		Thoughtlessness
		Failure to take responsibility
	Caller's irresponsibility	Not accepting telephone advice
		Calling too late

Figure 2. Outline of themes and categories relating to the concept of inappropriateness.

with during the day were also inappropriate. Inappropriate calls came from patients who lacked knowledge about the practice's arrangements and showed a lack of timeliness either by calling too soon (usually in the case of minor illness) or too late (usually where the doctor could have dealt with the problem during the day). Other groups considered to generate inappropriate calls included demanding patients, those exercising a 'right' to have a home visit, and ones expecting a continuous 24-hour service. These

patients were said to misunderstand the emergency nature of out-of-hours care or to have asked for a home visit for reasons of convenience. On occasion, nursing and residential home staff were said to have failed to take responsibility and were calling the GP to 'cover themselves'. Calls from visiting relatives of elderly patients and 'virtuous third-party calls' were also reported in this category.

Examples were given of inappropriate calls from patients and other health professionals because of the unavailability of out-of-hours or other services more suited to meeting the patient's needs (i.e. the calls were necessary but inappropriately directed). These included a perceived lack of dental services, district nursing services, and social services. Out-of-hours calls about social problems were considered generally inappropriate. A major frustration for responders in this study lay in their perception that other agencies were not available out-of-hours and, by implication, ought to be.

## Discussion

This study documents a substantial consensus about the kinds of calls thought to be appropriate such as those concerning medical urgencies and suspected serious illness. It also documents some unexpected dimensions of appropriateness such as the importance of the patient valuing the GP and being respectful to them. The responders in this study appeared to have well developed and readily articulated personal classifications for out-of-hours calls. This is perhaps not surprising because in the management of their out-of-hours workload GPs often work alone, differentiating between calls that require a home visit, an out-of-hours surgery appointment, or telephone advice and then prioritising their response.

For some GPs it was not so much the medical problem but the attitude or behaviour of the caller which determined whether the out-of-hours call was considered appropriate or inappropriate. Patients perceived to be demanding, thoughtless, aggressive, not helping themselves or exhibiting a lack of respect for the doctor were judged to be making inappropriate calls. In contrast, patients found responsible, appreciative, understanding, and valuing of the GP generated appropriate calls. These observations are consistent with the extensive nursing literature on the identification of good and bad, popular and unpopular, desirable and undesirable patients.<sup>15</sup> There are similarities too with the sociological literature focusing on the typification of patients by doctors. This work has largely been based in accident and emergency departments, for example<sup>16-18</sup> and although caution may be required in generalising to other medical settings there are many similarities between the casualty doctor and the GP on call. In both situations, patients have relatively uncontrolled access to the doctor and there is a risk of medical staff being overwhelmed by demand. Also, GPs on call and doctors in casualty have case mixes that are more similar than one might assume; as much as 40% of patients presenting to accident and emergency having a primary care problem.<sup>19</sup>

A questionnaire survey was not our first choice of study design. Focus groups or in-depth interviews would have enabled us to explore the attitudes and opinions of GPs in more detail. However, by incorporating this work within a

funded postal questionnaire we were able, with no additional resources, to collect data from 146 GPs about a previously little understood area. Moreover, this opportunistic method yielded rich data including several unanticipated key themes. Among these, perhaps the most concern is raised by the finding that the characterisation of appropriateness of out-of-hours contacts included features that were related not only to the medical condition but also to the caller's behaviour before and during the out-of-hours consultation. While this study has generated some preliminary insight into GPs' perceptions of what constitutes appropriate use of their services out-of-hours, further work is required. In personal interviews, it would be possible to explore the individual doctor's awareness of the lack of objectivity in their responses and to assess their ability to distinguish the subjective feelings of annoyance from the more objective descriptions of inappropriateness. In addition, observational studies could be used to ascertain whether these subjective factors influence the GPs' decision about call management (telephone advice, consultation or home visit) or the subsequent treatment (both medical and social) that follows.

There is an interesting issue about who defines what is the appropriate or inappropriate use of out-of-hours services. Should it be the GP or should it be the patients, who perceive a need for help and presumably feel that their call is appropriate at the time they call the doctor? As in the very large body of work on the utilisation of secondary care health services, this study is confined to the professionals' interpretation of appropriateness.<sup>20</sup> This reflects the asymmetry in the doctor-patient relationship, as described by Parsons,<sup>21</sup> with the doctor occupying a dominant position by virtue of his or her specialised knowledge, skills, and the high status accorded to the medical profession. To explore the patient or caller perspective, a more helpful, shared nomenclature, such as necessary/unnecessary or immediate/next day calls might be preferable to appropriate/inappropriate, terms which are mainly used to describe the opinion of a professional. By moving to a more neutral, shared terminology one might observe shifts in the interpretation and definitions of 'appropriateness' expressed by the professionals.

The current trend towards greater consumerism in health care will lead to changes in the doctor-patient relationship and this is likely to bring about changes in future perceptions of appropriateness. While consumerism will lead towards a more patient-focused definition of appropriateness, there are other factors at work too. Notions of consumerism tend to assume that lay people act as 'rational' actors in the context of the medical encounter with the dominance of the 'reflexive self' (i.e. individuals acting in a calculated manner to engage in self improvement and being sceptical of expert knowledge). However, when patients are interviewed in depth they describe pursuing both the ideal type 'consumerist' and the 'passive patient' position simultaneously or sequentially, depending on the context.<sup>22</sup> In taking on board consumerism in out-of-hours health care we need to remain aware of the complexity and changeable nature of the desires, emotions, and needs that characterise the doctor-patient relationship.

The authors of the consultation paper *Developing*

*Emergency Services in the Community*<sup>23</sup> recognised the complexity of the doctor-patient interaction and the minimal impact that previous patient education campaigns have had on reducing patient demand. Instead of trying to reduce demand, they proposed a new service to deal more efficiently with undifferentiated requests. NHS Direct provides a single contact number manned by personnel who can give advice or redirect to the appropriate service. It remains to be seen whether this innovative service will lead to a reduction in those out-of-hours calls that GPs currently define as inappropriate or whether NHS Direct will encourage patients to consult outside normal working hours about non-urgent conditions that would previously have been seen in working hours. For NHS Direct, the findings of the present study may be useful in the development of patient information and also in the training of health professionals for telephone consultation and out-of-hours work.

This study confirms the need to develop some standardised measures of medical necessity and urgency. Such measures would enable the disaggregation of appropriate from inappropriate demand and allow more robust and objective evaluation of the impact of alternative methods of providing out-of-hours care.

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