

# A qualitative study of why general practitioners admit to community hospitals

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## SUMMARY

**Background:** Intermediate care, which is provided by community hospitals, is increasingly seen as one way of reducing pressure on secondary care. However, despite evidence of wide variation, there is little literature describing how general practitioners (GPs) use these hospitals. Because of the control they have over decisions to admit, development of these units depends on the co-operation of GPs.

**Aim:** To identify and understand the factors influencing the decision to admit to a community hospital.

**Design of study:** A qualitative interview study.

**Setting:** Twenty-seven practitioners from ten practices supporting five community hospitals in one region of Tayside, Scotland. Secondary support was identical for all sites.

**Method:** In-depth interviews were conducted with a purposive sample of GPs representing those who had the most and the least use of the five community hospitals. A qualitative analysis was performed to determine the factors that practitioners considered important when making decisions about admission. Results were presented to the study group for validation.

**Results:** All admissions required adequate capacity in the community hospital system. Primarily social admissions were straightforward, requiring only adequate hospital, nursing, and GP capacity. More typical admissions involving social and medical needs required consideration of the professional concerns and the personal influences on the doctor as well as the potential benefits to the patient. As medical complexity increased, the doctor's comfort/discomfort became the deciding factor.

**Conclusion:** Provided there was adequate capacity, the GPs perceived the level of comfort to be the prime determinant of which patients are admitted to community hospitals and which are referred to secondary care.

**Keywords:** community hospitals; decision making; patient admission; intermediate care facilities.

## Introduction

THE term 'intermediate care' is increasingly being used to describe a range of services designed to facilitate the transition from hospital to home and to prevent admission to the acute sector. For many years a minority of general practitioners (GPs) have accepted this extra workload and responsibility by caring for patients in community hospitals. The question is, why have they done this and, perhaps more importantly, what is required if this role is to increase in line with the anticipated need?

In a recent study, Seamark *et al* identified 471 community hospitals in the United Kingdom (UK) containing 8457 general practitioner beds and 10 122 consultant-led beds. Around one in five practitioners have admitting rights to community hospitals, although this figure rises to nearly one in two in rural areas.<sup>1</sup> The descriptive literature suggests wide variation in usage but has little explanation as to why such variation occurs.<sup>2-4</sup> If such units are to develop in the future then it is essential that there is a clearer understanding of their current use. The aim of this study was to identify and understand the factors that influence GPs' decisions as to whether or not to admit patients to a community hospital.

## Method

As part of a larger study the admitting behaviour of 43 practitioners in ten practices, with admitting rights to five Tayside community hospitals, was studied. The local district general hospital (DGH) was between 14 and 30 miles away, with a tertiary centre between 20 and 52 miles away. This provided a sample with mixed community hospital and general practice contexts in which admission practices varied by a factor of four, but whose secondary support was from the same site. Qualitative research methods were chosen as they are best suited to exploring and understanding such a complex social process.<sup>5-7</sup>

A qualitative interview study was conducted by the first author using an iterative approach based upon grounded theory as described by Strauss and Corbin.<sup>8</sup> To study the widest possible range of behaviours present, a purposeful sample was selected representing 'high' (over 50 admissions per year) and 'low' (under 20 admissions per year) 'admitters', as well as a mix of practices, experience, training and additional qualifications. An interview guide was developed following a review of the literature and discussions with GP colleagues. It was subsequently piloted and refined with two GPs outside the study area. Semi-structured interviews were conducted using the guide, which was refined and modified to accommodate the developing analytical themes (Box 1). Initially, interviews focused on the types of patients GPs admitted to their community hospital and what they felt were the main issues involved in making the decision to

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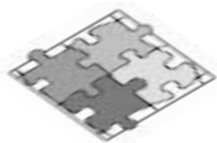
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**HOW THIS FITS IN***What do we know?*

The process of admission to the majority of community hospital beds is under the control of local GPs. However, the widespread variation in how these beds are used and what they are used for is poorly understood.

*What does this paper add?*

Sometimes, community hospital admissions are not made because of a lack of available beds, insufficient nursing resources, or pressure on GPs' time. Other factors include: GPs' concerns about possible inappropriate care in a district general hospital balanced against their own competence and confidence; GPs' attitudes or motivation towards community hospital care; and the potential benefits of more intensive care or investigation. GPs commonly consider borderline decisions in terms of their own comfort/discomfort with retaining responsibility.



1. Can you describe for me the circumstances around a recent admission you have made to the community hospital? Explore medical reasons (types of patients), social, logistical, patient preferences, past experiences, risk, multiple pathologies, continuity of care.
2. Can you tell me where an admission has been made and subsequently went wrong? Explore how it went wrong, and the effect on subsequent admissions.
3. What makes you confident or alternatively anxious about admitting a patient to the community hospital? It has been suggested that there is a certain type of doctor who actively uses a community hospital. Explore enjoyment, enthusiasm, workload, and finance.
4. How do you see the community hospital affecting your role as a general practitioner? Explore training, attitudes.
5. How might it be done in the future? Explore alternative approaches, time constraints.

*Box 1. Questions used in the final interview guide.*

admit. Subsequent questions explored attitudes to other specific situations and latterly to emerging analytical themes. All 43 practitioners were approached in writing. Twenty-seven interviews were conducted, with at least two practitioners from every practice except from one small practice, from which only one practitioner was interviewed. The interviews were conducted in the responder's surgery and were audiotaped and transcribed verbatim.

Analysis was conducted using an iterative process of theoretical sensitisation, coding, and interpretation as advocated by Strauss and Corbin.<sup>8</sup> The initial four interviews were jointly coded and discussed. Subsequently, new themes were identified by one researcher from repeated readings and immersion in the written and recorded data. These were verified by the other author during regular coding meetings. After all the texts were coded the relevance and interplay of the key themes were discussed in iterative cycles between the two researchers with reference to the original data until agreement was reached. To assess consistency of coding, 100 randomly selected codings from later interviews were double coded (94% agreement).

**Trustworthiness**

**Researcher.** The leading author is a senior partner in one of the practices concerned and lead clinician for the local health care co-operative. He is known locally to have a special interest in this topic. The potential influence of this was recognised and repeatedly considered throughout data collection and analysis. To counter this the author received formal training in qualitative research and worked under the close supervision of a more experienced researcher/mentor. Great care was taken to reassure responders that he was on sabbatical, acting as an independent researcher, and that the interview had no influence on services and would be treated in confidence.

**Responder validation.** Responders were invited to two meetings, at which the analysis was presented for corroboration/challenge. Eight of the 27 attended. The analysis met

with universal approval without any significant challenge to the interpretations made. As the influence of the leading author's local position could have influenced responses appreciably, the other author inquired as to whether this had occurred. Only one responder reported that this had had any conscious impact; he had emphasised the need for nurse training in the hope this would influence its provision.

**Disconfirming cases**

Finally, all 27 of the tapes were reviewed to ensure compatibility with each case and to seek disconfirming examples. One case, in which nursing staff were limiting one doctor's activities, proved difficult to accommodate. Conflict with nursing staff was not reported by other doctors, even at the same hospital, and such strong interpersonal issues or a dysfunctional team are not included within the model presented. It may, therefore, not be applicable if the clinical team is dysfunctional.

**Results**

There was a wide variation in how the hospitals were used, but these practitioners all felt their use of the community hospital provided benefits for patients.

*'I think it's an optimal care they are getting by being in the community hospital. It's doing what should be done with the time and resources which lots of other people [doctors] don't have.'* (Practitioner 25: 16.)

However, some practitioners expressed doubt:

*'There is the risk that having worked in the community hospital for years that actually you are beginning to be involved in activities that aren't making much of an impact, but your nose is so close to the ground that you don't know it.'* (Practitioner 11: 25.)

Six themes were apparent, i.e. three contextual or 'primary' influences and three non-contextual or 'secondary'

groups of influences on the admission decision. In addition, it appeared that a practitioner's perceived level of 'comfort' was the mechanism by which these influences effected the final decision on where to admit each patient (Box 2).

### Primary influences

The context at the time of a potential admission emerged from all the interviews as fundamental to the admission process. This is described in terms of hospital capacity, doctor's capacity, and patient preference. The hospital capacity, primarily bed availability, was a limiting factor. This was linked by several responders to the level of nursing staff and the type of admission proposed.

*'It is the blocked beds, we cannot utilise the beds to bring someone in.'* (Practitioner 3: 30.)

*'The staffing levels are such that if you have a couple of acutely ill patients it does restrict what they [the nurses]*

*can do for other patients on the ward.'* (Practitioner 21: 10.)

The doctor's capacity reflected the recognition by many practitioners that their feelings at the time were important. Such feelings varied from being positive towards the admission process to the frankly negative. Factors such as their interest in a particular patient and the time of day the patient presented were recognised as important.

*'We all have our own thresholds and they vary from day to day. They may also vary depending on how interested we are in a particular condition or how much commitment we feel to a particular patient.'* (Practitioner 14: 80.)

*'Sometimes you could see it [admitting a patient to the community hospital] far enough.'* (Practitioner 13: 28.)

All of the practitioners were sensitive to patient preference

#### Primary influences

The core components that have to be in place if admission to a community hospital is to be considered.

##### Hospital capacity

Circumstances, actual or perceived, relating to the receiving hospital's structure and processes that influence whether admission to the community hospital takes place.

##### Doctor capacity

Pressures that influence whether or not an admitting doctor is willing to take on the added responsibilities of admitting a patient to the community hospital at a particular time.

##### Patient preference

Views expressed by, or attributed to, the patient that materially influence the decision as to where and when to admit the patient.

#### Secondary influences

Factors which were found to influence admission decisions by potentially generating comfort/discomfort in the admitting doctor.

#### Professional concerns

##### Problems with the community hospital

Perceived problems concerning the community hospital that make the doctor reluctant to admit or the patient reluctant to be admitted.

##### Problems with the DGH

Perceived problems with DGH care, or its response to the request for care, which make either the patient reluctant to be admitted or the doctor reluctant to admit.

##### Medical uncertainty

Insecurity about what is going on medically with the patient.

##### Process of care

The specific elements of care in the community hospital, including therapies and procedures, that may be either beneficial to the patient or potentially detrimental to care.

##### Support systems

Peer, nursing or consultant support that may encourage or discourage local admission.

##### Training and experience

Training and experience that influence the doctor's ability or attitudes towards admitting patients to a community hospital.

#### Competence

The appropriate skill, knowledge and capability of the admitting doctor that allows them to manage inpatient care.

#### Peer perception

When the admitting doctor's behaviour is influenced by what their colleagues might think.

#### Personal influences

##### Anxieties

Worries experienced by the admitting doctor when, for instance, an unsuccessful outcome is possible.

##### Attitudes

The way the admitting doctor reacts to the opportunity to admit to the local community hospital.

##### Beliefs

A doctor's view or opinion on the personal benefits or drawbacks of community hospital work.

##### Confidence

The self belief in the doctor that he/she is able to deal with the admission within the community hospital.

##### Control over care

The importance to the admitting doctor of his/her ability to direct the care of the patient and influence the decision to admit locally.

##### Professional motivators

Perceived benefits to the admitting doctor's professional life from the use of the community hospital.

##### Personal motivators

Factors providing some non-professional gain or loss that might influence the GP; for example, finance.

#### Potential benefits

The doctor's view of the gains achievable from patient admission to the hospital that will most appropriately meet the patient's needs.

##### More appropriate care in the DGH

Belief that the care required is outwith the competence or resources of the admitting doctor or the community hospital.

##### More appropriate care in the community hospital.

Belief that the care in the community hospital may be more appropriate than the care in the DGH.

Box 2. Definitions of themes and categories.

regarding the admission. This was reported as commonly in favour of a local admission.

*'Patients overall would prefer to go to the cottage [community] hospital, they always have done simply because of the proximity even for visiting and the fact that it's a much smaller unit and they feel, they certainly would say, that they get much better care there.'* (Practitioner 16: 23.)

If there was adequate hospital capacity, doctor capacity, and the patient preference was favourable, then local admission became an option. This did not automatically mean this occurred, as other influences that we have termed 'secondary' came into play and the doctor's comfort became the deciding factor.

### Secondary influences

The secondary influences have been grouped into: professional concerns, personal influences, and potential benefits. Referral to secondary care was likely if any one of these induced appreciable discomfort.

### Professional concerns

All practitioners considered the nature of the presenting problem, recognising increasing concern as the problem became more complex or 'medical'.

Several practitioners were ambivalent about the site of care. Problems with the community hospital were recognised, particularly the risk of the practitioner failing to take timely management decisions. However, there were greater problems with the DGH in terms of a perceived unfriendly and inappropriate atmosphere for this patient group.

*'Sometimes patients come in [to the community hospital] and there are no clear plans made — they kind of drift.'* (Practitioner 4: 86.)

*'I think that these places are intimidating [the DGH], for any of us, they are intimidating for us if we go in as a patient.'* (Practitioner 9: 124.)

*'I think that we actually save them from the risks of junior doctors and over-enthusiastic investigations and treatments.'* (Practitioner 12: 40.)

When probed about the types of medical problems they would be prepared to handle, practitioners' worries about diagnostic and medical uncertainty, the process of care available, and the support systems for community hospital care, emerged.

*'We are all afraid of missing the diagnosis which may or may not be obvious, there is always a question of whether we are doing the right thing.'* (Practitioner 9: 136.)

*'The nurses develop a very close relationship with the patients, they are able to support us and very clearly say what they think.'* (Practitioner 7: 32.)

Training and experience, as well as competence, also emerged.

*'I think what you do in time is that you realise that what you do is actually working so it is fine so you don't have any problem with that, but I think it adds to your feelings of confidence if you have actually gone on a training course.'* (Practitioner 10: 116.)

However, several practitioners were concerned about how colleagues might perceive their decisions, especially if they did not admit locally the types of patient that they were used to looking after (peer perception).

*'The hospital team would have probably thought why is he doing this when he could have managed this locally.'* (Practitioner 1: 29.)

### Personal influences

It was clear that admissions with increasing medical complexity resulted in factors related to the practitioner as an individual becoming critical. These could be positive, encouraging local admission, or negative. The most common negative influence was expressed as anxiety about the possible outcome of local admission and whether this would ensure the most appropriate care.

*'Do you feel the patient is getting the best deal out of this, I mean am I the best person to look after this patient?'* (Practitioner 4: 108.)

Common positive factors were attitude, confidence, control, and motivation.

The practitioner's attitude towards community hospital work was a recurrent factor.

*'I realised that that was extra workload for me personally — but I was just happy to take that on.'* (Practitioner 6: 65.)

*'It's commitment. And wanting to spend your time working.'* (Practitioner 23: 42.)

The practitioner's confidence was often an important issue that was commonly influenced by their previous knowledge of the patient and their illness.

*'If it is a recurrence of a pre-existing condition that they had before and we know how that has been managed and what has happened and we feel happy with that, then it is reasonable to take them straight into the cottage, if that is what they want to do.'* (Practitioner 9: 56.)

An example of this was the elderly patient with a malignant effusion who was brought into the community hospital regularly for treatment.

*'I have had patients with pleural effusions. I've brought them in and I've tapped their chests once a week to relieve their respiratory distress.'* (Practitioner 14: 80.)



Practitioners usually valued retaining control over care, which helped outweigh other considerations, such as workload or concerns over competence.

*'It's a type of benevolent control trying to ensure the best for your patients and trying to be in charge of what is happening for the good of the patient.'* (Practitioner 4: 82.)

*'It makes it easier from the point of view that the whole thing I think is in your hands. And when you have control over something, personal control over something, I think it's easier to deal with.'* (Practitioner 26: 50.)

Many also reported a personal satisfaction from providing an appropriate level of care themselves, which increased professional motivation. This was enhanced by the continuity of care provided within the community hospital.

*'There certainly is enormous benefit and job satisfaction from my end from seeing the patient through.'* (Practitioner 6: 119.)

Perhaps surprisingly, financial reward did not feature as an appreciable personal motivator.

*'Potentially it is an issue and in fact, you know, looking at, as I say, how much work is involved it seems a reasonably paltry sum, shall we put it like that.'* (Practitioner 13: 80.)

Many practitioners revealed general beliefs that supported their community hospital practice.

*'It gives me opportunities for further development.'* (Practitioner 1: 97.)

*'It just allows you to be a much more complete doctor.'* (Practitioner 14: 32.)

### Potential benefits

All responders accepted it was essential for practitioners to identify patients whose care would be more appropriate in the DGH. Such patients usually required more intensive care and investigation than was available locally. However, when this was not required patient care was often more appropriate in the community hospital.

*'The community hospital always seems to make them better and you know I'm certain in the hustle and bustle of a DGH ward that would not have materialised. You can't measure it but it was tangible. It was obvious they were flourishing and it was just the environment.'* (Practitioner 25: 110.)

### Types of admission

The influences outlined above cannot be considered without some reference to the spectrum of admissions described.

These ranged from the primarily social, through increasing complexity to clearly 'medical' patients. Most patients were elderly with a combination of problems.

When the admission was primarily social and there were no wider issues, only the three primary contextual factors had to be considered, as the doctors perceived little medical challenge or discomfort. Admission to a DGH was unlikely, provided a local bed was available, the doctor was not overwhelmed, and the patient was content.

Four distinct types of more typical 'socio-medical' admission could be identified within the spectrum of patients that included a mix of social and medical need. These were: admissions for assessment, 'step down' transfers from secondary care, 'can't cope', and anticipatory admissions. Two practitioners used the last approach by making proactive admissions where they identified a need.

Lastly, some practitioners were prepared to admit patients with more challenging medical problems, requiring greater personal skill and increased competence from nursing staff; for example, those patients requiring the tapping of effusions, transfusions, intravenous fluids, or drug therapies that other practitioners did not feel competent to offer. They would normally be admitted to a DGH, but some practitioners decided to care for them personally.

*'If we know the diagnosis and the problem, we are willing to get on with it ... I admitted a diabetic who is insulin dependent at ... and who didn't respond to glucagon or IV glucose very adequately because he kept on collapsing. I just admitted him to the community hospital, put a drip up and looked after him.'* (Practitioner 10: 34 and 35.)

Terminal care was the most common type of medical admission, but again, some doctors were willing to accept greater challenges than others.

*'My most recent admission is a 55-year-old who has breast cancer and has been coming into the hospital for regular IV pamidranate infusions. She is now in for terminal care in terms of transfusion, analgesia and symptom control.'* (Practitioner 13: 28.)

For these types of patients, attitude and competence appeared important, and, by implication, training and experience improved the doctors' comfort. Satisfaction seemed to result from maintaining control of the patient's 'complete care', which outweighed the additional workload. Although those clinicians recognised that they provided care that many of their colleagues would not offer, none reported peer pressure not to do so.

### Comfort in decision making

It was clear that different factors operated in every admission decision. Over half of the practitioners spontaneously reported their decisions in terms of 'comfort'. Comfort appeared a common pathway through which secondary influences could affect decisions.

*'A lot of it would relate to your feeling of comfort with*

*managing certain situations or certain conditions.*' (Practitioner 4: 106.)

*'The difficulty is that when you are getting outwith your competence and comfort zone, there is a small problem in that the doctor may feel that he has put a person in the community hospital and then has to phone the district hospital.'* (Practitioner 7: 74.)

*'I'm comfortable with, I suppose, what I would term the simple things: chest infections, chronic obstructive airways disease, maybe increased angina in somebody who is elderly, and terminal care if I think we can stabilise them in hospital.'* (Practitioner 19: 22.)

Comfort/discomfort was doctor-specific and thus differed between individuals facing similar situations.

*'Inevitably someone's comfort will be another person's nightmare and I think that's down to the individual practitioner.'* (Practitioner 5: 26.)

Another practitioner described it like this:

*'Can you explain what makes you comfortable or what makes you uncomfortable?'* (Interviewer.)

*'...if I don't feel they are going to get any better care in the district general hospital I feel comfortable admitting them. I think if they have got very complicated acute medical problems then I don't feel comfortable 'cause I feel I'm out of my depth — if I feel really uncomfortable I don't admit them.'* (Practitioner 19: 21.)

Practitioners weighed up the risks against their competence, training/experience and support systems (including access to specialist opinions) when making borderline decisions. They talked about discomfort in this situation as leading them to be reluctant to accept responsibility, and a secondary care admission more likely.

## Discussion

This study successfully gathered and analysed data from 27 in-depth interviews with GPs purposefully selected to offer insight into community hospital admissions in one healthcare locality. The local profile of the interviewer assisted recruitment, but had the potential to influence responders. This concern was raised at feedback meetings, but we were assured that responders did not consider this to have been an issue. We believe that the advantage of access to responders and the additional insights and informality that the researcher's familiarity provided outweighed any effect on data collection. Perhaps more importantly, the fact that both researchers were GPs may have led to a narrow or medically focused analysis being presented. This is for the reader to judge in the light of the research question.

The transferability of the findings is limited by the single rural Scottish setting studied, but no comparable qualitative studies investigating this topic were found on literature review. Therefore, we suggest that the findings of this study offer the best available insight into this process in the UK as

a whole.

Understanding how GPs utilise community hospitals is crucial, as their support and participation is required to develop intermediate care facilities to their full potential. Previous studies have endeavoured to understand referral to secondary care, but intermediate care systems have received little attention.<sup>9-11</sup> Dowie developed a model of referral decision making under three headings: professional attributes, personal style, and knowledge of the healthcare system. This model was based on conflict resolution, in which the referral decision emerges as a consequence of the coping pattern adapted to deal with uncertainties of a particular patient.<sup>12</sup> Newton *et al* agreed that psychological factors are integral to decision making, but argued that social and cultural variables also have a role.<sup>10</sup> Wilkins and Smith recognised that referral was a complex process which involved interaction of both social and psychological factors.<sup>13</sup> In the community hospital setting, where practitioners may elect to retain or discharge clinical responsibility, it was found that both psychological and cognitive factors were clearly involved.

The data supports the concept of 'comfort' in the decision making process as important for most practitioners, particularly as the medical challenge increases. Such a determinant is clearly similar to Dowie's model, in which the satisfactory resolution of conflict is necessary for the referral decision to be made. The recognition of 'comfort' and hence 'discomfort' in medical decision making is not a new one. Bradley studied critical incidents and identified the phenomenon of discomfort in general practice prescribing decisions.<sup>14</sup> He found complex decision making and the occurrence of discomfort almost universal. In contrast, our responders described everyday situations in which they often saw the decision as simple and comfortable. The complex decisions were case-specific and dependent on the nature of the care required and the perceived balance of potential benefits to the patient, professional concerns, and personal influences. It is interesting that the end result of this balancing act is reflected as a feeling, implying that the psychological component of this process may be more pervasive than we like to acknowledge. The picture is of a multi-factorial, idiosyncratic admission process that allows the more committed practitioners to offer extended services while others operate comfortably within their own competencies.

The processes described appear to be related to current thinking in complex systems theory.<sup>15-16</sup> This would suggest that it is the outcome of the adaptation and interaction of the factors involved rather than the factors themselves which are important. These interactions are non-linear, such that small causes may have large effects; for example, a patient who did not like the way she was handled on a previous admission refuses to be admitted to the same hospital on a future occasion. Such interactions and complexities highlight the problem of trying to understand the process only in terms of its component parts. It emphasises the need for further research.

Ramaiah suggested that for community hospitals to have an increased role, they need to be more effectively managed.<sup>17</sup> However, this may conflict with the existing system, which is governed by the practitioners themselves.

Reducing their control may induce 'discomfort' and dramatically reduce the enthusiasm and professional satisfaction that currently maintains this work. Those developing intermediate care services around community hospitals need to take account of the factors that influence practitioners' perceived comfort with their role. If the types of patients managed in community hospitals are to change, then specific training and ongoing support, recognising these factors, is required.

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