Do general practitioner attitudes and characteristics of their practices explain patterns of specialist referral?

Martin Roland, Jeremy Grimshaw, Richard Grol, David Shanks, Anthony Johnson, Ian Russell, Ross Taylor

Objectives: To describe attitudes of general practitioners to their work, and to relate these to characteristics of their practices and to rates of specialist referral.

Methods: Data were collected from 109 Scottish general practitioners. Questionnaires were used to measure doctors' perceptions of their responsibilities, their tolerance of uncertainty, their perception of benefits resulting from specialist referral, and perception of the incidence of a range of conditions which might require specialist referral. Rates of specialist referral were measured prospectively over a one-year period.

Results: There was wide variation in the responses to all questionnaires. More developed practices (e.g. computerised, with access to hospital beds) reported a greater sense of responsibility for the care of their own patients, and perceived less benefit from specialist referral. Doctors who perceived serious disease as relatively uncommon and those who saw themselves as responsible for a wide range of conditions referred fewer patients to specialists. Doctors working in practices which conducted regular audits and those who had access to hospital beds also referred fewer patients to specialists.

Conclusions: Attitudes of general practitioners to their roles, and the types of practice in which they work, are related to their use of hospital specialists. If, as in the UK at present, general practitioners take an increasingly restricted view of their 'core responsibilities', this could increase the numbers of patients referred to specialists. However the results of this study are also consistent with the view that, given appropriate practice development, general practitioners could carry out a greater proportion of work which is currently referred to specialists.


Introduction

There is wide variation in the rates at which individual general practitioners refer patients to specialists. Although some of this variation is due to chance, previous research suggests that some of the variation in individual doctors' referral behaviour may be related to their work satisfaction, their willingness to take risks, their individual clinical skills, their response to pressure from patients, and the context in which the referral decision is made. In most studies it has not been possible to explain more than a modest proportion of the variation in terms of characteristics of the doctors, their practices, or their patients.

In many countries, it is policy to move a greater proportion of care from the secondary sector to primary care. The success of such moves may depend on the willingness of general practitioners to take on new roles. In the UK, increasing movement of care from secondary to primary sectors has led to conflict between general practitioners and the government about the tasks which should be carried out in general practice. The attitudes of general practitioners to their roles and responsibilities is an important factor which will need to be taken into account. Better understanding of these attitudes will help to improve the organisation of care at the interface between primary and secondary care.
The aim of this study was to describe three sets of general practitioners' attitudes and beliefs about their work, and to identify areas for improvement. The results indicate that there is widespread dissatisfaction with the current system of primary care in the United Kingdom. The survey also revealed that many GPs feel overworked and underpaid, and that the workload is not evenly distributed among practitioners. The study suggests that there is a need for more resources to be allocated to general practice, and for better support to be provided to GPs. The results of the survey have been disseminated to local government and national government, and have been used to inform policy decisions. The study also highlights the need for further research into the factors that affect the quality of care provided by GPs, and the need for better training and support for GPs. Overall, the study provides valuable insights into the current state of general practice in the United Kingdom, and identifies areas for improvement in the future.
to describe the relationship of these attitudes to practice characteristics and to their use of specialist services. The first attitude measured was the general practitioners’ perception about which tasks were truly the GP’s responsibility. Views on this are known to vary both within and between European countries: the debate about what are appropriate tasks for general practitioners to carry out is a key part of the development of general practice in Europe. Secondly, we examined the general practitioners’ tolerance of uncertainty and their perceptions of how commonly a range of serious diseases occur. Management decisions in general practice are often taken under conditions of uncertainty and response to uncertainty may influence both patterns of referral and investigation. Differences in the ways in which generalists and specialists react to uncertainty, and how this is influenced by their perception of the risk of missing serious illness forms an important part of the training of young doctors as generalists. Third, we included a measure of the benefit that they believe results from specialist referral. A doctor’s decision to refer is based both on his own assessment of the problem, and on external influences such as pressure from the patient. We hypothesised that the doctor’s own view on the benefit to be gained from referring a variety of conditions might explain differences in patterns of referral.

Methods
This research was undertaken as part of a study of referrals for four tracer conditions (back pain, varicose veins, menorrhagia and dyspepsia) which was part of a quality a sample of general practitioners in Grampian, a geographical region in the North East of Scotland. It therefore offered the opportunity to study referral behaviour in general, as an addition to the original study aims.

Regionwide surveillance of referral letters over a 15-month period in 1990/91 captured 92% of NHS referrals without systematic bias. General practitioners referring more than two patients with tracer conditions during the first four months of data collection were eligible for the main study, and were also asked to complete the questionnaires reported in this paper. In the UK, each general practitioner provides care for a defined ‘list’ of patients, so for all doctors, we calculated rates of referral based on total number of referrals during the period and the average list size in each practice. In addition, for 51 (47%) doctors, data were available on the actual number of consultations carried out by each doctor during the study period: for these doctors we also calculated a rate of referral based on their workload, i.e. the number of consultations carried out.

Data collected about general practitioners included their age, previous hospital appointments, qualifications, clinical interests, outside appointments, and medical committee membership. Details were also collected of practices, including numbers of partners, attached staff, access to services, responsibility for hospital beds or accident and emergency care, and involvement of the practice in teaching, training, audit, research, and developing clinical protocols.

GPs’ perception of their responsibilities was measured using the questionnaire shown in table 1. This was derived
from a questionnaire used previously with Dutch and British general practitioners. The questionnaire used to measure tolerance of uncertainty was one which had been used on Dutch, British and Belgian general practitioners, with the addition of two questions relating to specialist referral (appendix). This questionnaire was interpreted by its authors as measuring the extent to which doctors were prepared to take risks in the face of clinical uncertainty.

To measure perceived benefits from hospital referral, a questionnaire was developed which asked how much benefit the GP thought would result from referral of 12 conditions to hospital. The conditions and scale are shown in table 2. To estimate the perceived incidence of conditions which might require hospital referral, GPs were asked how frequently they thought an average general practitioner would encounter the 11 conditions shown in table 3. Conditions chosen ranged from common to very rare, and were ones which might be expected to result in specialist referral.

**Statistical methods**

Scores on individual items on each questionnaire were summed to give an overall score. The summed scores for the scales were all approximately normally distributed. Analysis of variance was initially used to compare the mean scores of psychological variables, entering doctor and practice characteristics as factors in the analysis or as covariates for continuous variables. Stepwise multiple linear regression was used to relate doctor and practice characteristics to number of referrals made. We used the number of referrals made as the dependent variable in each regression analysis, with denominators (list size or number of consultations) as independent variables in the regression equation. The psychological and practice characteristics were introduced as additional independent variables. Cumulative probability plots of studentised residuals were inspected to check the assumptions of normality in the regression analyses. The abbreviation "CI" refers to the 95% confidence interval.

**Results**

One hundred and eighteen general practitioners (36% of all Grampian general practitioners) referred more than two patients with tracer conditions during the first four months of the study and were eligible for further study. In total, 114 (97%) doctors agreed to participate and were sent the attitude questionnaires, 109 (92%) of which were returned.
Table 4. Multiple regression analysis: associations of GP and practice characteristics with numbers of patients referred.

<table>
<thead>
<tr>
<th>I. Denominator=workload (n=51)</th>
<th>Regression coefficient</th>
<th>Standard error</th>
<th>Significance level</th>
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<tr>
<td>Number of consultations</td>
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<td>0.023</td>
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<td>Perceived incidence of serious disease</td>
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<td>Adjusted multiple r²=0.37</td>
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<table>
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<tr>
<th>II. Denominator=list size (n=104)</th>
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<td>Perceived incidence of serious disease</td>
<td>-4.8</td>
<td>1.5</td>
<td>0.0016</td>
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<td>Regular clinical audits</td>
<td>54.8</td>
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<td>Extent of GPs= responsibilities</td>
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<td>Adjusted multiple r²=0.20</td>
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Appendix
Questionnaire to measure tolerance of uncertainty.
(Statements 1-5 from Grol et al)

Respondents recorded agreement/disagreement with the following statements on a five-point scale:
- When in doubt it is preferable to refer to a specialist than to wait and see.
- A GP must not take any risks with physical illness.
- As far as physical complaints are concerned, a GP should do everything possible to find out the cause of the complaint.
- A GP must prefer the certain to the uncertain.
- As a GP, you must always be aware that each complaint can be the start of a serious illness.
- GPs should be more prepared than other doctors to be uncertain about a diagnosis.
- In general practice, treatment often has to start without a clear diagnosis.

Items were scored 1 (strongly agree) to 5 (strongly disagree), except items 6 and 7 which were scored in the reverse direction.

Referral data were available for 104 (88%) doctors.

I. Extent of general practitioners' responsibility
The responses to this questionnaire are shown in table 1. Doctors believed that they should have a wider range of responsibilities if they came from practices having responsibility for hospital beds (mean score 45.9 (beds), 50.8 (no beds), CI of difference=1.4-8.4, p=0.001), or if they worked in computerised practices (mean score 48.3 (computerised), 56.2 (not computerised), CI of difference=1.9-13.9, p=0.004).

II. Tolerance of uncertainty
Using scores on the tolerance of uncertainty scale in the appendix, trainers were more tolerant of uncertainty (mean score trainers: 24.1, non trainers: 21.1, CI of difference 2.3-3.7, p=0.017), as were doctors who saw smaller numbers of patients each week (p=0.002).

III. Perceived benefits from specialist referral
The responses to this questionnaire are shown in table 2. Doctors in computerised practices perceived less benefit from referral (mean score computerised: 36.6, not computerised 40.5, CI of difference=0.5-7.3, p=0.009).

IV. Perceived incidence of serious illness
The responses to this questionnaire are shown in table 3. There were no significant relationships between responses to these questionnaires and any of the available doctor or practice characteristics.

V. Associations with rates of referral
Rates of referral varied from 61 to 344 referrals per 1000 patients per year, and for those 51 general practitioners whose workload data were collected, from 1.6 to 7.8 referrals per 100 consultations. In the multiple regression analysis, there were significant associations between numbers of patients referred, two of the questionnaire scores and two practice characteristics.

With workload as a factor in the multiple regression analysis, available for less than half the sample, numbers of referrals were significantly related to the number of consultations, to the practice having responsibility for hospital beds, and to the perceived incidence of serious disease (table 4). The proportion of variance in numbers of patients referred (adjusted multiple r²) was 0.24 for the number of consultations alone; this increased to 0.37 with the addition of the practice- and doctor-related variables. Rates of referral were 3.5 referrals/100 consultations in practices with access to beds (37% of practices in this predominantly rural area) and 4.2 referrals/100 consultations in those without access to beds. The unadjusted mean scores on the perceived incidence of serious illness scale for doctors with referral rates in the top and bottom quartiles were 36.6 and 39.9.

In the analysis using list size as the denominator, doctors who perceived serious illness as relatively uncommon had lower rates of referral to hospital, as did doctors who saw themselves responsible for a wider range of conditions, and those working in practices which carried out regular clinical audit (table 4). The unadjusted mean scores on the perceived responsibility scale for doctors with referral rates in the top and bottom quartiles were 50.9 and 47.5. Unad-
References

1. 1994:11:9-14
2. Reference continued on page 151

(Continued)

References

1. 1994:11:9-14

References

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References

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Discussion

We have shown relationships between areas of referral and

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<tr>
<td>p-value</td>
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<td>&gt;0.05</td>
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</table>

In practices which reported using clinical protocols

* P = 0.007, * P = 0.001

31.1% and 14.9% for referrals in primary care respectively. Regular attendance was more common than

mean values of referrals for practices with and without

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