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

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Objective: 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.

The aim of this study was to describe three sets of general practitioners’ attitudes and beliefs about their work, and to identify possible problems or areas for improvement. The study was designed as an anonymous postal survey of a representative sample of general practitioners in the United Kingdom. The survey was conducted as part of the Royal College of General Practitioners’ (RCGP) National Survey of General Practice, which is a regular and ongoing quality assurance initiative. This study required the accurate identification of specialist referrals across all conditions that general practitioners may encounter. The results of the survey have been used to inform policy and practice in general practice.

Table 1. Perceived extent of general practitioners’ responsibility* (figures are % of 109 doctors).

<table>
<thead>
<tr>
<th>Extent to which task is the responsibility of the GP</th>
<th>5 (Not at all)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1 (Totally)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insertion of an intra-uterine device</td>
<td>1</td>
<td>3</td>
<td>12</td>
<td>28</td>
<td>57</td>
</tr>
<tr>
<td>Diagnosis and treatment of varicose ulcers</td>
<td>3</td>
<td>5</td>
<td>13</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Diagnosis and treatment of duodenal ulcer</td>
<td>2</td>
<td>5</td>
<td>13</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Evaluation of pulmonary function using peak flow and spirometry</td>
<td>2</td>
<td>5</td>
<td>13</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Diagnosis and treatment of nocturnal enuresis in a six-year-old child</td>
<td>2</td>
<td>5</td>
<td>13</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Management of chronic depression</td>
<td>0</td>
<td>4</td>
<td>13</td>
<td>57</td>
<td>23</td>
</tr>
<tr>
<td>Fundoscopy</td>
<td>2</td>
<td>12</td>
<td>29</td>
<td>54</td>
<td>8</td>
</tr>
<tr>
<td>Use of dithranol for psoriasis</td>
<td>4</td>
<td>8</td>
<td>33</td>
<td>44</td>
<td>11</td>
</tr>
<tr>
<td>Treatment of vaginal prolapse with a pessary</td>
<td>6</td>
<td>13</td>
<td>30</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Wedge resection of an ingrowing toenail</td>
<td>8</td>
<td>13</td>
<td>31</td>
<td>24</td>
<td>24</td>
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<tr>
<td>Diagnosis and treatment of alcohol addiction</td>
<td>2</td>
<td>13</td>
<td>39</td>
<td>40</td>
<td>6</td>
</tr>
<tr>
<td>Interpretation of an ECG</td>
<td>5</td>
<td>20</td>
<td>46</td>
<td>26</td>
<td>4</td>
</tr>
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<td>Aspiration of knee effusion</td>
<td>13</td>
<td>28</td>
<td>30</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>Treatment of insulin dependent diabetes in adults</td>
<td>7</td>
<td>37</td>
<td>42</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Diagnosis and treatment of hyperthyroidism</td>
<td>11</td>
<td>31</td>
<td>40</td>
<td>14</td>
<td>5</td>
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<tr>
<td>Assessment of hearing loss in an eight-year-old</td>
<td>14</td>
<td>39</td>
<td>30</td>
<td>13</td>
<td>5</td>
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<tr>
<td>Intra-partum care</td>
<td>24</td>
<td>27</td>
<td>30</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Intra-ocular pressure measurement</td>
<td>37</td>
<td>32</td>
<td>21</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>

* The rows in tables 1, 2 and 3 are ordered to demonstrate the approximate frequency with which responses were given, not the order of the statements in the original questionnaires. These are available from the authors.
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 assurance study. 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 atti-
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 where 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 auditing (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


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Acknowledgements

Work which is currently referred to specialists.

The results of this study are also consistent with the view that given appropriate practice development, even if the number of patients referred to specialists increases, we used an analysis of self-referencing. Equally, even though general practitioners with access to beds referred fewer patients than those without, it does not follow that their care was worse.

The number of patients referred to specialists with access to beds referred fewer patients than those without, it does not follow that their care was worse.

Doctors who perceived sessions disease as occurring frequently.

Discussion

We have shown relationships between areas of referral and general practice. We have also identified a number of characteristics of practices and general practitioners reporting rates of referral greater than 30%.

By reported in primary care, patients who were more commonly referred to regular general practitioners. Regular general practitioners were more common and our regular regular general practitioners were 131 and 149 referrals/1000 patient visits.