

A new role for the general practitioner? Reframing 'inappropriate attenders' to inappropriate services

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This qualitative study describes the impact of deploying general practitioners (GPs) as primary care physicians (PCPs) in three Accident and Emergency (A&E) departments in Greater Manchester as part of a Health Action Zone initiative to promote integration of systems of care more responsive to the needs of inner city population groups. The setting was three Accident and Emergency Units in Greater Manchester. Semi-structured interviews with the PCPs and key A & E staff (n = 32) before the PCPs were deployed, then at intervals throughout the project. Interviews were audiotaped and transcribed. Transcripts were analysed using constant comparison to identify emerging themes. Key themes centred on the assumptions and negotiation surrounding the emerging roles of the PCPs (as seen by themselves and other staff), particularly the conflict between operational (day-to-day work with patients) and strategic (forward planning) roles. The PCP appeared to act as a catalyst for the view that patients were not presenting "inappropriately", rather, the problems presented at A&E might be best dealt with in different parts of the healthcare system, or by different personnel, and it is the service currently available that is inappropriate. By deploying the GP in a new role as PCP, but with the traditional autonomy associated with being a GP, and allowing him/her to develop the role according to local need, the new service evolved to identify and meet the needs of patients more appropriately. The use of the expanded role of the GP may be more successful in achieving 'joined-up' services than deploying other professional groups, such as nurses, to fulfil a specific role.

Key words: A&E units; inappropriate attenders; primary care physicians

'Where this piece fits'

What do we know?

Patients attend Accident and Emergency (A&E) units with problems that A&E staff label as 'inappropriate'. Previous initiatives, putting general practitioners in A&E, have failed to alter patient behaviour.

What does this paper add?

Deploying general practitioners (GPs) within A&E challenged the ways that ideas about what kinds of patient are *appropriate* or *inappropriate*, and highlighted how the label of 'inappropriate attenders' is constructed by health professionals working there. The primary care physician (PCP) role provided the opportunity for GPs and other health professionals to begin to view and reconstruct their role in a way which fits a more systemic way of conceptualising appropriate and inappropriate demand, thus providing a service to meet the needs of the local population.

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Introduction

A common perception in the NHS is that some patients present to A&E departments due to inappropriate referral, either by the patient or GP (Cohen, 1987), and would more suitably be managed in the community (Dale, 1992; Murphy, 1998a). Consequently, solving the 'problem' of inappropriate attenders is seen as making a potentially important contribution to reducing the load on A&E. Whilst in the past a 'victim blaming' approach to defining inappropriate use of services was evident in the literature (Rogers *et al.*, 1998), this has been tempered recently with a growing recognition that if the right alternative services were in place then inappropriate referrals to A&E could be reduced (Henser *et al.*, 1999; Murphy, 1998b). In this paper, we describe the results of an initiative that initially intended to reshape this 'inappropriate demand' by deploying general practitioners in A&E departments to deal with primary care problems where these arose. The paper reports on the way in which this new role for the GP was constructed and negotiated between different parties in three hospitals in the Greater Manchester area.

The long standing concern with 'inappropriate demand' has tended to centre on services which patients have discretion and freedom in accessing – hence the particular concern with the use of A&E (Rogers *et al.*, 1998). However, the idea that a significant proportion of people seeking help in A&E do so inappropriately is itself problematic and the notion of inappropriate demand for health care is a contested one. It is shaped by both the policy environment and professional perspectives (Rogers *et al.*, 1998). Previous research suggests a complex set of processes, including past experience of illness management and prior contact with services are involved in the generation and sustaining of demand and help-seeking for primary care services (Rajpar *et al.*, 2000; Rogers *et al.*, 1998). Additionally, inappropriate referrals seemingly result from inability of patients to access services 'out of hours' (Carlisle *et al.*, 1998), other perceived deficiencies in primary care services (Murphy *et al.*, 2000), lack of availability of supporting services (Driscoll *et al.*, 1987; McKee *et al.*, 1990) and a lack of co-ordination between services provided by different agencies (Green and Dale, 1992; Reilly, 1981). Given the uncertainty presenting illness poses for diagnosing physicians,

and that lay people's judgements are based on symptoms, attributions of 'inappropriateness' can usually only be made in retrospect (Rogers *et al.*, 1998). As a result of this, various lay policy and professional meanings have become attached to and shaped the notion of appropriate and inappropriate demand.

In the past, it has been difficult to address these problems (Cohen, 1987; Murphy, 1998a). Despite evidence that demand (inappropriate or otherwise) is in large part generated by physicians themselves (Armstrong *et al.*, 1990), and that 'appropriateness' is part of a negotiated process operating at the level of the doctor-patient interaction (Kunamaki and Kokko, 1995), the portrayal of inappropriate demand has been dominated by a view of the problem lying with individual patients or with another part of the health care system. In addition, different professionals may be using different criteria of 'appropriateness'. Inappropriate demand for A&E services is frequently seen as appropriate demand for primary care services (Elston and Holloway, 2001), thus solutions to this perceived problem may be approached through primary care. Negotiation of what constitutes appropriate demand for treatment and care also occurs at the boundaries between primary and secondary care and between different specialities within the NHS (Rogers *et al.*, 1998). The latter focus constitutes the concern of the current study.

The study: The primary care physician in A&E

The contemporary political context of clinical governance within PCG/Ts, the new NHS plan (Department of Health 2000) with its aim of improving access, and the evolution of NHS Direct (McInerney *et al.*, 2000), all offer a new climate and expectations about how to address access and responsiveness to health problems. The initiative discussed in this paper, funded by the Manchester, Salford and Trafford Health Action Zone (HAZ) was directed at providing an integrated service response to so-called 'inappropriate' attendance at A&E units. The project involved the appointment of three local general practitioners to work as 'primary care physicians' (PCPs) in three A&E departments in Greater Manchester. Two A&E units were in District General Hospitals and one

was in a major teaching hospital. The PCPs were employed for two years starting in Spring/Summer 2000. Each PCP was employed for four sessions per week with a remit to assess how these sessions should be best deployed after consultation with the A&E staff, and with the aim of assessing and dealing with the problem of so-called 'inappropriate' attendance in the A&E units. The PCP at each site worked with the A&E Unit to choose the times of the sessions. Initially the times were chosen mindful of the initial aims of the study to address the perceived problem of 'inappropriate attenders' and sessions were timetabled at busy periods, particularly evenings and weekends.

When the change in emphasis of the study became apparent (with feedback of themes from interview data and observational data) at the three sites, the session times changed to suit the new requirements of the strategic role.

The aim of the study reported in this paper was to develop an evaluative investigation designed to achieve a comprehensive understanding of the impact of deploying primary care physicians to respond to so-called 'inappropriate' A&E attenders whose problems may well have been more appropriately managed elsewhere.

Methods

Semi-structured interviews were carried out with the PCPs before the start of the project and planned at two to three monthly intervals over the two years of the project. Semi-structured interviews with key staff (including medical staff from consultant to senior house officer (SHO) grade, nursing staff and nurse managers) in each A&E department were carried both before and planned at regular intervals for the duration of the project. A total of 58 interviews were conducted with 32 different personnel.¹ Some individuals (for example SHOs) were only interviewed once, whilst others (for example the PCPs, consultants and nurse managers) were interviewed up to four times. The interviews lasted for between 15 and 90 minutes. Each interview was audio-taped and transcribed. The transcripts were analysed by constant com-

parison (Strauss, 1986) with interview schedules being modified to further explore the emerging themes. Interpretation and coding of the qualitative data was undertaken by CCG, AR and EB: the transcripts were coded individually, then through discussion to achieve agreement on the meaning and interpretation of data.

Results

The results of our qualitative analysis fall into two intimately connected themes. First, we explore the ways that the PCP role was developed in interaction with other staff in A&E. Secondly, we explore the areas in which the PCP acted as a catalyst for changed views and practices around ideas about 'appropriateness'.

The emergent role of the primary care physician

Whilst in principle the role of the GP had been sanctioned by the HAZ, in order to be incorporated as a valid contributor in the A&E department, the PCP's role had to be negotiated with a number of 'stakeholders'. This was important in establishing the legitimacy of their work. The perceptions that the PCP had of themselves and their role, and the perceptions of key staff in A&E of the PCP project and individual, were key influences in establishing workable and acceptable arrangements for establishing the project. The need to arrive at some sort of consensus about the nature and response to inappropriate attendance was matched by the necessity of incorporating the role of the PCP within the organizational and structural arrangements operating within each A&E unit. There was initial uncertainty about the role of the PCP:

A&E Sister, site 1: I think it has to be different to some degree, but how? Obviously an integrated part of the team, and for everyone to know.

(pre-project)

An ambiguous role was attributed to the PCP (and by the PCP her/himself) reflecting, possibly, the initial lack of clarity in the remit outlined by the HAZ.

The position of the PCP as part of a team was deemed vital by many respondents:

¹ The funding from one site was withdrawn before the planned finish of the project due to local reasons.

Consultant 1, site 3: . . . she's very quickly assimilated herself into the team and has become a valuable member of the team.

(start of project)

Others, however, felt that they should not be seen as an ordinary A&E doctor:

Consultant 1, site 1: . . . I don't mind if we kit the person out in greens, but I think it would be advantageous if they actually looked different, that they looked like a GP. . . it would be very easy for them to slip into the role of being an extra Cas[ualty] doctor, I hope they don't, but I can see them doing it at busy times. (pre-project)

The need to develop the role was stressed:

Consultant 2, site 2: I think there will certainly be overlap, but as it goes on, I would like to see him develop more of an independent role, if he doesn't, then all we are saying is 'just buy another, extra, pair of hands', and I don't want that. I want somebody who can actually create something.

(Interview 1)

The views of the key A&E staff varied along a spectrum between those who thought the PCPs should be seeing so-called primary care patients and those who felt the strategic role was much more vital:

Consultant 1, site 2: Working out, in their opinion, how much primary care stuff comes through the department, at all times, not just when they're on duty. And, perhaps, attacking, or trying to manage, whichever way you want to put it, at least one group of patients that comes, the one they think they're going to start with is the frequent attenders.

(pre-project)

Consultant 1, site 2: forget the patients as individuals, tackle the problems, then all the patients will know it's working. This project seems to have that kind of flavour.

(Interview 2)

The PCPs shared the uncertainty about their role:

PCP, site 2: The problem is, PCP is, what people see you as, really. You are, if you are,

you're seen as a GP working in Cas by nurses and doctors. (Interview 2)

The PCPs did agree that their time had to be deployed in a different way to previous initiatives:

PCP, site 2: I think there is a remit in A&E for primary care, not in the way it's been done in other departments. (pre-project)

There was a tension between the need to have an operational role, being seen to be working during their time in A&E, as well as a strategic, planning role:

PCP, site 1: But it might be that, take them out of seeing patients and have them in a small, strategic, managerial role, around organizing and expertise and input, around sort of structuring the services, but again, is that appropriate for using? (Interview 2)

PCP, site 2: now that is an individual case study, so she, individually benefited by accident, from seeing me, because I'm me. Because I'm a GP. Now, that actually changed the way the whole post-coital contraception is given in the department. For ever. Because now they get the updates from the family planning association, given directly to their prescribing supervisor. So, forever now, they will get that.

(Interview 3)

Whilst there was a consensus over the conceptualisation of the problem and the need for the integration of the PCP within existing organizational arrangement operating within the A&E department, differences emerged over the expectations and feasibility of what the PCP could achieve. An important facet of the PCP in A&E scheme was felt to be the potential for a liaison role between primary and secondary care, health and social care, a way of integration of services as identified in the NHS plan (Department of Health, 2000).

HAZ Director: I think the different departments will use it in different ways. There is a significant potential for liaison with other areas, but I think we have to be looking creatively using voluntary sector as well far more. So I would see it being a much broader approach which as I say, I think the GPs

we're putting into these posts should have the breadth of approach to actually do that.
(pre-project)

Consultant 1, site 2: His role is about linking with absolutely everything, and, you know, interestingly, we have already volunteered him to some groups within the hospital which have a community base, things like the management of head-injured patients, and the bed management group.
(Interview 1)

For the PCPs, whilst they recognized this potentially important role, how it would work in practice, particularly in the management of individual patients, was a difficult proposition:

PCP, site 1: I think a lot of it is going to be around developing relationships, communicating not just with GPs but voluntary sector, social services, education, local authorities, building up relationships for the department, building up a resource so that, when, it [*the project*] is only to be there for two years, but if there's a problem that presents, a patients presents with a certain problem, that you could be a resource file and say that this is best managed by accessing this service.
(pre-project)

The PCPs came to see their role, not as being about the management of individual patients, not about being seen in the A&E units 'taking the next patient who should have been seen by their GP' (PCP site 3, Interview 3), but about creating links between the generic services in the locality. The operational role was seen to be less important and the PCP's work subtly changed within the hospital trusts. Their work became increasingly about forward planning and strategy, and less about day-to-day patient contact.

The value of PCPs in A&E: Inappropriate attendance versus inappropriate service delivery

However difficult and diffuse the business of negotiating the professional role and purpose of the PCP was in practice, there is no doubt that it had an effect on the ways that primary care problems came to be seen by A&E staff. There was a widespread feeling, at the start of the project, that the problem to be tackled was, indeed, that of those

patients who were attending A&E 'inappropriately'. Respondents agreed that patients were presenting to A&E who might be dealt with instead by primary care:

PCP, site 3: Most of A&E is primary care in a non primary care setting.
(Interview 2)

A&E staff seemed to suggest the need for a systematic plan to deal with this group of attenders:

Consultant 1, site 1: I think the one thing I would like it [*the project*] to achieve is to have a sort of plan of action as to how to address the problem of frequent attenders.
(pre-project)

There was, however, discomfort with the use of the term 'inappropriate' from key A&E staff as well as the PCPs. This undermined the dominant assumption that the problem of inappropriate attendance lies with the patient:

Nurse manager 1, site 1: I think people used to use the term 'inappropriate attenders' but if you're in pain and, you know, there's nobody available, you're uncomfortable and especially if it's the middle of the night, then I don't think it's inappropriate, you know, if you're looking for help, and we're here, so ...
(Interview 1)

Staff seemed more willing to 'forgive' attendance at A&E by the patient, realising that this might be the only practical option for the patient.

In two of the sites, it might have been thought that lack of access to a GP would have meant more patients attending A&E. The third site was well-served by GPs (both in terms of numbers, low list sizes and practice opening times). As stated above, however, the perceptions of hospital staff and the HAZ that it was patients who acted inappropriately soon became reframed into a broader view that it was the services that needed to adapt to meet the needs of patients, and it was the PCP who could provide the much-needed link between primary and secondary care. There was a shift away from the view that individual patients were 'inappropriate' to a focus on the system and service deficiencies indicating a view that it was rather, the current services available that were 'inappropriate':

Consultant 1, site 3: I feel if a patient comes here it's appropriate for us to see them. But

I think there are general categories of patients whose needs are better served by other services. (Interview 1)

PCP 1, site 1: But again, sort of very few of them [*patients*] are inappropriate attenders, but it's probably inappropriate use of medical staff to actually deal with these minor injuries. (Interview 2)

Recognizing that the patient was not the problem was important because it allowed the PCPs and the A&E units to identify with the previously criticized loose aims of the HAZ proposal and allow the project to develop differently in the three sites:

Consultant 1, site 2: I think the chances of one person working four sessions having a massive influence on patients is unlikely. The best response you can get from that is for them to say 'yes, this individual you should know, er, but isn't there something we should be doing around guidelines or protocols or setting up systems to deal with this kind of patient and how you can help them. That is what I want to get out of it. (Interview 1)

The PCP in each site developed a role in teaching junior hospital staff, both doctors and nurses, which was pivotal in encouraging change in attitude:

SHO site 2: ... so he's helped us, with the debriefing sessions, to look at the bigger picture, to see the patient in the context of the family and community. Something that hasn't been emphasized before. (Interview 3)

A&E staff came to embrace the project with reference to the legitimacy and context of their own services and adherence to a systematic approach, rather than focussing the problem as one to do with individual patients. In contrast to previous studies of clinicians' views of inappropriate attenders, the respondents abandoned the notion that the individual patient was at fault for contacting the 'wrong' service. Rather, they framed their role according to an expanded view of primary care which they could fit into:

Consultant 1, site 2: Rather than just put a primary care physician in A&E and let him see primary care patients, why don't we put

somebody in who understands primary care, who can tackle the problems. Forget the patients as individuals, tackle the problems and then the patients will know it's working. (Interview 3)

What was crucial about this project, therefore, was that it *changed the ways that attenders were defined* and undermined the boundaries between appropriate and inappropriate presentations. A&E staff began to see appropriateness as a characteristic of services rather than of patients. Investment by the PCPs in establishing their role as legitimate, and their field of medicine as *patient-centred* meant that primary care patients presenting in A&E came to be understood as part of an under-served community of service users, rather than as individuals who were culpable for misusing A&E services:

Nurse manager Site 3: She's working with the PCT ... to look at out-of-hours care ... she understands primary care in a way we don't, she can get the ears of the local GPs in a way we can't. I respect her for that. (Interview 3)

This was a key shift in thinking across the range of A&E professionals. This shift, we believe, came out through the presence of the PCP working closely with the A&E staff.

Discussion

This initiative arose from the notion that patients presented to A&E departments with problems which might be more appropriately dealt with by a different service (Cohen, 1987; Henser *et al.*, 1999; Murphy, 1998a; 1998b). The starting assumption was that by deploying a GP-trained doctor (the PCP) within an A&E unit, patterns of patient help-seeking behaviour might be altered.

From the outset of the initiative, it was notable that the traditional perspective of the 'problem' of 'inappropriate attendance' came to be defined differently. The fact that this was a strategically directed initiative by the HAZ was significant. Health Action Zones were established as a key aspect of the Governments approach to health care policy which targets attention on the totality of services and influences on health in a specific

geographical locality. Aspirational features of Health Action Zones include the principles of partnership and cooperation and achieving a 'seamless' service (Powell and Moon, 2001). The Health Action Zone with its brief to promote innovative ways of working and ostensibly remove barriers that prevent agencies working positively together, in this instance, clearly offered a new opportunity to address and re-define a traditionally identified problem. Directed 'top down' catalyst for change has been accompanied by and is likely to have been reinforced by the extension and expansion of the traditional role of the GP. For example, there have been increasing expectations (e.g., through fund-holding arrangements) for GPs to engage with and develop inter-professional working practices (Elston and Holloway, 2001; Surrender and Fitzpatrick, 1999). The lack of consensus in previous models may explain why previous initiatives, deploying GPs in A&E units, did not seem to modify patient attendance patterns. The notion of team working and the legitimacy of GPs as medical practitioners and experts in patient-centredness was also a force for initiating change. It permitted the incorporation of the PCP not only as part of the team, but enabled mentoring and teaching across different specialties to occur, and allowed the PCPs to be accepted by professionals operating outside the immediacy of the primary health care team. Moreover, it was clear that the PCPs' awareness of 'community' and locality issues (which were not evident in the accounts provided by the A&E staff) enabled a whole systems approach to the PCPs' work to emerge in a way which moved the initiative towards examining and tackling factors which lay outside the confines of the A&E departments.

The PCPs were successful in identifying localities where access to primary care is difficult for certain groups of the population. They were able to suggest initiatives which are being taken forward by the HAZ in these areas. The PCP in site 2 took on a major role in discussions about out-of-hours care, the PCP in site 3 took on a major teaching role with both medical and nursing staff. Both these PCPs were given contracts by the hospital trusts once the HAZ funding terminated, a clear indication that the strategic role of the PCP was that which was deemed important by the A&E units.

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Conclusion

Deploying general practitioners within A&E, as part of a wider government initiative to tackle health inequalities through the Health Action Zone Initiative, challenges the ways that ideas about what kinds of patient are appropriate and inappropriate attenders are constructed by health professionals working there. It provides the opportunity for GPs and other health professionals to begin to view and reconstruct their role in a way which fits a more systemic way of conceptualising appropriate and inappropriate demand. This is important in terms of improving the quality of care received by A&E patients. But this kind of initiative also brings into the foreground other, deeply embedded, problems and tensions. We have suggested that these include uncertainty about professional *roles*, and about the *purpose* of new patterns of working. In undermining the notion that the 'inappropriate' patient was culpable in making the wrong kinds of demand on the A&E departments, the work of the PCPs itself became increasingly diffuse and drew attention to the ways that A&E departments themselves serve communities of users as well as individual 'attenders'.

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