but her effectiveness depends on her achieving and holding a balanced relationship with both doctor and patient, and that is a mechanism of the utmost delicacy.

SECOND OPINION BY CONSULTATION

The case for an increase in true consultation within the National Health Service

GERALD F. GREEN, M.A., M.B., B.CHIR., D.M.R.T.
Batley

A load of books does not equal one good teacher (Chinese Proverb)

At this time when discussion is taking place in many quarters into factors likely to improve the standard of medical practice, I should like to put forward the case for a much greater use of the true consultation, as a means of obtaining a Second Opinion.

I believe that an increase in the frequency of such consultations will be of benefit to patient, family doctor, consultant, and the service as a whole. I would define a true consultation as one at which the family doctor and consultant meet to discuss the patient, examine him together and then discuss their findings and decide upon the appropriate course of action.

It is clear that with the increasing complexity of medical science today, the frequency with which accurate diagnosis and control of treatment based entirely on the bedside observations of one man is diminishing, but at the same time his ability to treat is increasing rapidly. The opinion of colleagues in matters of radiology and pathology must be sought ever more frequently. Such an opinion, however, might be classed as an investigational second opinion. The freedom of the family doctor to obtain these opinions is a *sine qua non* of any healthy general practice; without it an efficient service is not possible.

However, when these facilities are available and have been fully utilized, there still remains a large number of cases where the opinion and advice of a colleague is required either upon diagnosis, prognosis, or treatment. It is with these cases (consultative second opinions) that I should like to deal in this paper.

Within the National Health Service the recognized method of obtaining a consultative second opinion is by referral of the patient with a letter to hospital outpatient department where there is no meeting between the practitioner and consultant; and secondly through the domiciliary consultation scheme which applies only to those cases not considered fit to attend the outpatient department, at

these when properly conducted, a true consultation takes place as in our earlier definition.

It will be remembered that the method by which all but the poor used to obtain a consultant opinion was by this type of consultation either in the home of the patient or at private consulting rooms. The outpatient clinic grew up in the voluntary charitable hospitals to arrange specialist treatment for the under-privileged free of charge, and to act as a source of material upon which a wide experience might be obtained for the aspiring and established private consultant.

It is perhaps unfair to take the view that the glorious (if self contradictory) ideal of the best medical attention for all, free at the point of need, within the National Health Service has lead to the almost exclusive adoption of the method reserved previously for the under-privileged.

The true consultation being reserved for those who are prepared to receive this service in the language of the motorcar manufacturer as an " optional extra " at extra cost, this of course with the exception previously mentioned. This is not to infer that all referrals for a consultant's opinion need a full-dress consultation. Many cases especially surgical are in fact sent with a request to treat rather than a request for advice, and apart from a possible loss of self-esteem the patient receives all that his condition warrants.

Let us now consider what are the advantages to all parties concerned in increasing the number of true consultations, as distinct from consultation by correspondence. The parties concerned are the patient, the general practitioner, the consultant, and the service as a whole.

Firstly, let us consider the person for whom the whole apparatus exists, the patient. The days when a patient was content to sit quietly and accept *ex cathedra* statements from his practitioner or a consultant are nearly over. Today, patients are much more widely aware of medical matters, and they are coming to require to know at least some of the rationale behind the advice they receive.

The general practitioner is coming to be regarded in the light of a personal physician to advise and guide the patient, to see, if special treatment or advice is needed, that it is not only obtained but obtained from the person best fitted to the circumstances. The practitioner is therefore expected to choose the consultant who not only by his knowledge, but also by his personality is the one best suited to his patient's needs. Indeed this has always obtained in private practice. How better can this service be demonstrably rendered than by the practitioner introducing the consultant to the patient.

The patient is assured that the details of his case have already been

discussed. He will have confidence that the circumstances surrounding his family or business life will have been considered in the summing-up. He will also feel that a personal relationsoip with the consultant has been inaugurated, and that should it be necessary for him to be admitted to hospital, at least he is known to someone at court. This attention to the feeling of uncertainty and helplessness which many patients feel on admission to hospital is perhaps not fully appreciated by all of those whose whole life is the hospital.

Furthermore, it is quite apparent that all consultants or specialists must pass through a period of apprenticeship as registrars, but it is not always the wish of the patient or his attending practitioner that it should be left to chance who is consulted. If on the other hand it is decided after due consideration that his case is one which is suitable for the registrar, then indeed he, the patient, might gain a little relief in considering that perhaps he is not so bad after all. The patient knows that if the consultant and practitioner meet together to examine and discuss him that they are each going to give of their best, since each will be observing and assessing the other.

Let us also remember that the occasion is likely to be a big one for the patient. He knows that he can ask his own doctor to explain and advise him then and there. He does not, alone in a busy outpatient department, have either the courage or the time to ask those questions which may be uppermost in his mind. He may make his way home in an agony of doubt which will last until he can discuss it with his own doctor. This may be several days later when the hospital letter has arrived. Even then discussion must be limited because the time for discussion is past, the decisions have largely been made.

Let us now consider the general practitioner. What does he stand to gain from a true consultation which will offset the fact that probably an hour or more of his already full day is taken up on one patient? There will be a perceptible tightening up of his own standards of history-taking and examination, since he may be cross-examined and must wish to appear as able as possible, in the eyes of his colleague, to whom the facile answer which might satisfy a layman will show itself in its true light. It is perhaps reasonable to assert that one of the great obstacles to continuing high standards in a general practitioner is that he works alone. He is the sole judge of his skill and conscientiousness in most cases, and it is easy when tired or perhaps not in good health to allow standards to fall a little. It is not so easy to make sure that one has restored them. Any meeting with a colleague, whether consultant or fellow general practitioner, to examine and discuss a patient does help to combat that isolation with its attendant dangers. Furthermore the meeting with a consultant colleague is more than that between doctors, it

has in it much of the relationship of pupil and teacher. It is very probable that the practitioner will learn more of real value from a discussion with a consultant than he is likely to do by reading a text-book or journal. It is (or should be) part of the continuing education of the profession that the practitioner should learn new methods by discussion with the leaders of the profession. Finally, the practitioner will be able to form an opinion about the consultant, not only as a fountain of specialized knowledge but as a man to whom he is to entrust his patients.

Let us now consider whether the true consultation has enough to offer the consultant to warrant the reduction of his " through put " for the day. It is true he receives a modest fee for a domiciliary visit under the National Health Service but I believe he receives much more than material gain. In the present day when specialization begins almost on the day of qualification, it is becoming relatively rare for a consultant ever to have had direct dealings with patients in their own homes. The consultant can learn much of the total patient from observation and discussion with the family doctor in the home. This apart from benefiting the individual patient must lead to a broadening of outlook and empathy on the part of the consultant. He will become better able to understand the problems and personality of the practitioner whose cases he sees in hospital. Thus he may often be able to read much more into the letter about a patient from a doctor whom he knows personally and whom he may well have assessed. He is enabled also to perform the high duty of continuing to teach, which will in itself act as an incentive to his own search for knowledge.

We have now considered the advantage of frequent true consultations to the individuals concerned. Now of the service as a whole. It must of course cost more, but personal service always must. We have shown that an improved standard of practice all round is likely from the frequent meeting of practitioner and consultant. From time to time there are heard stories of outpatient clinics being " log jammed " by patients with whom it would appear the practitioners are too dilatory to deal. On the other side, one hears stories of patients receiving scant courtesy, and even less time in outpatients, perhaps even with injudicious comments on the prior treatment.

Obviously both these abuses, marginal though they are, will become much rarer when both consultant and practitioner know that they will be likely to meet, and indeed the very fact of knowing each other personally will reduce the desire to act in this way.

The health service itself will gain in status because its members—the public—will see that they are indeed treated as individuals.

There will be less tendency to feel that had one paid, one would have received preference either in technical treatment or in more imponderable human matters such as moral support and explanation. This in itself will help to sustain the faith of the public in its doctors, a faith which, though at root still sound, has suffered from the tendency of politicians to score party points out of the teething trouble of the service, and of irresponsible newspapers to magnify out of all proportion every patient's real or imagined grievance.

How can this increased frequency of true consultation be achieved? In the first place by ceasing to restrict the use of domiciliary consultations to patients unfit to travel to hospital; perhaps even some of the monies set aside to improve practice might be used here. Possible abuse of this system is not likely to be a serious factor because the time element will preclude this for the consultant. And it must be a condition that both parties are present at the same time.

Secondly, by opening up certain of the outpatient sessions to patients accompanied by general practitioner. Here again the time factor will preclude frivolous use of this facility.

Thirdly, by allowing, indeed encouraging, senior registrars to take part in the domiciliary consultations and outpatient consultation schemes, both with and without the presence of their chief. This will be a great help to many of these aspiring consultants in that they will gain early much greater experience of both doctor and patient in his natural environment and so facilitate that broadening of experience and wisdom which distinguishes a consultant from mere specialist. It may indeed help to abolish the state of affairs which was epitomized, I believe, by Sir Heneage Ogilvie who recounted an occasion when a man entered an interview a registrar and came out a consultant.

THE CALIBRATION OF DOCTORS

D. BRENNIG JAMES M.B., B.S.
Marlow Common

Common conditions commonly occur, rare conditions rarely occur, but rarities as a group are not uncommon, which puts the doctor in a dilemma since he cannot easily acquire the experience and information required to deal with them efficiently. The answer is of course to pool the knowledge of many doctors and so collect sufficient knowledge to paint a full picture.

This is relatively easy when the diagnosis is clear-cut and straight