SECOND OPINIONS

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Taking a broad and catholic view of general practice, it must be accepted that, young or old, new-fledged or experienced, with the lowest diploma or the highest degree, it is quite impossible for any one of us to practise fundamentally good, comprehensive, modern medicine. Taken at face value, this might be construed as demanding the end of the era of the family doctor, but I hope to show that there lies a way out of this predicament, whereby we may continue to be family doctors in good measure and yet afford our patients a service of very high calibre. The cause of our plight is, of course, the terrifying rate at which we are even now acquiring new knowledge of medical science: new diagnoses, new investigations, a very fantasia of new drugs, and new techniques in medicine and surgery of both mind and body. So much is this so that the time-honoured consultation takes on a new role, and our whole approach to the problem requires urgent reorientation.

There must remain the family doctor; the man or woman to whom our patients may turn in time of trouble, for advice and guidance and peace of mind. And we may well be reminded of the Hippocratic dictum on the physician's threefold task; " to cure sometimes, to relieve often, but to comfort always ". To achieve this end we must know something of everything in medicine, and we must renounce all ideas of knowing everything about anything. It has been stated that in general practice we probably achieve an adequate diagnosis in only about 30 per cent of cases: we may well ask what happens to the remainder? The majority are treated empirically, this majority varying with the individual ability and experience of each of us, but there must always remain a proportion in whom we cannot afford to leave the issue in doubt, and for whom we must seek a second opinion. And this is the primary valid reason for requesting a second opinion; because we do not know.

Not even the most ardent of planners can expect us to present a uniform front of knowledge and technical ability within the ranks of general practice. We are endowed with varying intelligence, which we apply with varying determination, and we have our own personal traits which render us very much individuals in the practice of our art. We approach our work with widely differing philosophies, and we enjoy widely differing facilities within the hospital service. So it is that the problems for which we seek a second opinion show wide differences; in their intrinsic nature (depending largely on our

experience), in their manner of posing (to a great extent dependent on our ability and keenness), and in what we require of the consultant. But in our work we encounter a number of situations in which we can make a firm diagnosis, and in which we know quite well what to do, but in which we are unable to provide proper treatment, because of personal or administrative limitation. In these cases we must again seek a second opinion (the second valid reason for so doing), not because we do not know, but because we cannot do.

There can be very few of us who have never had a patient who requested a further opinion. If we decline such a request we are in a very poor position, as either the patient will find himself someone prepared to sit in judgment over us, and most likely not at all the sort of opinion we would welcome, or we run the risk of having made a serious error and having refused our patient further advice, at a time when it might have changed the course of events. So disagreeable is the situation in either case that we will be wise never to refuse such a request unless it be utterly ridiculous, but to make use of Sir Robert Platt's " retrospectroscope " in trying to discover why the request was made. For it must be accepted that such a request indicates a lack of faith on the part of the patient, and therefore a failure on our part to manage the situation to the best effect. It is a very real part of the art of general practice to anticipate such a situation, to suggest seeking a second opinion, and to observe the subsequent relief in our patient, even if we know ourselves able and equipped to manage such a matter in someone else. The whole difference is a matter of faith; faith that our patients rest in us; faith which we engender by the conduct of our professional lives. If then we fail to afford some patients this modicum of confidence, we cannot but see this as a third valid reason for seeking a second opinion: we know, we can do, but we have failed to win that confidence without which medicine is no longer an art; so we need moral support.

Whom, then, shall we consult? And what may we reasonably expect from the consultation? Here we must cast back in time and then look ahead, for the nature of our consultants is even now changing from that of our fathers', and we must ponder the ways in which we may make the best use of the consultants of the future. For in the past all consultants were men of experience and wisdom, who graduated through long years of general practice, and to whom we could turn as wise men, to be consulted. And while this worked well enough so long as man could learn the bulk of medicine or surgery within his mortal span, the situation has already so altered that no man can possibly aspire to a full knowledge of his art, unless he confine his scope to ever-decreasing limits: and this

tendency is a continuing one, so that Sir Heneage Ogilvie's " one-tool technician " and " one-disease diagnostician " are by no means sheer fantasy. And with this inevitable " sub-speciality " trend in the consultants of the future, there must run a very real risk of the fact being forgotten, that there is a human being attached to a particular and possibly fascinating dysfunction. Here we are in a position to do much to combat this effect, for it is in general practice that it is most readily apparent that medicine is an art, making use of an ever-increasing moiety of science, whereas in consultant practice the accent is unavoidably and increasingly on the minutiae of medical science. It must be in the marriage of these two parts of modern medicine that we may expect progress, but it is at present uncertain who should " wear the trousers ".

Taking this to the extreme, to what may be regarded as its logical conclusion, if we abandon the concept of a consultant as a wise man, substituting that of a technical specialist, then it is obvious that our whole approach to second opinions must be reviewed. We are now seeking a highly specialized, scientific opinion, and one which we cannot possibly acquire in any other way, but we must not expect the wisdom of the old-school consultants: this, if we still want it, we must find elsewhere.

Looking to the future, then, we may expect a continuance of the already marked trend for hospital specialists to become more and more limited in scope, with a concomitant enormous increase in their highly specialized medical knowledge. But what of general practice? Is there anything afoot which might save the day, or is there any prospect of finding a means of stabilizing the situation. Happily there is much to report on progress in general practice over the past few years: John Hunt's " Renaissance of General Practice " is a very real force in British medicine today. Much has already been done to implement what Professor Richard has heralded as a " return to the old conception of the general practitioner, though on a much higher scientific plane ", and we may look forward with greater confidence to the appearance of a proportion of general practitioners who not only set out to increase their own knowledge, but actually increase the scope of their already " broad-spectrum " lives, add either individually or collectively to medical knowledge in a way none other can do, and in the doing achieve a wisdom which may well fill the void left by the further specialization which must continue within the hospitals. So that we may find that in years to come there are wise men to consult who once again have stemmed from general practice, and who are in a position to make the best use of the medical scientists of tomorrow.

Crystal-gazing has a definite but limited usefulness, and we must

now turn to a consideration of some of the more practical aspects of the consultation. In the bygone era of leisure, a consultation was a three-cornered affair, in which the patient enjoyed the benefit of two professional men. The family doctor contributed his specialized knowledge of the patient, the consultant his specialized knowledge of disease; combining in discussion over his problem. Too often nowadays we excuse ourselves by saying we are busy, and write an inadequate note, by way of requesting a consultant to take over a problem from us. And in this we lose one of the most important assets of the consultation, its educational value. For there can be no more readily assimilable and lasting manner of learning than by the private " tutorial ", and this is just what we can make of the consultation, if only we take the trouble to do so. If we do, our patients get an enhanced value from their consultations, both in the impression that we are interested in their problems and in the subsequent use we may make of our new knowledge; the consultant is called upon to give of his best, having a critical, professional audience to satisfy as well as a patient; and we return home with a further addition to the fabric of our personal professional knowledge. We cannot possibly read all the specialist journals, and even if we could we would be unable to separate the good from the indifferent, so that we should consider seriously just how much we miss by evading proper consultations. And even if we cannot find the time to accompany our patients to the consulting room, we may be able to enjoy the same stimulating educational session by arranging the occasional domiciliary consultation.

Perhaps we should pursue the educational aspect of second opinions in reverse. Historically, consultations have been as between teacher and pupil, and there was no absolute bar to the pupil in due course becoming teacher. As we have shown, the consultants and general practitioners of tomorrow can never be viewed in quite this light, as they are of two quite different strains, though of the same breed. No longer can we as general practitioners look forward to the prospect of ultimately becoming consultants, for the schism is nowadays wider and commences earlier in our professional lives. And though, by judicious use of consultations, we may expect to increase our knowledge and understanding of medical science and of medical scientists, there seems little opportunity for the medical scientists of tomorrow acquiring an adequate insight into the problems and possibilities of our more humble lives. Yet it is quite possible for this to be countered, at any rate to a degree, by ensuring that the budding consultant sees something of general practice *before* the inevitable schism occurs, perhaps in the manner envisaged by Paterson (1956). For, while the budding general practitioner has always had some hospital

experience, this is unhappily untrue of the budding consultant, and this to the detriment of the whole service.

We have observed the relationship between consultant and general practitioner in consultation, as being that of teacher and pupil, and this has been true in the past. Its truth in the future will be in a rather different vein, for whereas we sought knowledge tempered with wisdom, we shall in future learn to expect information of a highly scientific nature, and without the wisdom born of experience. And this causes a change in the eyes of our patients, for over the years they have come to regard the consultation as a means for a consultant to impart wisdom to us, and they are ever being told of the wonders of medical science and of the hospitals. And this has resulted in a relative belittling of general practitioners in the eyes of our patients. If we take this too seriously, we may fall prey to a sort of occupational paranoia, and this in turn must make us look all the sillier to our more discerning patients. What we should do, of course, is to turn the present trend to good account; to demand further and country-wide access to diagnostic facilities, to develop postgraduate education to a high level, and to make it apparent to our patients that they are in fact getting a service of high scientific calibre outside the hospitals, which we must demonstrate to be superior in its results to the old ways. In short, we must show that the advances in medical knowledge have not remained within the walls of the hospitals.

Many people have complained that this has all been caused by the National Health Service which they cite as a dreadful bogey, overshadowing the old and proper ways of medicine. It is probably true that the economic pressure of a fixed capitation fee payable for good or bad work has accounted for a sort of " dumping syndrome ", whereby anything looking like work is sent to hospital, which is far from a valid reason for requesting a second opinion. But this again must have accentuated the lay impression that " proper " medicine is something appertaining to the hospitals. Certainly it is true that in country practice, where the " dumping syndrome " is impracticable, patients on holiday from the towns frequently express surprise at the scope of our work, and not infrequently recall that this is what they used to enjoy before the advent of the National Health Service. Perhaps we should share some of the blame for this state of affairs—we surely cannot expect our patients to think highly of us, if we send them all off to hospital for anything more than a cold. No, let us practise good, honest medicine, so as to earn anew the regard which we may feel we have lost.

Theoretically, at any rate, our patients have a free choice of family doctor. Most of us privately enjoy a small conceit, in

thinking what a thin time so-and-so's patients must have; for we, with our professional knowledge and experience, are in a position to judge so-and-so's ability rather more soundly than can his patients. At times we are met with the request for a consultation with a particular consultant, most likely, one we do not know personally, and whose work is unfamiliar to us. In this case, we are in a position to judge scarcely better than our patients, although we may gain some useful information from *The Medical Directory*. What to do depends largely upon what can be discovered about the particular consultant, but, if there appears no definite contra-indication it is wisest for us to give our patient our blessing, while making it quite clear that this is not our choice. This implies that we, as family doctors, are the proper persons to choose consultants, and this is generally sound practice. But it also implies that such a choice must be made in a reasonable and responsible manner; and putting old stick-in-the-mud in the way of a few easily earned guineas is no sound indication. In the first place we must consider the nature of the disease in question, so as to make a scientifically appropriate choice, and this is most often relatively simple, although we must all recollect occasions when we have sent our patients to the wrong consulting room. And then we must make our choice of individual consultant from within the speciality indicated by our first consideration, so as to achieve most towards helping our patient. The importance of this will vary with the approach of our patients to the consultation; some will be content to go to anyone we name as the appropriate specialist, while others will require much thought, before we make our choice. And, of course, this will depend again upon the reason for which the consultation is sought; whether for information and advice, for action, or for moral support.

The next point over which we may find ourselves obliged to advise is whether our patient should be referred for a consultant opinion within the framework of the National Health Service or whether the consultation should be a purely private arrangement. There are amongst us some doctors who feel a trifle hard done by when they attend a patient night and day for twenty-two shillings a year and then see the same patient willingly part with a private fee for a consultation. There are, too, some consultants who give the impression that they are scarcely interested in problems other than by private arrangement. Both views are at fault, in that, within the National Health Service, we contract with the State to undertake the patient's care, and this should be good enough. There are, however, two matters which we must consider; the time factor, and the patient. By and large it is true to say that a consultation under the National Health Service will involve a variable delay,

unless the matter be urgent, whereas a private consultation may be arranged earlier. One view of this, and that favoured by certain politicians, is that it is a great evil that money can buy preference. On the other hand, if a patient wishes to pay a fee for the benefit of making an arrangement suited to his convenience, it seems quite reasonable that this practice should survive, always providing that urgent matters be given preference without regard to the nature of the contract. And then there is the patient: while some view private practice as a matter of course and find that their private, public or business lives make private medical care an economy, we must all recognize the fact that there exists a class of patient in whom a private medical attendant, and more particularly a private consultant opinion is vital to their self-esteem: this is a form of snobbery, and it is quite useless to attempt to persuade such a patient that he will get as good advice, and as good treatment under the National Health Service, as he would privately; and this is the class of patient so regularly battened on by the charlatan. This being so, our duty is plainly to accept what we know to be a ridiculous conceit, and to arrange a private consultation with a reputable specialist, who will both deal with the complaint and satisfy the snobbery.

If we fail to achieve a three-cornered consultation, then we must rely upon the written word: but this means letters in both directions. If we seek helpful letters from consultants, we must see to it that we afford them the greatest assistance in the first place. I once saw a patient who was accompanied to a casualty department by a note, written on the back of an used envelope, of which the text was the single word, "Eye?" The proper answer, after removal of the foreign body from the cornea, was, "Aye". But perhaps the greatest single cause of disharmony between consultants and ourselves is the delay we suffer before we receive reports. In the first place we should set ourselves the task of being sure that every patient we send to hospital or consulting room is either preceded or accompanied by as full and helpful a letter as we can produce: we should remember that in this way we are playing our part in the professional discussion that is the consultation, and that we are expected to bring our special knowledge of the patient to the notice of the consultant. If we honestly attempt this, we may expect a response in like vein, and only in this way are we in a position to demand an improvement in the present situation. For discontent there is, and upon occasion well founded, with delays sometimes of weeks before we have any specialist information about our patients. Our patients lose faith, we lose face, and both to the detriment of the consultation. While there are problems of administration in the smaller hospitals, these are all problems which could be

solved, if we were to merit it.

With the matter of letters there must come the consideration as to, " who tells the patient ". Not infrequently we hear the complaint that the hospital doctor, " did not tell me anything ", and this is generally felt to be a bad thing. It is much less frequently heard of a private consultation, as, with a private fee, the consultant naturally has more time to discuss the problem in hand. Again, we sometimes hear patients comparing what has been said by Doctor A and Doctor B; this is unfortunate, since it leads to lack of faith. For no professional man can use his professional terms, when trying to explain an intricate problem to a layman, so that an essential part of " telling the patient " is a translation of a technical problem into non-technical language. Even if two of us are in complete agreement over a clinical problem, our interpretations must necessarily be coloured by our personality, as also by our audience, so that what we say individually may appear to be contradictory: hence the lack of faith in our patients. Perhaps the most satisfactory solution to this problem, short of the true personal consultation, is for us as family doctors, to take on the task of interpreters; but we can only do this well, if we have adequate and timely reports.

Frequently we send patients to hospital for a second opinion, only to find that they have been seen by a registrar or other junior member of the staff and not by the consultant to whom we have addressed our request. This is a pity because it is possible that we have taken much care in the selection of the particular consultant, possibly reassuring the more timorous of our patients by giving them some description of him, only to have a report from a registrar we may not know, and who probably does not know us. However excellent the registrar, this is not a satisfactory state of affairs from our patients' point of view, or from our own. Yet it is difficult to see how this can be avoided, as not only must the consultants of tomorrow gain necessary experience, but the enormous increase in the number of patients referred to hospital has not been accompanied by a proportional increase in the number of consultants. Unhappily, the obvious solution to a part of the problem, of promoting senior registrars to consultant status, is not one which readily commends itself to the administrative pundits of the Ministry of Health, so that the problem remains, and we continue to operate a system which is far from perfect.

It is therefore useful at this point to consider in what way we may relieve the pressure upon the consultants we have, so that they may the better attend to our patients. And here we must return to the reasons for requesting a second opinion, for it is clear that this will greatly influence what improvements we may discover. If we

require a second opinion for the purpose of affording us moral support in a matter we understand but in which our patient has no faith, then there can be no alternative to a consultant opinion, and to be seen by a registrar is a second best which should not be permitted in an improved service. If we request a consultation because we are unable to deal with a problem which we nevertheless understand, then the employment of a registrar may be legitimate, except in matters of exceptional difficulty, when the consultant would wish to play his part. But, if we want information about a problem, there is more we can do, if only we are allowed to do it. Many thousands of consultations are requested every month because that is the only way in which we can gain technical information. In ten years the National Health Service still affords x-ray and laboratory facilities to only a proportion of the family doctors in the country. The more fortunate amongst us are able to have straightforward estimations performed or simple x-rays taken, by which we are enabled to practise better, more valuable and more satisfying medicine than our less favoured colleagues, and at the same time we find substantially less need to call upon the services of consultants. This, properly extended to all family doctors and systematically developed so as to include certain therapeutic measures not suited to domiciliary work, could be the way in which the gross overloading of the hospital outpatient departments were relieved, and thus the road to fewer and better consultations.

During our professional lives many of us develop particular interests, which we may follow with laudable drive and of which we may gain considerable knowledge and experience. And this, of course, is just how the consultants of yesterday reared up out of the bog of general practice. But today—and tomorrow—the ladder of success is a much more sophisticated and elegant affair, with its feet set upon the sterile floor of the hospital and its rungs disappearing into clouds of pure science. We must beware the tendency to regard those energetic colleagues who develop particular interests as specialists, for this they can never be, in the modern sense of the word. And this is the danger inherent in group practice, as in the more highly organized partnerships, that members may come to be regarded as consultants. No, the only true consultantship attainable in general practice today is in the co-ordinating role of wise counsellor, which is being lost in hospital practice, and which must eventually be recognized, when the last of the old consultants has gone.

Even so, there is a sort of consultation left to us within general practice, and one of great value, if we keep it within bounds. For how else apart from bitter experience, does the young doctor come to possess a useful knowledge of practical medicine, but by the

sober opinion of his seniors? The assistant, if he be not a fool, learns much from his principal, by the old-established method of informal consultation and discussion. And, as the modern world demands that old things must take on new names if they are to survive, we have the trainee general-practitioner who is none other than the graduate apprentice or assistant; rather in the way that the registrar is in relation to the consultant.

In retrospect, then, we must first admit our limitations, and then appraise our accepted institutions. We must analyse our requirements and see how far present arrangements fall short of our ideals. And, if we do this, we cannot but be struck by a sense of instability in the present; we become aware that medical practice is in a transitional stage in its development, both as a science and as an aspect of human relations. We see an inevitable advance in medical science, which must have a profound effect, both on humanity and on our profession, and which demands radical changes in its practical application. And, if we are not to be whisked off the higher rungs of the ladder into the immense spaces of scientific theory, nor yet be engulfed in the bog of an out-moded art, then we must ensure that these two poles meet; for it is in their marriage that modern medicine may prosper. But what shall be their meeting-ground? Who shall wed them?

There can be none of us gifted to the extent that we may give a sure prognosis as to who shall wed them; however intently we peer into the glass, we cannot hope to be certain of the future. We may believe that there will emerge a sort of super general practitioner, competent to integrate the fungoid ramifications of modern medicine, but of one thing we may be sure: that the meeting ground must be the consulting room. For no one of the team can ever again be complete in himself, so that more and more must the solution lie in the consultation. It may be necessary to expand this until it assumes the proportions of a conference, but the same essential principle must remain—that we, being incomplete in our knowledge, must needs seek a second opinion.