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A problem halved?*

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SUMMARY. In this paper I shall trace the history of the development of the referral system in Great Britain and comment on the role of the second opinion as it affects the three parties concerned: the patient, the specialist and the general practitioner.

THE men who examined James Mackenzie in the qualifying examination at the University of Edinburgh in 1878 and awarded him his degree were, like their counterparts in England and Ireland, consultant physicians and surgeons, Fellows of their respective Colleges. Like many great Scottish medical men, both before him and since, the young Mackenzie packed his stethoscope and set off for England, fame and a reasonably fair fortune. This was a fascinating time in the development of medical practice in Britain. There had barely been time for the Medical Act of 1858 to take effect; indeed, it takes about a quarter of a century for the effect of any change of such magnitude to work through the system as we, I am sure, will be observing with the changes that follow the recent introduction of obligatory vocational training.

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The evolution of the specialist

Until the nineteenth century the medical profession had comprised three distinct groups of practitioners: physicians, surgeons and apothecaries. The physicians were mainly sons of the élite: they had received an élitist education at Oxford or Cambridge, they treated the élite and they thought of themselves as being élite. Among their roles was the supervision of the apothecaries. Apothecaries were not only the purveyors of the remedies prescribed by the physicians, they also sold these drugs directly to those members of the population—that is, the vast majority—who could not afford the fees of a physician. Thus the apothecaries also needed to understand the action of the drugs they dispensed. As part of their role as supervisors of the apothecaries—a function they did not lose till the Apothecaries Act was passed in 1815—the physicians expected the apothecaries to refer to them difficult patients the apothecaries could not treat—but only, of course, those patients who could afford the physicians' consultancy fees.

The early surgeons were solely technicians and allied to the barbers. They were inferior to the physicians by birth, by education and in social status. The first steps in the gentrification of the surgeons came when they separated from the Company of the Barber-Surgeons. The process was taken a stage further when the surgeons transformed their Company into a College.

At around the same time as the Apothecaries Act established the right of the Society of Apothecaries to supervise the training of their members, the Royal College of Surgeons created the grade of Membership as a supplement to their existing Fellowship qualification. Membership of the Royal College of Surgeons was intended for the ordinary run-of-the-mill surgeon, and a large number of practitioners opted for the double qualification of a Licenciate of the Society of Apothecaries and Membership of the Royal College of Surgeons. Those who were successful in both endeavours described themselves as surgeon-apothecaries.

The term 'general practitioner' did not appear until the late 1820s, but it was that title which survived and not the more elegant title of 'surgeon-apothecary' which today is seen only in the designation of those appointed as general practitioner to the Royal Household.

Specialists—those who restricted their practices to a limited field—first appeared in the nineteenth century. Most began as members of the staff of one of the teaching hospitals, but there they were not allowed to specialize and so they founded their own specialist hospitals. The first in England was Moorfields Eye Hospital in the City of London, which opened in 1804. Here, it was said, a physician interested in ophthalmology could see, in three months, a far greater variety of diseases of the eye than he could expect to see anywhere else in Britain in a lifetime, even in the largest of the teaching hospitals.

The new knowledge and technical expertise of the specialists revolutionized both diagnosis and treatment. It also benefited the specialists themselves, who gained in prestige and income. Specialization became a form of self-advertising, for it was possible to claim a total skill in a limited field beyond the experience of one's years. When Robert Louis Stevenson's novel *The Strange Case of Dr. Jekyll and Mr. Hyde* was first published, one lady demanded to know, before she would invest her shilling in a copy, whether Dr Jekyll was a specialist.

Erasmus Wilson, when he was starting in practice, sought the advice of Thomas Wakley, the founder and first editor of the *Lancet,* who said to him:

> "Hang anatomy: stick to skins. Read about skin, write about skin, speak nothing but skin, and that as publicly and as often as you can. Get your name so closely associated with skin that directly the name of Erasmus Wilson is mentioned in any drawing room, everyone present will begin to scratch."

So successfully did the young Dr Wilson follow Wakley's advice that, in addition to collecting a knighthood, he was able to fund—with his own money—a chair of dermatology and also to pay for the erection of Cleopatra's Needle on the Thames Embankment. When he died he left £200,000 (a large fortune in those days) to his College. At that time dermatology was regarded as belonging not to the province of the physicians but to the surgeons. As a College treasurer, I wonder whether Erasmus Wilson's generosity to the Royal College of Surgeons was what perhaps inspired the Royal College of Physicians to take dermatology under their wing.

General practice and the hospitals

The origins of an outpatient service in Britain can be traced to the dispensaries, the first of which opened in London in 1696. Originally these were separate from the hospitals, but later the hospitals began to provide their own dispensary or outpatient service. It was, however, not until the middle of the last century that the outpatient departments really came into their own and there was an enormous expansion both in London and the provinces in the number of patients attending. In the original dispensaries a letter of introduction from some local dignitary—for example an alderman, church warden or overseer of the poor—was necessary; in the newer outpatient departments the patient had to produce a letter from either a governor or a subscriber to the hospital before he could be seen. According to Abel-Smith it soon became the practice for employers to subscribe to the hospitals so that their workers could take advantage of the services provided (Abel-Smith, 1964). He went on to say that at the end of the last century a poor man could "get the best consultant opinion by waiting his turn in the outpatient queue or by tipping the porter". I will not comment on who gets the tip today, but I can understand why the National Union of Public Employees are less co-operative than hospital porters of the pre-NHS days. Outpatients attended on a specific day and were seen by the physician or surgeon to the outpatient department—a post given to a consultant in his early years before he was 'promoted' to the charge of inpatient beds.

In parallel with the outpatient services were the casualty departments. These were originally intended for 'casuals' rather than for the treatment of trauma. Indeed, at many of the London teaching hospitals there were distinct medical and surgical casualty departments. Casualties did not need a letter of referral and patients could turn up at any time of the day and even at night.

It is not always realized just how impoverished many general practitioners were before the NHS. In the last century and the first half of this, poverty was endemic in Britain. The doctors' bills often went unpaid. Some practitioners could expect to receive sufficient income from their wealthier patients to cover the absence of a fee from the rest, but those practising in the poorer districts had few, if any, affluent patients.

The new breed of general practitioners felt particularly threatened by the expansion of the hospital outpatient services, for those attending were their potential fee-paying patients. That threat, certainly as far as their working-class patients were concerned, diminished with the introduction of National Health Insurance in 1913. Indeed, the less conscientious among them soon realized that they could reduce their work by sending more patients to the hospital outpatients while suffering no loss of their capitation fees.

Furthermore, in the inner city areas the teaching hospitals still cried out for new patients—both to provide clinical material for teaching purposes and to maintain their numbers of 'admissions', on which figures they based their appeals for money. (The term 'admissions', or 'admissions to the charity' to give them their full title, encompassed both out- and inpatients.) If the hospitals did not actually encourage unnecessary referrals, they never actively discouraged them.

By ensuring that at least part of their income was guaranteed, Lloyd George's National Health Insurance Scheme protected the financial base of general practice, particularly in the economically difficult years between the two World Wars. This financial base was strengthened further when the NHS was introduced. Furthermore, by expecting patients to register with a general

practitioner and to consult him or her for all medical problems, as well as by finally separating the organization of general practice from that of the hospital service, the NHS preserved general practice at a time when it was disappearing from the scene in other countries.

General practice in Britain was also, to an extent, protected from the challenge of specialization by the way the NHS consultant service was organized. I have often asked myself what would have happened if the model selected for referrals had not been that of the voluntary hospital outpatient system. This is not the pattern adopted in most other countries, even where there is a state-funded health insurance service. What difference would there have been if the specialists had not opted for a salaried service in 1948, but instead had chosen a fee for service payment? Presumably they would then have seen patients in their own consulting suites, possibly attached to the hospital to ensure a geographical full-time service.

The second opinion

The practice of seeking a second opinion goes back into antiquity. What has changed over the years is not that honourable custom, but the process by which it is achieved and, to an extent, its aims and objects. To understand what is happening today, we need to understand how the process has developed.

The consultation is a communication between two individuals with a different means of expertise (Shires and Hennen, 1980). The primary purpose is the discussion that should be taking place between two physicians about a patient for whom the diagnosis or treatment is in some doubt or the prognosis so serious that there is, as it were, an appeal to a higher authority. The doctor called in consultation will, perhaps, have a special knowledge of the subject or will be an expert in the use of a specialized diagnostic or therapeutic resource. Sometimes the opinion of the consultant is sought for all three reasons: he is a specialist in that field, he knows how to use a gastroscope and he has acquired a reputation in the giving of second opinions.

In North America a distinction is made between 'consultation' and 'referral'. A consultation describes the seeking of a second opinion from another physician (or surgeon) with the first physician (usually described as the attending physician) retaining medical charge of the patient. Incidentally, the attending physician is not necessarily a general practitioner or family physician, he is often a specialist; indeed, generalists at present constitute a minority of those delivering primary care in the USA.

Referral is an equally explicit term in its North American usage. It means the referral of a patient by his 'personal' or 'attending' physician to another specialist for the total care of that illness and sometimes, indeed, for all future medical care.

Originally a consultation was precisely that. The general practitioner looking after the patient would seek the opinion of another doctor because he did not know the diagnosis or because the treatment—often different treatments—so far prescribed had failed to cure the patient. Outside the major urban centres it would usually be another general practitioner who was called in to give the second opinion. When a difficult medical problem arose in Burnley, a neighbouring practitioner who was known to have more knowledge or experience of that type of illness was called in to give an opinion, and James Mackenzie was, of course, very soon recognized by his neighbouring general practitioners to have an expertise in cardiology. Only in the major cities were there full-time consultants. One of the objectives of the NHS was to make specialist care available in every part of the country. Previously if a patient needed to see a specialist, he or she would have to travel to one of the larger centres, though—for a fee—the specialist would travel to the patient's home (Barber, 1973).

A large number of pre-NHS consultants had originally been general practitioners. There were many reasons for this, not least economic; the pay of junior hospital doctors was extremely low before the NHS, barely enough to survive and certainly inadequate to contemplate marriage. The prospective consultant would set up in general practice to provide himself with a living income, and hope to increase his consulting practice in stages till ultimately he could discard the general practice side.

Whether Sir James Mackenzie originally had intentions of becoming a consultant when he started in practice in Burnley I cannot say. The impression I have is that this ambition came later as his fame in the world of cardiology spread.

In 1948, most of the physicians on the staff of teaching hospitals were still generalists; few were full-time specialists, though some had a special interest. Indeed, a few had more than one special interest: I knew a physician who at one hospital was a paediatrician, while at another hospital he was called in consultation for gastro-enterological problems in adults.

Defining the illness

If all the problems brought to a physician conformed to the textbook model, the process of consultation would be easier to define and the outcome more predictable. The traditional model of medical consultation is that the patient will present to his or her doctor one or more symptoms. To this background the physician adds information he collects by asking questions concerning other bodily functions, and he will also fill in some details about the patient's previous tilts with pathology—which data we call the previous medical history. That this history is coloured with the patient's own perspective of his illness seems often not to be recognized; not infrequently relevant episodes are forgotten or concealed. Sometimes, too, a disease that was investi-

gated but not confirmed gets elevated to the status of an actual event: "In 1951 they thought I had TB; in 1962 they thought I had a duodenal ulcer."

"They thought" becomes the diagnosis. Yet is this surprising? What does a patient say to his friends after he has spent two weeks in hospital being investigated for indigestion and all the tests are negative? In the same vein, what does a housewife with a headache do when, during a consultation with her doctor about a persistent headache that her family feared might be due to a tumour, she reveals that she has a boyfriend, and is so afraid her husband might find out she cannot sleep? How does she reply to her mother-in-law when she asks her what the doctor said?

In the traditional model we also seek details of what we call a family history, but most of us seem more concerned to know the nature of the illness that finally killed the patient's mother rather than learn how their patient got on with her: and as Pereira Gray reminded us in his James Mackenzie Lecture 'Feeling at Home', the more relevant details of the social history can often only be acquired by actually visiting the patient in his or her native habitat (Gray, 1978).

A persistent late caller

I remember a family I used to look after some years ago who were notorious for the frequency with which they requested a home visit late in the day, which meant that each request was responded to by the partner on duty. When it was my turn to respond to one such call, the receptionist who passed on the message pointed out how often this pattern had been repeated with that family. It is indeed fascinating what repositories of vital information good receptionists can be. The reason for the visit was to see the youngest child who "had tonsillitis" and had had a sore throat for five or six days; certainly no emergency. Clinical examination showed a snotty-nosed five-year-old with an open mouth and a pharynx that was perhaps a little red. The sore throat, I gathered, was worse when the child woke up. Why then a call in the afternoon? I decided to follow this up and, uninvited and unannounced, I returned to the house again the next day at noon, after morning surgery. Though I knocked on the front door very loudly, it was more than a minute before a sleepy-eyed mother came to the door in her dishevelled night clothes. The curtains inside were all drawn, and the entire family still in bed; the reason for the late calls was now clear. The rest of the story, too, is equally instructive. The older siblings had all lost their adenoids and most of them had had a tonsillectomy as well, in each case for similar recurrent sore throats which had been diagnosed as tonsillitis. In the dim light of that house, and in the stress of a late-in-the-day so-called emergency call, I am not entirely surprised at the sequence of events: the history of sore throat, the pharynx a little red, a diagnosis of tonsillitis. When subsequently there were further attacks, each time with an emergency call, was it not inevitable that sooner or later the child would be referred to an ENT clinic as a preliminary to the ritual sacrifice of the accessible parts of Waldeyer's ring? Later, when we were communicating—as Berne would have it—like adults and not as children, it was the mother herself who said: "It isn't that the operations ever did them any good, though they did all recover by the time they took the 11 Plus"—which both dates the episode and provides the clue to the aetiology.

Making the diagnosis

I have deviated from my theme, though I do not apologize for so doing. This is how the pattern of history-taking often goes in general practice, where time can be used as a factor in collecting the relevant data and often, too, time is relevant in providing the solution or remedy to a clinical problem. But let me return to the traditional medical model.

Having completed the history, we examine the patient. If we follow the textbook teaching, no orifice is omitted from our probing. We are now in a position to produce a list of possible diagnoses for each of which there is, hopefully, one or more tests which will confirm or deny the possibility. As undergraduates and junior hospital doctors we were led to believe that the brighter we are—and the more assiduously we read textbooks and the latest journals—the longer will be the list of differential diagnoses we can produce, and the more varied the investigations we order. Yet, in spite of all this mental and physical activity, the more rapidly can we come to the final diagnosis. Armed with that knowledge, all we need to do is prescribe a magic bullet or remove an offending organ. As Marinker and others have demonstrated, it does not always work that way, certainly not in general practice (Marinker, 1981).

Reasons for referral

Let me now turn to an examination of the reasons why a general practitioner refers a patient to a specialist or consultant. When I ask medical students why they think patients are sent by their general practitioner to see a specialist, the most frequent answer is that the doctor is "passing the patient to a higher authority" because he or she does not know what is the matter or what to do. Incidentally, also built into their answer is the assumption that the specialists—their teachers—will be able not only to make a diagnosis, but also to cure the patient. But are the medical students correct in their answer? In an amusing and perceptive review of the subject, Harris divides our reasons for referral into two main groups: those reasons for referral that are respectable and those that are not (Harris, 1976). I propose to follow this division, though my classification differs slightly in places from his.

"Respectable" reasons

Diagnosis

Let me start with the respectable reasons. The most common is because we do not know the diagnosis, included in which category are those patients whom we have seen so often we fail to recognize the insidious development of a pathological process, for example myxoedema. Some patients are suffering from a disease that we fail to recognize because we have never seen it before. In some instances we fail to make the diagnosis because we have a blind spot. Diagnostic errors and omissions by the general practitioner are beloved by many medical teachers and form part of the staple diet of their teaching. One advantage of the introduction of general practice teaching into the undergraduate medical curriculum is that we can now return the compliment.

A major reason for the referral of a patient with one of the less frequently encountered diseases is that the general practitioner, though he may have the knowledge, has not got the experience of the specialist to help him decide which of the alternative treatments should be selected. This is particularly true where there are available locally the facilities of a super-specialty team.

Support

Another common reason for referral—and I believe, an eminently respectable reason—is to get support from another doctor for our management of a patient with an incurable disease. Abercrombie in the 1958 James Mackenzie lecture (Abercrombie, 1959) quoted Sir Clifford Allbutt, who in 1889 had said: "No man should die of acute or obscure disease without a consultation." In my opinion the same philosophy still holds true today.

But the term 'incurable disease' applies equally to many of the chronic and recurrent illnesses which occupy such a large proportion of our time in general practice, for example such skin diseases as eczema and psoriasis, many of the gut disorders such as non-ulcer dyspepsia and the irritable bowel syndrome, and most of the rheumatic group of ailments. Most patients with one or other of these diseases will want a second opinion at some stage in that illness, and some will want a third, fourth and fifth opinion.

The neurotic patient

There is, however, an exception to this rule. Though depression may, for some patients, be equally incurable, referral to a psychiatrist is relatively infrequent and most of these patients are treated for their depression in general practice. The reasons for referral to a psychiatrist were analysed by Rawnsley and Loudon (1962). They identified a very relevant feature: referral patterns in psychiatry are determined to a great extent not by the clinical condition of the patient but by the characteristics of the practice population. However, it is not true to say that these patients are always treated in general practice. Many of them, though not referred to a psychiatrist, are frequently referred to other specialists; hence the acquisition by many neurotic patients of a fat folder. I believe that there is, inside most fat folders, a neurotic patient waiting to escape from his anxiety.

Some patients trail up and down Harley Street sampling the wares. If they cannot afford that luxury—though they would call it a necessity—they attach themselves to a collection of outpatient departments. Some add to their own confusion and that of their doctors by exaggerating their symptoms in such a way that their general practitioner has little option but to seek specialist advice because he cannot identify any pathology that fits the story they present to him.

They are, of course, manipulators and many of them are manipulators in their social life as well as in their relationship with the medical profession. Nevertheless, making this diagnosis does not always help. Often it is necessary to allow them a consultant's opinion before they will accept the possibility of an emotional aetiology. Unfortunately, a second opinion carries with it the risk of encapsulating the patient's neurosis.

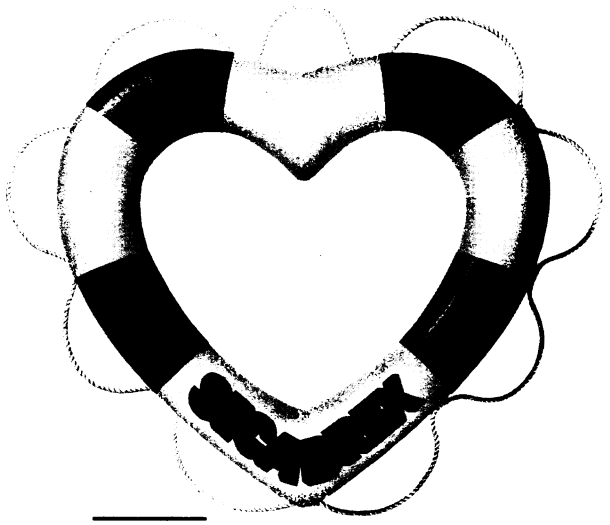
To add to our difficulties, these patients will frequently quote a remark made to them sometime in the dim and distant past by one of 'their specialists' as proof that their present problem has some validity or that their need for some type of therapy is essential.

The hardest lesson we have to learn when we set out to help these patients is summed up in the dictum: every neurotic dies and it is unlikely to be his neurosis that kills him. For these patients also have their share of organic illness and their neurosis provides them with no immunity. Indeed, there is good evidence that those whom we call neurotic have more than their fair share of organic illness. Furthermore, a study at the National Hospital for Nervous Diseases (Slater and Glitheroe, 1965) showed that in a long-term follow-up of patients originally diagnosed as suffering from conversion hysteria, almost a third were found subsequently to have an organic basis for their symptoms.

When this is identified it is the general practitioner who is particularly vulnerable. Because he is providing continuing care he may be held responsible for having failed to recognize that there was an organic component. Labelling the patient neurotic in these circumstances may be regarded by the patient, or the relatives and friends, as tantamount to neglect. However, it is my experience that the organic component in no way diminishes the element of neuroticism in the patient's make-up. Part of our skill as general practitioners is in moulding together the organic and the psychiatric influences on the patient's soma.

Reassurance

Referral may sometimes be necessary to reassure the patient. Sometimes it is necessary to reassure the patient's family and sometimes to reassure the referring



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1. *Am. Heart J.* (1980), 99, 443-445 2. *Am. J. Cardiol.* (1980), 46, 301-305
3. Taylor, S.H., Symposium, Malta, 1974 4. *Curr. Med. Res. Opin.* (1981), 7, 526-535

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doctor. Sometimes, too, it is also necessary to refer a patient to protect ourselves from criticism.

Therefore, I do not apologize for the fatness of some of my patients' folders; nor do I criticize myself for referring them to a specialist when no disease can be found.

It is also part of our skill to anticipate a patient's request for referral to a specialist and to make the proposal just before he or she makes the suggestion.

In a study of the assessment by patients of their family doctor (Cartwright and Anderson, 1981), it was shown that the doctor's willingness to refer patients to a specialist ranked fourth in their assessment of his positive qualities, while holding on to patients to an undue degree, being disinclined to seek a second opinion and being offended if the patient requested a consultation ranked equally high in the negative attributes.

Pre-consultation advice

It is important to remember that patients will, not infrequently, consult a non-professional source before consulting us. They may have sought advice from their next-door neighbour, Granny or the chemist before deciding that it was necessary to come to the surgery, and often they will have been told: "You'll need to go to the hospital for that. Get your doctor to give you a letter."

Relatives can be particularly irritating in this respect, especially when they are trying to assuage their own guilt feelings for not having been more helpful to the patient. We all, I am sure, have had experience of the following kind of telephone conversation: "This is Mrs Hyphen-Jones speaking. My aunt, Mrs Brown, is one of your patients. I've been speaking to her over the phone and she tells me you have given her pills for her backache for the past three months and she is no better. I've told her she has got to see a specialist."

An interesting facet of pre-consultation advice is seen in certain ethnic groups whose traditions in health care are different from ours. I recently read an unpublished thesis by two social workers who studied the medical consultation behaviour of the Hasidic community in New York. Hasidim are an ultra-orthodox Jewish sect with a belief in the mystical role of their Rabbi, whom they regard both as their leader and also as a purveyor of patronage, not only in religious affairs but also, for example, in matters of health and disease. In New York there is no organized general practitioner service and most patients go either directly to a specialist or to the emergency room of a hospital. Though the Hasidim generally hold the medical profession in great respect, it is thought desirable that some guidance be sought before embarking on such a hazardous adventure as placing themselves or their family in the hands of a doctor whose reputation—and, possibly, even integrity—is not known to them. Therefore, the Hasidim look to their Rabbi for guidance in these matters, as they do in many other fundamental aspects of their lives.

"Not respectable" reasons

I want now to consider the reasons that fall into the category referred to by Conrad Harris as "not respectable". My first description is of a referral pattern I am sure we all recognize.

The puppy syndrome

When a patient comes to us complaining of a symptom for which no explanation can be found, it is often difficult to be absolutely certain that no organic illness is present, particularly if that symptom is as vague as "I don't feel well."

As undergraduates we were frequently reminded how important it is never to miss a physical, and thus possibly treatable, cause for any symptom. Much of our specialist-orientated postgraduate education is directed towards the same end. Faced with a patient whose complaint he or she cannot diagnose, the general practitioner—particularly one who is inexperienced—may feel that referral to a specialist will provide the answer. Sometimes a recent lecture on one of the more esoteric diseases that we rarely see in general practice may have put into his or her mind the possibility that the patient might have the very disease about which the lecture was given.

I call this the 'puppy syndrome'. Let me give you an example:

> Dear Specialist,
> I came to your lecture at the postgraduate medical centre last week when you spoke to us about the importance of general practitioners not missing a case of phaeochromocytoma. You told us that in a review of eight cases recently reported in the American literature, fatigue was a symptom in two.
>
> Mrs Payshant has been complaining of tiredness ever since she registered with me three years ago when she moved to High Rise, a local tower block. Does she have a phaeochromocytoma?
>
> I would be very grateful for your opinion and advice.

Premature referral

A referral can sometimes be a substitute for inadequate time to sort out a problem, or inadequate records. A variation is the repeat prescription syndrome. A note is left in the letter box on Monday: "Could I please have some more of Granny's cough mixture, and some of Dad's rheumatic pills, and also could I have a bottle of cough mixture for Johnny who has been coughing all week." Two days later a second note would appear: "Could I please have a prescription for a stronger cough mixture." Was it surprising that the third note through the letterbox read: "Could I have a letter for Johnny to go to the hospital as he's still coughing." At that stage it was too late to suggest that perhaps I ought to examine Johnny: I had already demonstrated my inability to cure. The time to examine him was before I wrote the first prescription, not after.

The dumping syndrome

There are many variants of what I call the dumping syndrome. You will not be surprised to learn that the "Dear Sir, Please see and treat" letter—sometimes scribbled on an NHS prescription form, which at least identifies the sender—is alive and well and flourishing in some parts of the country, and not just the inner cities. "Get the patient off my back" is a more respectable modification of the dumping syndrome.

For many years until the consultant's retirement, I used to be able to off-load some of my middle-aged women patients whom I found troublesome by referring them to a certain medical outpatients where it would take about two months to complete their investigations. These were invariably negative, and then the patients were passed on to the surgical clinic where—with a couple of follow-up visits—they would hopefully sojourn another two months, after which time they would be transferred to the gynaecology clinic. And so, with a bit of luck, for about six months I could say to them as they came into my surgery: "Sorry Mrs Jones, but you're under the hospital and I'm still waiting for the specialist's report." Well, at least my last remark was invariably correct.

Anonymous referrals

A common practice, particularly in urban areas, is the habit by some general practitioners of referring patients to an anonymous hospital doctor, identifying only the department in which the patient is to be seen: for example, "The Physician in the Gastroenterology Department", or just simply "The Physician, St. Somewhere Else's Hospital". Some years ago I worked as a clinical assistant at the Princess Louise Hospital for Children in Kensington, where all three consultant paediatricians were women and no male doctor had held this post for at least a decade. Yet the majority of referral letters they received were addressed: "Dear Sir".

The habit of referring patients anonymously is encouraged by some hospital outpatient administrators. On many of the standard referral cards it states that if a speedy appointment is wanted, a particular physician should not be identified. This has always seemed to me to be wrong. I accept that on some occasions my patient will not be seen by the consultant but by one of his or her registrars; nevertheless, I wish to know who is accepting ultimate responsibility for that consultation. In my own practice I have made it a rule never to refer a patient anonymously, and it has been my impression that my patients have received better service from the named consultants as a consequence.

I now learn that private clinics are being introduced at which the referring doctor and his patient need not necessarily know in advance the name of the consultant. I do not know whether this is a phenomenon peculiar to London, but unless the practice is resisted I am sure it will spread to other large cities.

My criticism does not apply to the referral of a patient to an anonymous specialist for a purely technical procedure, for example an x-ray or an ECG, but this is not the same as the referral of, say, a child to an unnamed paediatrician or a patient with a renal problem to an unknown nephrologist.

The traditional consultation involved one doctor seeking the opinion of another. Anonymity destroys this relationship. Anonymous private clinics debase this opinion further.

Both the general practitioner delivering primary care and the specialist delivering secondary care must respect the traditional professional relationship for which British medicine has become famous and which has led to the generally high standard of care available in this country.

I would like to suggest that our College discusses with the other medical Royal Colleges the desirability or otherwise of anonymous referrals, both within the NHS and in private practice.

Referrals to casualty

Some general practitioners use the casualty department at their local hospital as a dumping ground for their unwanted workload. It is not possible within the limited context of this paper to discuss in any depth the problems of these departments, in particular the way they are misused and even abused by patients, general practitioners and hospital staff.

Prior to 1948, many inner-city residents went to the hospital casualty department for all their primary medical care as they could not afford a general practitioner's fee. That tradition has persisted and, I have no doubt, is encouraged by the habit of some of our colleagues in referring to the casualty department, ostensibly for a second opinion, a proportion of the patients they see. When I was a casualty officer at a children's hospital in the East End of London 30 years ago, I was surprised to find that my opinion was being sought by established general practitioners.

The Acheson report (Acheson, 1981) commented on the non-availability of some inner-city practitioners, even the inability in some instances to make contact by telephone with anyone connected with the practice. In some of these practices, when the doctor is not available the patients are instructed either by a note on the front door of the surgery or by a recorded message on an answering machine, to go to the hospital casualty department if they do not want to wait to see their doctor at his next surgery hour.

In addition there are a number of families who refer themselves to the casualty department for a second opinion, believing that the doctor that they see at the hospital is better able to advise them than their general practitioner. Some go because they believe—rightly or wrongly—that they need an x-ray or that they need to be admitted to hospital and that they will achieve their object more rapidly by this means.

As far as admission goes, certainly in respect of children, they are often correct in their assumption, for it is a very brave junior hospital doctor who will turn away a feverish child. Frequently the child will be discharged from hospital the next day, but that is too late if we are to establish in our inner-city areas the same pattern of home care for sick children that exists elsewhere. The way the parents describe their action when they go to the hospital reflects their perception of the event: "I rushed the child to hospital . . ."; "The doctor took one look at him . . .".

There are some whose capacity to control their own anxiety, coupled with a high degree of manipulative skill, has made them expert at by-passing the general practitioner and getting to the hospital, even to the extent of calling an ambulance to make sure nothing obstructs their path. There are those who have discovered the casualty departments where medicines are dispensed free of the normal prescription charge. Then there are the patients who go to a casualty department because they believe that is the way they will get an earlier appointment to see a specialist, which regrettably is all too often the case. How can a hospital claim that its casualty department is being misused by general practitioners when it gives a quicker specialist appointment to patients referred to outpatients by the casualty officer than it gives to those referred by the general practitioner?

It is one of my dreams—I hope it is not fantasy—that among the benefits to be derived from the presence in many casualty departments of general practice vocational trainees will be a better understanding within the hospital service of the respective roles of general practice and the casualty department in emergency and quasi-emergency care.

Let me also say that we, too, have to put our house in order if patients are to be expected to call on us rather than go to the hospital for primary care.

There is one other inconsistency I would like to mention. In most cases an emergency admission to hospital is arranged between the general practitioner and the duty registrar. On arrival at the hospital the patient is first examined in the casualty department. In some hospitals our letter of referral is filed there and the ward notes and the subsequent discharge report will read: "Admitted from casualty", implying that the general practitioner had failed in his duty to provide the initial care.

By-passing the general practitioner

I want now to refer to the times when the general practitioner is by-passed in the process of seeking the opinion of a specialist. In the battle that was fought at the end of the last century, at the time when the hospital service was rapidly expanding, the consultants and specialists won control of the hospitals but the general practitioners retained the patients (Stevens, 1966). Nevertheless, I have never ceased to be surprised at the

number of private patients in London who go directly to see a specialist. There must be very few consulting rooms indeed in the Harley and Wimpole Street area where primary care is not practised by physicians who regard themselves—and are regarded by others—as specialists.

By-passing the general practitioner is not confined to private practice. There are numerous ways in which this can be done within the NHS. The order in which I list them has no significance other than it follows the flow of my thoughts and my pen. If perchance I have omitted any other by-pass mechanisms, I trust that those who use them will not be offended.

Local authority clinics

Antenatal clinics are sometimes used for this purpose, though the opportunities to do so are restricted, if only because the woman stops attending the clinic after six to eight months. However, the family planning and well woman (or cervical cytology) clinics are relatively frequently used as a by-pass. Many women believe, perhaps because of the way the publicity is phrased, that a cervical smear will identify any and every gynaecological disorder, rather as many believed that a mass x-ray of the chest was a diagnostic panacea for all chest diseases. The public and also, I regret to say, some doctors need to recognize the difference between a screening test on a patient who is asymptomatic and a diagnostic work-up on someone who already has symptoms.

The battle between general practice and the infant welfare clinics and school health services was fought long and hard in the first half of this century. General practitioners accused the medical officers of health of taking the bread out of their mouths by providing a free service, and the medical officers of health pointed to alleged inadequacies in our service. That battle ended with the general practitioners establishing their right to be the final arbiter of which children should be referred for a specialist opinion. Nevertheless, in spite of the seven-day rule which, at least in theory, prohibited clinic doctors referring children to a specialist without first giving the general practitioner a week in which to express his objections to the referral, the rule was, and still is—frequently in some parts of the country—honoured more in the breach. Alas, it is not always the clinic doctors who are to blame: often the general practitioner is only too happy to have the burden of decision taken off his shoulders.

May I, at this point, offer an olive branch and interpose a few words of comfort to my friends who were medical officers of health and are now struggling to find a role in the carousel of community health: "Come back; all is forgiven!"

Industrial health services

Another mechanism for by-passing the general practitioner in specialist referral is the industrial health service. Indeed, not only may the patient be referred by the industrial health physician—often himself a general practitioner doing part-time sessions—but sometimes even by the industrial health nurse. Direct referral is particularly frequent where the complaint has possibly got an industrial connection, for example skin diseases or those due to an accident.

Social workers

Social workers, too, sometimes feel it is their right to refer a patient to a psychiatrist without first getting the approval of the family doctor, though they usually tell us what they have done after the appointment has been made.

The 'top man' syndrome

Private insurance for specialist medical care has increased quite considerably although, and this is relevant to what follows, there has not been any private insurance for general practice. (Some years ago a scheme did exist, but this has long since ceased except for the few original subscribers.) In 1950 only 120,000 people were covered, by 1960 the number had increased to 1 million, by 1970 to 2 million and by 1980 to 3½ million. (Perhaps we should remind ourselves that this is still only 7·5 per cent of the population.) However, as a consequence of this insurance cover, we sometimes now encounter what I call the 'top man' syndrome.

An executive telephones his doctor: "I know you are very busy doctor, and I don't want to waste your time. My company quack tells me I've got a bit of blood pressure. Who is the top man in Harley Street for hypertension and can you leave a letter with your receptionist so that I can go and see him?"

The NHS is not divorced from this manoeuvre, for usually the patient will expect his doctor to supply him or her with NHS prescriptions for any medicines recommended by the specialist. Of course, I can refuse to refer the patient to a specialist, and sometimes I do, but only rarely is the outcome of such a confrontation satisfactory, whichever way I play it.

It could be suggested that what the patient is saying, in effect, is: "Look doctor, I don't really trust your opinion in this matter and, rather than waste my time following your ritual, can I go straight to someone else?" This may sometimes be the explanation, but usually the request is made because the patient has not really given thought to the matter. Whenever it is possible to explain this—which, by the way, usually takes longer than the rest of the consultation—I find the patient ceases to want a specialist opinion. Sometimes, unfortunately, so much heat is engendered before the patient can discuss his or her problem with me face-to-face that it is not possible to explain anything. Giving way to the request may be the best prophylactic for my coronary arteries as well as the patient's.

As McWhinney has pointed out, some physicians

look on referral as a defeat, but a readiness to refer is, in his opinion—and I agree—a sign of maturity (McWhinney, 1981). However, I add a proviso. The absence of an objection to a second opinion implies that the general practitioner has attempted to give a first opinion.

There are some patients—not many, but they remain in one's memory—who start the consultation by asking for a referral. At social gatherings I sometimes meet professional or executive people who give the impression that the most important asset a general practitioner can possess is to know the best specialists and arrange the earliest appointments. I often wonder how they get on with their own doctor.

Referrals study

In an attempt to get an overview of some of the problems I have been referring to, I sent a questionnaire earlier this year (1981) to my colleagues on the Council of the Royal College of General Practitioners and to the members of the General Medical Services Committee. I took the view that, with such a sample, I would be getting the experience and opinion of a section of the leaders of general practice.

Results

I received 80 replies, 83 per cent of those to whom the questionnaire had been sent. Exactly half of those who replied have charge of hospital beds, but except for those who work in a general practitioner hospital, these are mainly restricted to obstetric and geriatric beds. I have often wondered what would happen if general practitioners could admit patients to hospital under their own care as they do in the USA. The logistics of the problem are immense. The actual number of acute medical beds available in Great Britain (excluding those already in the care of general practitioners) is 65,000, which means that the average general practitioner has less than 2·5 patients in such a bed at any one time.

Twenty-eight per cent held sessions either as a clinical assistant or hospital practitioner. Almost everyone did his own dip-stick testing of urine and, in addition, 53 (66 per cent) did some other pathology tests at their own surgery premises.

In only one general practitioner's consulting suite was there x-ray equipment, and one other had access to equipment within his building. Everyone, however, had direct access to some x-ray facilities at their local hospital. Usually, the range of investigations was limited; for example, a quarter could not order a barium enema. In most cases there was a delay in getting an appointment for the x-ray: 10 per cent even reported delays in getting an ordinary chest x-ray. Sixty-one per cent had their own ECG equipment which was used approximately once per thousand patients per month, and 60 per cent had direct access to a hospital ECG service. Only 5 per cent had neither their own ECG machine nor direct access to a hospital service. Only a very few had direct access to gastroscopy and colonoscopy (eight and four respectively).

I have already mentioned the increase in private practice. I was, nevertheless, surprised to find that in almost every part of the country some patients were being referred privately to a specialist. Only four respondents reported that none of their patients had had a private referral in the previous year.

Delays are frequently encountered in getting an outpatient appointment, although in many clinics an appointment could be arranged in less than a month; the general pattern for the difficult departments is similar throughout the country. By and large, the longest delays were in getting an orthopaedic or ENT appointment—in some districts there was a delay of over a year.

Domiciliary consultations

Instead of being an extra service for our patients and an educational exercise for us, domiciliary consultations have all too often become the key that unlocks the door to a hospital admission. For example, in geriatrics only one third of the respondents said that in their district it was never necessary and in psychiatry barely a half. In only paediatrics and ENT was this practice never necessary; or, using the football analogy, they returned what I might call a clean sheet.

In Sir James Mackenzie's time the general practitioner and the consultant frequently met, especially in the patient's home. Such meetings are today a relatively rare event. Abercrombie described the elegant protocol which governs these encounters and emphasized the importance he saw in that relationship for good medical care (Abercrombie, 1959). Today most of the communication between general practitioners and specialists is by letter, and there have been many studies of the quality of these communications and the frequent absence of information, both in the general practitioner's referral letter and in the specialist's reply, which might be of importance in assisting in the management of the patient's problem.

Communications

It is, to an extent, consoling to know that the poor quality of communications between the family doctor and his hospital colleagues is not confined to the British National Health Service. From the voluminous literature on the subject, I would like to extract one particular paper. It is from the Israeli journal *Family Physician* (Berry and Furst, 1980). The authors—one a family physician, the other a hospital doctor—viewed with dismay the adverse effect on patient care as a result of inadequate communications between the two branches of the profession in their country. They describe the consequences as "The Yiftah-Pinkhas Syndrome". The biblical scholars among you will remember in the Book of Judges (Judg. 11:30-39) how the great warrior Yiftah—or Jephthah as he is called in the King James'

translation—vowed that if he was successful in battle against the Ammonites he would offer to the Lord the first living creature who came from his home to meet him on his return. Alas, when he returned victorious, it was his daughter who came to greet him. The sages, whose commentaries on the scripture are inscribed in the Midrash, asked why Yiftah did not seek—as he was entitled—to have his vow annulled by Pinkhas, the High Priest. Alas, the sages comment, both men were stubborn and proud. Neither would make the first approach and so there followed a tragedy that might have been averted. How many unnecessary tragedies are there in modern medical practice because we behave as Yiftah and Pinkhas?

The referral letter

Today most of the communications between general practitioners and specialists about patients are by letter. What, then, constitutes a good referral letter? Because our writing is sometimes illegible, referral letters should, if at all possible, be typed. I do not like standardized forms; in my opinion they are too impersonal and sometimes inadequate, though they are valuable as a pre-registration document for the outpatient clerk.

The contents of the letter can be considered under those items that are essential and those items that are desirable.

Essential contents

—Name and address of the general practitioner (the principal and not the trainee, for he is a transient in the practice).

—Name of patient: he will know his own address and age, so if time is short these two could be omitted.

—Diagnosis (if known) and reason for referral.

—Treatment given to date and its effect.

—Known drug sensitivities, allergies and major risk factors (for example diabetes, epilepsy). In some respects this is possibly the most important information; many patients will either not know or have forgotten the existence of some of these complications.

Desirable contents

—Patient's age and address; occupation.

—History of present episode and clinical findings.

—Relevant previous history.

—Other medical conditions present, for example psoriasis.

—Whether referred for an opinion or treatment or ongoing care.

Such an outline leaves ample room for the personal touch—though I would caution against any of the more critical comments that are sometimes inserted, remembering that the patient now has the right to demand sight of any documents on his case.

Subsequent communications are even more inadequate than the initial communication. I am told by my specialist friends that it is extremely rare—certainly in London—for a general practitioner to send a follow-up letter, yet this can be most helpful. There are two specific instances when such a letter would be particularly relevant. Firstly, it is quite possible that there will have been a change in either the clinical condition of the patient or the treatment prescribed in the interval between the referral letter being written and the time of the outpatient appointment. Secondly, after the patient has been seen at the hospital, the general practitioner may have decided to discontinue or alter the treatment recommended by the specialist, either because of an adverse reaction to the drug or because the circumstances have otherwise altered between appointments.

I have also found it very helpful to produce, from time to time, a list of the current drugs being prescribed, having first checked with the patient that this is what he is taking (by asking him to produce all the medicine bottles in his possession). It is amazing how often the final list the patient and I jointly produce differs from what is in my records or those of the hospital. What these lists also achieve is a demonstration of the way the patient is or is not compliant. Another set of questions I pose to students commences with: "Who is in charge of the patient's treatment when he is in hospital?" The answers vary from the consultant to the registrar or the houseman and—quite often and probably correctly—the ward sister. I then ask who is in charge of the patient when he is at home. On occasions such as this most students are anxious to please and the most frequent answer is: "The general practitioner". "No" is my reply, "It is the patient himself who determines what he takes. There are", I add, "a number of patients who treat their collection of different coloured pills as they would a race-card from which they pick the day's selection."

What I also confirmed from my questionnaire was the occasional absence of any report from the hospital and, even more frequently, the absence of any follow-up report. The general practitioner is informed by the consultant that the patient has been seen in the outpatient department and investigations ordered. Indeed, a quite long and detailed report may be sent at this stage, usually repeating the history and the physical findings—which are probably well known to the general practitioner and have not infrequently been included in his referral letter. But thereafter silence: what the investigations revealed, what conclusions were drawn and what action was advised is left to the general practitioner to guess in the light of what the patient tells him. Sometimes, all the general practitioner has to go on is the collection of tablets the patient produces when he asks for a repeat prescription.

Admissions

There are many reasons why contact should be maintained with our patients when they are admitted to

hospital and it ought to be helpful if there was some dialogue during that time between us and the doctor in charge of the case—and preferably with someone more experienced than the house physician. This does not happen very often but, when it does, I am sure that the patient benefits. However, for contact to be maintained we have to be informed when our patients are admitted from the waiting list. (We know when they are admitted as an emergency.) Some hospitals do this routinely, but as many as three quarters of my respondents said they did not often know when their patients had been admitted. Only 5 per cent said they were always informed when a patient was admitted. It is even more important that we know that a patient has been discharged, yet only 5 per cent said they always received some form of discharge summary when the patient went home.

Referral from specialist to specialist

The cross-referral of a patient from one specialist to another is a complaint frequently expressed by general practitioners. There are occasions when this can be justified; for example, the patient with carcinoma referred to a physician, who then requires a surgical opinion, or a surgeon who requires the opinion of a radiotherapist for such a patient. A case might even be made for the immediate referral to another department of the hospital if a patient is found to be in need of urgent treatment. However, in my opinion, there can be no justification at all for the cross-referral of a non-urgent problem that is unrelated to the original reason which led the general practitioner to refer his patient. For example, the patient with an inguinal hernia who is referred to a surgeon and in turn passed to a dermatologist because he has psoriasis, even though he may already be having treatment from his general practitioner or even another dermatologist. Yet only three respondents (5 per cent) said that they had never been distressed by a cross-referral. As Hull said recently: "One wonders how consultants would react if a general practitioner entered their ward and altered the management of their patients" (Hull, 1981). It was no consolation to learn from the American literature that this problem is not unknown on the other side of the Atlantic Ocean (McWhinney, 1981).

Follow-up and discharge

Our specialist colleagues frequently complain that they cannot cope with the volume of work in outpatients, yet only one respondent said that his patients were never followed-up longer than was thought necessary by the general practitioner. Almost three quarters said that this happened to their patients frequently, 7 per cent going as far as to say it was "always happening". Not only should we know when our patients have left hospital, but also what was found and what treatment they received. Only two (3 per cent) said they always received this information.

Death is such a major event that it would be nice if I could report that every time a patient died in hospital, the general practitioner was informed by telephone as soon as possible. I am aware that it is often difficult to contact some of our colleagues by phone—I have already referred to the Acheson report which studied this difficulty in London (Acheson, 1981). Nevertheless, the inadequacies of some general practitioners are used as an excuse by hospital doctors for never attempting to contact the general practitioner in this way. My health centre telephone is never on transfer; it is answered by a 'live' operator 24 hours a day. Yet I have been offered, by way of excuse for not informing me sooner that a patient had died, "Oh, I tried to get you on the phone but your number was on transfer." Over a quarter of the respondents said that they sometimes only heard of the death of a patient by way of a routine discharge summary.

There is, of course, the other side to that last coin: the patient who is discharged from hospital too soon. How often does this happen? Only 14 per cent said they had never encountered it, but 10·5 per cent said it happened frequently and the remaining three quarters that it happened sometimes. Are these not matters that ought to be thrashed out in the District Management Teams?

Who prescribes?

In the questionnaires, I asked specifically about the recent change in hospital prescribing patterns. Previously, most hospital pharmacies dispensed enough medication to last the patient until his next attendance in the outpatient clinic but, since cash limits were imposed, many hospital pharmacies have been dispensing only enough drugs to last the patient two weeks and instructing the patient to collect further supplies from their general practitioner. Though this practice is contrary to the oft-repeated Department of Health and Social Security policy that the doctor in clinical charge should issue his own prescriptions, only 11 said that this was not happening in their area, and nearly two thirds of the 69 to whom it did happen said that this practice worried them. It certainly disturbs me because it places the doctor in the position of being the hospital's clerk. I detect, in some doctors, an attitude that the general practitioner is there solely to write prescriptions, issue the certificates and make the house calls.

But let me end the report of my questionnaire on a happier note. Overall, I asked, how happy were you with the communications between yourselves and hospital doctors, and how satisfied were you with the service provided by the hospital for your patients? Seventy-two per cent replied that they were satisfied (5 per cent very satisfied) with the communications, and as many as 83 per cent were satisfied (10 per cent very satisfied) with the service provided.

Rates of referral

There has been a plethora of published reports giving the number of patients referred to a specialist for a second opinion (Loudon, 1979). From the Annual Reports of the DHSS, we know the total number of outpatients referred, the regional variations and the proportions that are medical, surgical and so on. We also know that the majority of these referrals are initiated by general practitioners and, from the same DHSS reports, we know the number of practitioners providing general medical services. We can thus easily calculate reasonably approximate national and regional average referral rates. I did not, therefore, think it worth while repeating this particular exercise. What other studies have revealed is the enormous range of referral rates. Whilst the overall range is not dissimilar in different countries, variation within a country (Loudon, 1979) and, indeed, within a practice (Cummins *et al.*, 1981) are what is most interesting, and possibly more illuminating.

For example, in response to a questionnaire in 1976, among 309 (of the 420) general practitioners in the Lothian Health Board Area (Fulton *et al.*, 1979), 18 per cent said they referred most of their hypertensive patients to a hospital specialist for the initial assessment. This is similar to the proportion of general practitioners who were not prepared to initiate a prescription for an oral contraceptive, but were prepared to write a repeat prescription, in a study in the North Hammersmith District in 1974. Clearly, the referral threshold for these doctors is very low.

Sharing care in chronic illness

Most of the published studies I have identified relate the number of specialist referrals to the number of patients seen, but this approach avoids at least one important facet of the question. A patient referred to a specialist may remain under his care—or at least be under his periodic observation—for as long as that illness lasts, which in some diseases may be many years, or even for life. Yet, in counting the number of referrals, such patients will appear only once in the total unless a new referral is initiated, for example to a specialist in another hospital, either because they have moved or because a further opinion is sought. Furthermore, a count of the number of referrals in any one year will not identify those patients who were referred several years previously but are still under the care of that specialist.

A study to identify how the care is shared between general practice and the specialist service would, I think, be more useful than the simple head counts with which we have usually been provided. I specifically sought to determine what data there were concerning the proportion of patients with a chronic illness who were treated in toto by their general practitioner, what proportion by specialists and in what proportion was the care shared between the two. I was able to identify only a very limited amount of information.

In a survey of the records of 71 of the Lothian general practitioners (Parkin *et al.*, 1979) already referred to, it was found that of the 322 patients identified with hypertension, 32 per cent had been referred at some stage to a hospital specialist and 57 per cent were managed entirely by their general practitioner. (The remaining 11 per cent had had hospital treatment, not as a consequence of referral by their general practitioner but because the hypertension had been found incidentally whilst they were attending the hospital for some other reason.)

The decision to refer the patient to hospital was, to an extent, influenced by the general practitioner's assessment of the significance of his findings. Men were referred more often than women and patients with a diastolic blood pressure above 110 mmHg.

This, too, has been my experience. I looked at the records of a group of my own patients with a variety of chronic ailments, not necessarily hypertension. I practise in inner London. A relatively large proportion of patients move in and out of the neighbourhood each year and so have to change their general practitioner; some years ago over 20 per cent of the patients moved each year but the number moving now is only half that figure. Because of the mobility of my practice population, I have on my list a number of patients with a chronic illness who were already being treated by a specialist when they first registered with me, or had seen a specialist for that disease at some time in the past. Indeed, of that group, less than a quarter had never seen a specialist. (Excluded from that total are those patients who had attended hospital only for a diagnostic x-ray or pathology investigation.) I looked specifically at the records of 200 patients in whom I had first made the diagnosis of a chronic illness. Seventy per cent of those who had had their illness more than 10 years had seen a specialist at least once, and almost a quarter were under constant hospital review. However, of those who had suffered their ailment less than three years, only 30 per cent had so far seen a specialist.

Most of the studies I identified were of process, but what would be more valuable in the planning of a health care service are studies of outcome. In such planning we also need to know by whom the patient is being seen in the outpatient department. Does the specialist see the patient initially or the registrar? What proportion of the follow-ups does each see and how many are followed up by house officers? What is the role of the general practitioner clinical assistants and hospital practitioners?

Recently, Patrick Jenkin, when he was Secretary of State at the DHSS announced that the number of specialists would be doubled over the next 15 years, which presumably is going to affect the relative proportions of health care delivered respectively by specialists and general practitioners.

There is another question that has to be posed: will the new generation of vocationally trained general practitioners refer as many patients to a specialist as my generation does? Will they refer less or will they, perhaps, refer more? According to the chess board theory, you cannot move one piece without affecting the significance of every other piece on the board. With several almost simultaneous moves of such magnitude, it seems to me that we are going to need a few knights' moves if our planning is to be effective.

The cost of referral

I have seen quoted the expenditure within the health service allegedly generated by the average general practitioner. The sum is calculated by dividing the total cost of the hospital service by the number of general practitioners. Similar calculations identify the cost per outpatient referral. From this it is argued that if the number of referrals was reduced, the total cost would be less.

There are those (Fry, 1980) who regard it as part of the role of the good general practitioner to act as the protector of the outpatient department and, by avoiding unnecessary use of the expensive resources of the hospital, keep down the costs of the health service. Perhaps even more important is our role as the protector of our patients against the hazards of over-investigation. Does the number of patients referred reflect the quality of care provided by an individual general practitioner?

Conclusion

The problems that have not been resolved are: what constitutes unnecessary referral, and what constitutes an unnecessary investigation? Like beauty, the definition of necessity will be found mainly in the eye of the beholder. I wonder how many general practitioners would refrain from consulting a specialist if they—or a member of their family—were to be suffering from a serious or prolonged illness.

Our role as general practitioners is that of the primary assessor of previously undifferentiated clinical problems, coupled with the task of determining how best these needs can be met. One of our most important tasks is the co-ordination of all the resources of medicine and society (McWhinney, 1981). The personal resources of one physician can never be adequate to meet all the medical needs of his or her patients.

Referral to a specialist or a consultant is an essential component of good medical care—even more so today than it was a century ago when James Mackenzie was in general practice in Burnley. As general practitioners we need to know which members of the specialist diagnostic and therapeutic orchestra are available to us for the use of our patients and when we need to bring them into play.

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Words our patients use

"To kink"—to have a convulsion (South Yorkshire).
"To be the other way"—to menstruate (South Yorkshire).