The relationship between the Family Doctor and the Consultant is of necessity moulded through the various encounters that take place in the course of their work and leisure and which are listed in Table I.

They are encounters that each one of us is so familiar with but perhaps has never stopped to think how they affect our perception of one another.

**MEDICAL STUDENT – CONSULTANT TEACHER INTERACTION (THE SOCIALIZATION PROCESS)**

It is not simplistic to assume that the doctor is profoundly influenced by his consultant teachers who not only impart knowledge and skills but also consciously or subconsciously attitudes, emphasis, sentiments and values vis-a-vis the professional work for which he/she is being trained.

I graduated in 1975 with 39 others. 65% of us are working in a consultant capacity either in Malta or abroad. My impression is that in the past there was a tendency to foster the value of specialised care and let those students who want to go into general practice to do so by default.

Times, circumstances and needs have changed drastically since then but have our consultant teachers adjusted their emphasis and attitudes to match the needs of the future Family Doctor?

Related to this, is the undergraduate curriculum providing medical students with significant primary care experiences which compete fairly with specialised care for time, people, space and money?

To become a principal in general practice, having spent almost 10 years in hospital medicine is a situation demanding redress, as M. Keith Thompson pointed out in his discussion paper appearing in the Journal of the Royal Society of Medicine (Dec '86) under the name “A Concept of Disease to Educate the New Type of Doctor”. He goes on to say in his concluding remarks: “Doctors in their early training should no longer waste a decade away from normal human communities where they can become observers of human development.”

I shall not discuss in any depth this aspect but I think it must be mentioned first in order to reflect its chronological placing and underscore its importance in influencing the shaping of the relationship between consultants and future family doctors.

**HOSPITAL PRACTICE AND FAMILY PRACTICE**

It is at this interface that most communication takes place between the family doctors and consultants, whether directly or indirectly and I dare say that this is the area where it seems both parties are dissatisfied.

The interaction concerns individual patients and arises from decisions, often complex in origin, to seek consultant advice. Family Doctors vary in their referral rate and the same family doctor may himself vary over certain periods for various reasons (Table II).

None of these factors should be regarded as fixed entities and in any referral more than one factor can operate simultaneously e.g. the coping capacity of the family doctor can fluctuate and can be undermined for a time by an unnerving professional experience such as the unsuspected sudden death of an elderly diabetic patient from a silent infarct.

The salaried doctor dealing with demanding, sometimes disrespectful, patients in a system that is not personalised or does not cater for continuity of care is not motivated to refer frugally and appropriately.

The quality of service available from hospital may vary over time e.g. a particularly

<table>
<thead>
<tr>
<th>Table I</th>
<th>FAMILY DOCTOR-CONSULTANT ENCOUNTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MEDICAL STUDENT – CONSULTANT INTERACTION</td>
<td></td>
</tr>
<tr>
<td>• HOSPITAL PRACTICE AND FAMILY PRACTICE</td>
<td></td>
</tr>
<tr>
<td>• THE DOMICILIARY CONSULTATION</td>
<td></td>
</tr>
<tr>
<td>• POST-GRADUATE MEDICAL EDUCATION</td>
<td></td>
</tr>
<tr>
<td>• FAMILY DOCTOR – PATIENT – CONSULTANT RELATIONSHIP</td>
<td></td>
</tr>
<tr>
<td>• SOCIAL ENCOUNTERS</td>
<td></td>
</tr>
</tbody>
</table>
sympathetic usually new consultant may attract more consultations.

Patients and relatives are greatly influenced by the media. We all have experienced a sudden increased demand for mammography following some programme on breast cancer on TV or even after it is revealed that one of the actors in a popular TV series develops a lump in the breast.

Unless the consultation takes into account all these factors operating on the Family Doctor in making a decision for referral there is bound to be misguided criticism if not downright obstructive behaviour from his side.

I will hasten to add that this does not exonerate the Family Doctor from communicating sensibly to the hospital doctor or consultant. Indeed it underscores the need for clear communication.

There is an old medical joke about the GP’s letter that said “Dear doctor, Please see this patient, chest” and got the reply “Dear Doctor, chest present”.

I am aware that hospital doctors grumble about Family Doctors’ letters of referral which are sometimes regarded as largely irrelevant, lacking in structure or seriously incomplete. Inevitably there is a cultural divide between doctors who have a long term relationship with patients and are mainly interested in human behaviour and doctors to whom selected patients are referred, ideally for a specific clinical problem to which the consultants have an answer. These differences are reflected in the data each provides for each other.

However, serious mistakes can be committed if junior doctors in hospital do not take the Family Doctors’ letters of referral seriously and take it upon themselves to decide whether to keep a patient who was referred for admittance to hospital by the Family Doctor without consulting themselves with a consultant beforehand.

I am sure that several Family Doctors have had the unfortunate experience of having a patient refused admission by the junior staff with disastrous consequences. I believe that when this happens the consultant involved should take the necessary disciplinary action and before this happens Consultants should impress on their staff that most GP’s have a good reason for referring.

CONSULTANT’S COMMUNICATION WITH THE FAMILY DOCTOR

What does the Family Doctor receive by way of a discharge letter from the consultants? I have great respect and gratitude for those consultants who compose the summary of a complex case for the Family Doctor. How can one plead for cognitive as well as sophisticated skills if those who have the most skills undervalue them by delegating them to their juniors?

Discharge letters consisting of an interminable list of negative investigations without an opinion as to the diagnosis or a mention of the prognosis are of no use to anybody least of all to the patients.

It is also not good practice to delay issuing a discharge letter until the results of investigation are all available which can take weeks if not months. The doctor needs to be kept informed ideally pari passu with the development of the case and this not merely to keep the doctor informed but also to be able to pass on suitable information in the comfort and familiarity of one’s surgery to the patient. Very often the patient comes out of the hospital bewildered and full of doubts and questions which he expects to be answered and explained by the Family Doctor. Whenever there is dual care, the danger of confusion from poor communication is always present. It is sometimes forgotten that what the hospital doctor and the Family Doctor say to the patient is at least as important as what they prescribe and seldom do the two doctors know what the other one has said.

This brings me to the point of when a patient is discharged from hospital. I am glad to recognise the increasing tendency of many consultants to discharge patients from outpatient quite early on, if the case allows it, to the Family Doctors’ care. Apart from unloading the OP clinics there really is no point in extended review of the patient by progressively more junior members of the hospital team.

<table>
<thead>
<tr>
<th>TABLE II</th>
<th>FACTORS INFLUENCING REFERRAL RATES OF FAMILY DOCTORS TO HOSPITAL</th>
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<tbody>
<tr>
<td>• THE FAMILY DOCTOR’S MOTIVATION TO TAKE RESPONSIBLE DECISIONS.</td>
<td></td>
</tr>
<tr>
<td>• THE FAMILY DOCTOR’S SKILLS OF DETECTION, INTERPRETATION, REASSURANCE AND TREATMENT.</td>
<td></td>
</tr>
<tr>
<td>• THE COPING CAPACITY OF THE FAMILY DOCTOR, PATIENT AND FAMILY.</td>
<td></td>
</tr>
<tr>
<td>• THE PATIENT’S BELIEFS AND EXPECTATION THAT A PARTICULAR SYMPTOM IS A MATTER FOR HOSPITAL.</td>
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</tr>
<tr>
<td>• THE DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF THE PRACTICE POPULATION.</td>
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</tbody>
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THE DOMICILIARY 
CONSULTATION

The Domiciliary Consultation has a long history in Malta as in UK the place we emulate most in matters medical. It had attained a
quasi magical aspect with an aura surrounding the Consultant, his
knowledge, behaviour and powers. There was a way the GP attended to
the Consultant and a way the patient’s relatives attended to and
addressed the Consultant and the GP.

Although this form still survives in a less melodramatic
setting, certainly the number has diminished for various reasons. I
firmly believe it should stay, however, for it still serves a very
valid purpose in our local scene. To mention some advantages of the
Domiciliary Consultation:

1 The intimacy of the setting. It
provides the opportunity for a
specialist opinion to be given
at the patient’s home and for
the consultant to experience
on a personal level the social
and personal environment in
which the patient lives. This
often colours important
decisions in short and long
term management.
2 It often avoids unnecessary
admissions to hospital.
3 It is a learning experience for
the consultant and GP alike.

POSTGRADUATE MEDICAL
EDUCATION

The family doctor in Malta
has up till recently played the
passive role of a listener on most
activities of a medical educational
nature. Subjects discussed and
lectured on have been heavily
biased towards hospital medicine
and understandably so. I dare say
that the setting up of the College
has been the first significant step
tangibly taken by the local Family
Doctors to foster continuing
medical development and raise
standards from our end. The
College’s participation in the post
graduate CME programme should
hopefully be the beginning of a
more active interaction and
cooperation between hospital
medicine and family practice,
which has been until recently sadly
lacking.

It is my impression and I’m
sure of many of us Family Doctors
that a good number of Family
Doctors would welcome the
opportunity to keep in touch and
participate in the hospital care of
patients, on a part time basis. This
can take the form of attendance at
Out Patients sessions of some
particular speciality. This form of
Family Doctor participation in
Hospital care, I believe, would be
beneficial to the Family Doctor and
Consultant alike since

1 It is one way for the Family
Doctor to keep au courant
with Hospital Medicine
2 It bridges the sometimes
diverging paths taken by
hospital medicine and general
practice. Because of the direct
and personal interchange that
constantly takes place be-
tween the Family Doctor and
consultant, the right milieu is
created to help iron out
lingering prejudices, coopera-
tion is enhanced and mutual
understanding of each other’s
problems is fostered.

Maybe the possibility of such
participation is explored in a more
serious manner in the near future by
the parties concerned.

FAMILY DOCTOR-PATIENT-
CONSULTANT RELATIONSHIP

By this I am mainly referring
to the way the patient understands
or perceives the role of the Family
Doctor and Consultant. I believe
that the present local medical and
paramedical scene sometimes
leaves the patient in a wilderness of
confused indecision. I sense a lack
of direction in people’s ideas of
good medical care. Roles are
confused and in this maelstrom of
misconceptions are caught the
Family Doctor and the consultant.
To whom does a patient with a
painful knee refer himself, directly
to hospital, to his GP, to a bone
specialist, to a physiotherapist, to an
acupuncture clinic or to a faith
healer? How does a doctor be it a
GP or consultant react to the oft
requested ‘good check up’? While a
lot can be done to educate the
people through the media the
Family Doctor and Consultant are
in a prime position to do their part
of education provided each keeps to
his role.

Patients go to their Family
Doctor either because they fear that
they may have a disease, in which
case reassuring is what is needed, or
because they actually have a disease
when they expect to be treated
quickly, efficiently, and certainly
with the least hassle and at home or
near their home.

However these two functions
can be achieved ONLY if the
Family Doctor is seen by the patient
to be clinically competent and to
have the authority to reassure. If the
patient does not fully trust his
doctor he frequently finds himself
looking over his shoulder for
further investigations or a second
opinion.

After all, Consultants find
themselves in a similar position.
They depend on their clinical skills
and appropriate selection of patients
and so they need competent and
reliable family doctors in the
community who refer appropriately
and not just to get rid of problem
patients. Understandably,
consultants resent diluting their
specialist experience with cases that
can easily be dealt with by the
Family Doctor. An important
achievement of specialist medicine
is the shortening of hospital
admission times, but early
discharge depends on the
consultants being able to refer the
patient to a competent Family
Doctor. Day care surgery depends
on a good domiciliary service.
To complete the triangle, like they say that GP's get the patients they deserve, also perhaps Consultants get the GP's they deserve.

SOCIAL ENCOUNTERS

I still remember, from my Lyceum days, an over-enthusiastic Religion teacher who in his zeal claimed that one can convert a person to Christianity over a cup of tea. In our context it is more like 'in vino veritas'.

Notice over an apothecary's shop in Manchester in 1940's.


FAMILY DOCTOR/CONSULTANT ROLES

We can look back with complacency at this blurring of the boundary between medicine and grocery. This chap was extracting teeth and delivering babies and selling London pickles and lemonade etc. But I feel that sometimes we doctors, by our pattern of work, do blur our roles of Family Doctors and Consultant's.

Underlying all these encounters between the Family Doctor and Consultant that determine the nature of the relationship is the role that both doctors play in caring for the patient.

The basic features of Primary Medical Care or General Practice are essentially first contact and continuing care of individuals and families over long periods of time: whereas the consultant's is organised to provide short term episodic care often in artificial communities. The Family Doctor is involved with whole-person relationship developed within a formative society. He is often faced with an undiagnosed and unselected mass of health problems which are brought to him when the patient considers it necessary to consult him. The hospital consultant deals more with highly selected and availability of investigative means at the desk top the temptation is greater: but if we Family Doctors keep in mind that family practice is not the sum of a series of specialties practiced at a superficial level we avoid the trap of acting as consultants ourselves.

I STRONGLY BELIEVE THE FAMILY DOCTOR CANNOT BE A FAMILY DOCTOR AND A SPECIALIST SIMULTANEOUSLY AND CONSULTANTS SHOULD NOT ADOPT A FAMILY DOCTOR PATTERN OF WORK. To summarise the Family Doctor/Consultant relationship should be one of mutual respect and understanding based on the role and competence in one's field. Nourished by frequent exchanges of information and close working relationships and last but not least on the appreciation of the fact that we are destined to work together for the good of the patient for the rest of our active medical life.

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Dowson S, Maynard A. (1985) General Practice
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A protocol is an agreed method of dealing with a process that relates to medicine which is written down, worked to by a group of people and which is regularly reviewed.

1. One needs a protocol to ensure consistent management between doctors;

2. One also needs a protocol to guide fellow paramedics about what one needs them to do.

3. A further reason to have a protocol is that if one is working as a team say in the care of diabetics, if everybody involved in the care — the specialist, the GP, the nurse and the health educator have all been involved in the drawing up of the protocol they will all feel committed to it and they will all know what other members of the team are doing.

4. Having drawn up a protocol, one can then assess what skills are needed by everybody involved in the care. If needed, further education can be given if anybody involved lacks the necessary skills.

5. If one has a protocol, one has defined exactly what one is aiming to do and if good records are kept after a few months one can go back and assess whether one has kept to one's protocol and what standard of care has been given to the patients. This is practice audit.

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<thead>
<tr>
<th>TYPES OF PROTOCOL</th>
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<td>In general, in family medicine, there are two types of protocol:</td>
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1. Operational protocols: These govern the way in which patients are able to contact the doctor, the way in which medical care is delivered and the management and finance of the practice.

2. Clinical protocols cover the principles for management of specific diseases. As an example of a clinical protocol I would like to offer our protocol for the management of hyperlipidaemia. It is based on an outline protocol produced by the British Heart Foundation.

1. Management of elevated blood lipids will only be carried out in the context of an integrated strategy for CHD risk factor management. Thus in every patient an enquiry will be made about smoking, alcohol intake and exercise. Family history will be recorded and blood pressure and weight will be measured. Action will be taken concerning these factors at the same time as managing lipid levels.

2. Every patient on the list will be offered a general health check every 3 years. As part of this test a lipid measurement will be carried out. In Bedford we do not have the facility to measure lipid fractions so total cholesterol measurements are used. We accept that triglycerides are rarely independent risk factors for CHD.

3. Patients with cholesterol less than 5.2 mmol/litre (40% of the population in the UK) will be reassured, but encouraged to maintain an ideal body weight. Any other CHD risk factors will be dealt with i.e. smoking, high alcohol intake, poor diet.