Family Doctor-Consultant Relationship

John Gauci

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 Socialisation 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 I Family Doctor-Consultant Encounters

- Medical Student – Consultant Interaction
- Hospital Practice and Family Practice
- The Domiciliary Consultation
- Post-Graduate Medical Education
- Family Dcotor – Patient – Consultant Relationship
- Social Encounters

TABLE II FACTORS INFLUENCING REFERRAL RATES OF FAMILY DOCTORS TO HOSPITAL

- THE FAMILY DOCTOR'S MOTIVATION TO TAKE RESPONSIBLE DECISIONS.
- THE FAMILY DOCTOR'S SKILLS OF DETECTION, INTERPRETATION, REASSURANCE AND TREATMENT.
- THE COPING CAPACITY OF THE FAMILY DOCTOR, PATIENT AND FAMILY.
- THE PATIENT'S BELIEFS AND EXPECTATION THAT A PARTICULAR SYMPTOM IS A MATTER FOR HOSPITAL.
- THE DEMOGRAPHIC AND SOCIAL CHARACTERISTICS OF THE PRACTICE POPULATION.

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.

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 between the Family Doctor and consultant, the right milieu is created to help iron out lingering prejudices, cooperation 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'.

> *Surgeon and apothecary. Prescriptions and family medicines accurately compounded. Teeth extracted at one shilling each. Women attended in labour, two shillings and sixpence each . Patent medicines and perfumery. Best London pickles. Fish sauces. Bear's grease. Soda water. Ginger beer. Lemonade. Congreve's matches and Warren's blackening.*
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> **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 biased case material which has been pre-sorted and pre-diagnosed by the GP.

In many health care systems, access of the patient to the consultant is by referral from the Family Doctor. In Malta it often does not work that way and one main barrier of choice between the Family Doctor and the consultant is a pecuniary one. Should the situation remain like this or should there be a better delineation of roles. Certainly a complete demarcation of roles and function is impractical and undesirable but should the paediatrician dilute his skills and see the stuff that the Family Doctor should be dealing with and vice versa? How far should the Family Doctor embark in taking on the full management of difficult cases? With the easy 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 specialities 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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