CONSULTANT OR SPECIALIST

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There has been a lot of talk regarding re-certification and accreditation of specialists in Singapore in the last ten years. However, responsible medical bodies have for one reason or another not attempted to answer some fundamental questions such as, what it meant by the term specialist; what constitutes specialist practice; have training and postgraduate diplomas any relationship to the nature and efficiency of specialist practice; what is general practice; what is the scope of recertification; who should be the examiners; should examiners themselves be subjected to recertification? Obviously, without a clear idea on these basic points, the interest shown in recertification and accreditation is unlikely to produce any tangible positive result.

It has been the British pattern of medical practice to have a two-tier system, namely the general practitioner (also known as the family physician) and the consultant. The former is the first contact for any ailing patient, and is therefore directly accessible to any patient at all times. The general practitioner will undertake the treatment and diagnosis in the majority of cases, and only arranges for consultation if he has difficulties with diagnosis or treatment. The consultant only comes into the picture when he is called upon by the general practitioner, and as such therefore is not directly accessible to the patient except through the good offices of the general practitioner.

This pattern of practice is not a universal one, and in countries like the United States, Japan and many European countries, in place of the consultant, there is the specialist who is available as consultant to the general practitioner in much the same manner as the British counterpart, but who is also accessible to any patient who approaches him directly. At times, this has even gone on to a three-tier system of consultant,

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general practitioner and specialist, the last functioning as a general practitioner with specialised skill and usually confining himself to a narrower range of medical practice such as cardiology, neurology, dermatology, psychiatry, surgery etc.

Arguments have been advanced from time to time for and against the different systems. For the two-tier general practitioner/consultant system, it has been suggested that the two categories of doctors are complementary and not in competition with each other, that a patient would be guided in the choice of second opinion by a qualified man, and that, under proper care, the need for consultation would be promptly recognised.

On the other hand, those who are for the two-tier general practitioner/specialist system point out that a patient requiring specialist care is saved the additional time and cost involved in having to see a general practitioner first (in order to get to the consultant) that at times, the general practitioner may inadvertently cause delay, and that a patient has the right to seek any treatment he wishes, and should not be prevented from doing so by intra-professional arrangement, especially when such an arrangement would increase the cost of medical care.

Arguments of the above nature cannot be easily settled. Factors that must also be considered are the sophistication of patients, the ability of general practitioners, and the availability of consultants (1). Sophisticated patients often demand second opinion, and health education conducted by the medical profession for the public tends to increase this tendency. General practitioners with better experience and training tend to request fewer consultations.

The right and wrong of the different systems cannot be easily decided upon, because in judgements of this kind, factors other than logic is involved. However, it should be possible by the process of comparison to see if the above arguments for and against the systems are substantiated in any particular community. An attempt is therefore made to survey two hundred consecutive cases of a private practice to see if any of these factors applied locally and also to assess their relative importance. In this practice, patients are referred by doctors locally, and also from abroad, but in addition, the overwhelming majority of non-local cases were not specific referrals—either they came with some medical report and a general covering letter from their doctors with no specific referral by name, or they just came on their own seeking specialist opinion or care without waiting to go through the general practitioner. Two groups are therefore available for comparison—one following the British pattern to be called the referral group; and the other following the alternative system of direct access to specialist, to be called the unreferred group. The results are shown in Tables I to V.

TABLE I: Sex and Age Distribution

Category	Referred		Unreferred	
	M	F	M	F
< 10 years	1	0	1	3
11—20	3	1	8	6
21—20	1	3	9	19
31—40	1	4	23	17
41—50	2	3	14	24
51—60	2	1	10	12
61+	3	6	15	8
Total	13	18	80	89

TABLE II: Disease Category

Category	Referred		Unreferred	
	M	F	M	F
Neurology	5	7	19	4
Cardio-vascular	1	0	7	6
Alimentary	0	3	17	13
Respiratory	2	0	9	6
Psychiatric	2	5	15	18
Miscellaneous	3	3	13	21
Total	13	18	80	89

TABLE III: Duration of Illness before Consultation

Duration	Referred				Unreferred			
	M		F		M		F	
1 wk	2)		0)		5)		3)	
	)	36.5%	)	0%	)	31.5%	)	14.9%
1 wk—1 mth	2)		0)		10)		6)	
1 mth—6 mth	2		6		22		15	
6 mth—1 yr	0)		0)		6)		6)	
	)	63.5%	)	100%	)	71.5%	)	85%
1 yr	7)		12)		37)		15)	
Total	13		18		80		89	

TABLE IV: Appropriateness of Consultation

Group	Referred		Unreferred	
	M	F	M	F
Proper	8 (61%)	15 (83%)	45 (56%)	42 (47%)
Unnecessary	1 (8%)	1 (0.6%	16 (20%)	24 (27%)
Total	13	18	80	89

TABLE V: Status of Care before Consultation

Group	Referred			Unreferred		
	M	F		F	M	
No doctor	0	0	0%	6	8	12%
1 doctor	6	6	45%	19	11	18%
2 or more G.P.	2	2	13%	30	34	38%
Specialist	1	7	26%	10	10	12%
Hospital	3	3	19%	24	17	27%
Total	13	18	31 (100%)	89	80	169 (100%)

It can be readily seen that the proportion of referred to unreferred cases for this series is 13/80 (16.3%) for males; 19/89 (21.5%) for females, suggesting that a good proportion of cases is in fact from outside Singapore.

A consultation was regarded as appropriate if it was deemed *worth the patient's while* by the consultant, and as unnecessary otherwise. When doubt exists, the case is regarded as dubious. It can be seen that for referred cases, the proportion of appropriate cases for males and females are 61% and 83% respectively, and unnecessary ones 8% and 0.6% respectively. In unreferred cases, the appropriate ones for males and females are 56% and 47% respectively, and unnecessary ones 20% and 27% respectively. This shows that while there is no serious discrepancy in appropriate consultation, unnecessary ones are more common among the unreferred cases. As for the duration of illness, which might indicate the delay in getting the second opinion. Table III clearly shows that delay is greater in referred cases.

Coming to the status of previous care, bearing in mind the findings in the pattern of duration of illness prior to referral shown above, one may expect that in referred cases, there would be evidence of more patients having received medical care before consultation compared to unreferred cases. The actual figures (Table IV) obtained in this series are perplexing, for while it shows, as expected, that the referral rate is higher after seeing one doctor (referred:unreferred = 45%:18%), the rate is in fact lower after seeing more than one doctor (referred:unreferred = 13%:38%). After seeing specialists, the rate is higher (referred:unreferred = 26%:12%), but lower in cases that have been in hospital (referred:unreferred = 19%:27%). Explanation for these data is not easy, but the following may be considered:

(1) At the first contact between the doctor and the patient, the doctor is more likely to request a second opinion. The first contact doctor is on the lookout for complications, and hence his referral rate goes up. On the other hand, it is only when a patient has confidence in his first general practitioner that he will not seek another opinion on his own.

(2) In those cases where a general practitioner has difficulty in deciding whether to seek a second opinion, other doctors are apt to be in the same position. The patient is likely to go through several doctors resulting in a considerable delay before he is sent for consultation. Hence, the consultation rate is low when a patient has been seen by several general practitioners. On the other hand, when a patient has passed through the hands of several doctors, and is still not well, he is very likely to take his own initiative, and directly seeks a consultation.

(3) A specialist is in fact a consultant, except that he is directly accessible to the patient. It might be expected that the consultation rate would fall after a patient sees a specialist, whether he seeks consultation on his own or is 'sent up by the specialist'. However, the rates in both instances are reasonably high, and in fact higher in referred cases. This could be explained on the basis that a specialist is more restricted in his field, and hence more apt to refer patients away, if the problems are not within his field. Also, he is more likely to be aware of the complications and problems and hence will refer more often.

(4) Once a patient has been in hospital, it might be expected that he would have had his problems sorted out and subsequent care arranged. Hence, it is surprising that there is still a considerable number of cases coming up for consultation after having been in hospital (referred to unreferred = 19%:27%). This may imply a lack of patient satisfaction with hospital care. Preliminary study of some of these cases has indicated that there is in fact a number of reasons for dissatisfaction, and they include:

1. Patients are not given adequate information about their illness and treatment.

2. The after-care following discharge is usually unsatisfactory, *from the patient's point of view.*

3. The lack of doctor-patient rapport as the patient is often seen by different doctors on different occasions.

Much has been said about consultant and specialist practice. No objective study, however, has been made. On the basis of this short study, it would appear that quite a number of current beliefs with regard to consultant and specialist practice are mistaken. More studies should be done before the merit and demerit of either system become clearer.

REFERENCES

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