CONSULTANT AND SPECIALIST REGISTER

JAMES BLACK, M.D., F.R.C.O.G.

Johannesburg

Much has been written and many debates have taken place on the question of whether there should be a Consultant or Specialist Register. A decision must be reached by the South African Medical and Dental Council in the comparatively near future on what advice to tender to the Minister of Health, and I feel, as an elected member of the Medical and Dental Council, that it may be advisable to place before the medical profession my reasons for favouring a specialist register.

In some ways I feel I am in a unique position to express an opinion for, of my 47½ years of active medical practice, the last 26½ years have been spent in specialist practice and 21 years were spent in general practice. As a member of the Federal Council of the Medical Association for the last 18 years and of the South African Medical and Dental Council for the last 7 years, I have had an excellent opportunity of hearing the views expressed by various sections of the medical profession and of watching the development of specialism, which to my mind is one of the inevitable revolutionary changes brought about by the marvellous developments in medicine which have taken place during the last 40-50 years.

Furthermore, I think I can say that any views which I express can be accepted as completely unbiased. At my time of life I am well aware that my role as a consultant or specialist must inevitably become less and less and whatever decision is reached is therefore unlikely to affect me to any great extent; nor have I any relations in the Union practising medicine or taking up medicine as a career.

The 1937 *Resolution*

I was not present at the Medical Congress held at Pietermaritzburg in 1937, when the resolution was passed calling for a consultant register. I think, however, we can take it for granted that the resolution implied dissatisfaction with the prevailing conditions *re* specialism at that time and that it gave expression to a widely-held opinion that something should be done by way of statutory provision to ensure a proper training of those medical practitioners who set themselves up as specialists. I do not intend to enter into any discussion of the decision of the then Medical Council to establish a specialist register instead of a consultant register. I would only like to say that I had a high regard for its members and am sure that no selfish motives influenced their decision and that they honestly believed the specialist register was the only practical solution. (It should always be remembered that the Association ultimately agreed to the establishment of a specialist register.)

The Referendum

Now let me come to the referendum held by the Association. Incidentally, I have been blamed for voting against the holding of a referendum by the Medical and Dental Council; I voted against it because I did not consider that it was a function of that Council, and I think Dr. Braun, the mover of the motion, admits that now. After all, the Medical Council might just as well have been asked to take a referendum of the public, for the Medical and Dental Act was chiefly intended for the benefit of the public. I heartily agreed with the decision of the Medical Association to conduct a referendum and did my utmost to try and make it a success. But no matter how carefully a questionnaire is framed it is often difficult to interpret the result and that is the case in the present instance. To me it was a great disappointment to find that only about 37% of the profession voted; in other words approximately 63% of our colleagues appeared to look upon it as a matter of no importance to them. Then again, various interpretations of the result have been made and I would only add that I believe if those who voted for a consultant *and* specialist register had the opportunity of voting again and were told that it was not possible to have the double register, practically all of them would vote for a specialist register. Supposing this were the case then about 1,200 would have voted for a consultant register and about 1,000 for a specialist register—a difference of about 200 votes (and a great deal of propaganda took place in favour of a consultant register and practically none in favour of a specialist register). My interpretation will be questioned but I am as much entitled to my interpretation as others are to theirs.

It has been stated by those in favour of a consultant register that the referendum is 'overwhelmingly' in favour of a consultant register. I cannot subscribe to the use of such an adjective in this connection and feel that 200 votes are too few to alter the whole basis of the past and present methods of medical practice. Remember there are some 7,000 registered practitioners in the Union. The ultimate decision of course rests with the Minister (i.e. the Government) and all we can do, as members of the Medical Council, is to offer him advice. Personally, as a result of the poor response to the questionnaire and the actual voting of the 37% I say quite frankly that I cannot bring myself to advise the Minister to alter the law in order to bring about such a revolutionary change as a *statutory compulsory register confined to consultants*.

Consultant and General Practitioner

Many of our members, especially our younger members, have been led to believe that all the trouble between general practitioners and specialists started after a specialist register was introduced. This of course is a travesty of the truth. I remember how annoyed I used to be when I found, as a general practitioner in Springs 30-40 years ago, that patients went behind my back and consulted specialists or so-called specialists in Johannesburg, and I could quote many examples—I well remember one patient who saw 3 specialists in one day! But as I grew older this did not worry me for I found that ultimately most of these patients came back to me; and I feel certain that if a general practitioner knows his work well, realizes his limitations, and endeavours to be a real friend of the patient and his family, he has little to fear from the specialist. More than ever I feel that the general practitioner has a great role to play in the scheme of medical service, but I also believe that the introduction of a consultant register will do nothing to enhance his status. Status depends upon one's own work, on one's own personality and not on running down the other fellow. If I had remained a general practitioner, I should have been angry with some of my general-practitioner colleagues who today seem to be always talking about deploring and emphasizing their loss of status and calling themselves second-class practitioners. If I believed for one moment that the adoption of a consultant register would restore the status of the general practitioner and resolve the difficulties between general practitioners and specialists I should vote for it with both hands. I do *not* believe it.

Whatever we do, the specialist will remain an integral part of our medical service. The huge development of medicine in the last half-century has brought about the great increase in the number of specialists. This problem is one which affects the whole world and not South Africa only, and is therefore not caused by the specialist register, as is so often implied. It affects not only general practitioners, specialists and consultants but it vitally affects the public as a whole. The public cannot be ignored nor can they be dragooned into accepting any decision a medical association may consider desirable. They are very much alive to the benefits to be derived from the progress of medical science, and take a much more intelligent interest in their health and their diseases than the last two generations did. They expect more and, as in other walks of life, they realize that on the whole they are likely to get more expert treatment from a medical specialist who has made a special study of a certain branch of medicine than from one who has to deal with all branches. This is not an opinion; it is simply stating a fact which has been expressed to me by many patients and personal friends and it seems unwise to shut our minds to the truth just because it may be an unpleasant truth.

The Doctor-Patient Relationship

It seems to me that the profession has two big problems: One is to see that those who profess to be specialists in a particular line have had a certain minimum training, and the other that the public is educated to the advantages of having a regular family practitioner, one of whose functions should be to call in a specialist when the need arises. The former problem is much more easy of attainment

than the latter, which is the one with which I am concerned at the moment. I must say it interests me greatly to see how much stress is being laid by many, especially younger, general practitioners on 'getting back to the old days' while I, as one of the old brigade who can look back further, must emphasize the fact that we can never go back to the old days. I refer of course to the old doctor-patient relationship. One might as well say that we must go back to the other conditions which prevailed in those good old leisurely days. How many newly-qualified practitioners for instance are prepared to do most of their visiting rounds on a push bicycle or on horseback or with a horse and trap, as I had to do in 1911, when I thought nothing of a cycle run of 6 to 12 miles? Far from decrying the old doctor-patient relationship, I consider it was the ideal relationship for those times and I still believe it can obtain in country practices and in towns in a good-class type of practice. But can any general practitioner whose patients are chiefly in benefit societies or medical aid societies say that he is really the friend and counsellor of the families he attends? Several doctors may be attending in the same house, because the father, mother and adolescent children may come under different benefit societies.

The happy doctor-patient relationship depended chiefly on the attitude of the practitioner himself—he was a friend of the family and 'a man who'd have friends must show himself friendly'. Unfortunately there is not the time nowadays to develop the type of friendship which prevailed in those early days, and I think we are merely deluding ourselves if we think it is possible to return to those days. If general practitioners honestly face the problem I think they must admit that they cannot possibly give the type of service given in those old days, and I am quite convinced that, if the specialist register were done away with tomorrow, it would make no difference to the doctor-patient relationship; no law will bring those old days back. That type of practice was suitable for that particular period, and even today the more *any* doctor can make use of this art of pleasing and gaining the confidence of his patient the more successful is he likely to be. Many patients nowadays, though they deplore the passing of this happy relationship, state that what they want from a medical attendant now is not sentiment but science—they want the man who knows his work, the man who is most capable of diagnosing what is wrong with the machinery and the man who is an expert in repairing that machinery.

I am not condemning the general practitioner; I know very well what his difficulties are and I sympathize with him, for I think his chief difficulty is finance. In the old days as general practitioners our income seemed very small. At the end of my first year of married life my income from practice was £507; but that amount in those days was equal to £1,500-£2,000 a year today, for our expenses were comparatively low—a bicycle cost less than a present-day motor car!—and in proportion we were paid more for our work. In 1911 private fees were 10s. 6d. per consultation or visit and if one had to travel 6 miles out the fee was £2 2s. Nowadays a practitioner in Johannesburg may travel 6 miles in the town itself and receive half, or even less than half, the amount I received in 1911. It is unfortunate that cost of living was not added to medical fees at 5-yearly intervals since 1911! The present-day general practitioner is therefore forced in the course of a day to see far more patients than his predecessor in order to make a living commensurate with his outlay, experience and standing in the community; so naturally he has not the time for the social courtesies which contributed much to the pleasant doctor-patient relationship.

Specialist Practice

It is not fair, however, to blame the specialists for the present situation, when it is due to a variety of causes such as (1) the greatly increased cost of living, (2) the phenomenal development of medicine, (3) the huge industrial development which has brought about a great change in the type of medical service, and (4) the changed outlook of the public about the medical service they want. I would like to warn my general-practitioner colleagues and friends not to expect the introduction of a consultant register to bring about Utopia for them.

It may appear to the reader that all my remarks refer to the general practitioner's troubles and failings and that I have no criticisms to offer about specialists. Let me say that specialists like general practitioners consist of a cross-section of the population, and their ideals do not differ from those of general practitioners and the public generally. The large majority of them are also imbued with a desire to 'play the game' by their colleagues and the public, and it distresses me to hear it suggested that most of us have specialized merely because we shall be able to earn higher incomes and have an easier life. In my own case at any rate that is not true, for as a specialist obstetrician I worked harder than I did as a general practitioner and I should probably have been better-off financially if I had remained in the excellent practice I left in order to specialize. Too many irresponsible statements are made by colleagues regarding specialists, and I should like to impress on those who have not specialised that they have little idea of the difficulties and strains in the hard struggle to reach specialist status, or of the financial hardship encountered by would be specialists both in their training period and in the first few years of attempting to establish themselves. Many fall by the wayside.

We hear a great deal about the delinquencies of specialists and the way in which they have taken over patients from general practitioners. Sometimes unfortunately this does take place, and in such circumstances I consider that the general practitioner has real cause for complaint. Still I consider it most unfair that all specialists should be included in this category when probably a large majority are doing their utmost to play the game by their general-practitioner friends.

CLASSIFICATION OF SPECIALIST'S PATIENTS

The patients of a specialist fall into several categories:

1. *The patient who comes to the specialist through a general practitioner*

This is of course the ideal we should all like to attain, and it occurred to a greater extent 30-40 years ago than it does now. In such a case most specialists report and send the patient back to the general practitioner, unless the latter requests the specialist to take over the treatment of the case. If a specialist takes over such a case without the consent of the general practitioner the latter has a perfect right to lay a complaint with the Medical Council. A few such complaints would probably do a world of good; during the 7 years I have been a member of the Medical Council I cannot remember a single case of such a nature being brought before it. Is one therefore justified in thinking that this oft-repeated accusation is probably not nearly as common as propagandists in favour of abolishing the specialist register would make out?

Here I should also like to draw the attention of general practitioners to a most unfortunate development during the last 25 years—a development which apparently they do not realize is doing them a great deal of harm and breaking down the doctor-patient relationship. I refer to the fact that most so-called consultations are not consultations at all as they used to be understood.

When I was a general practitioner it was not uncommon for me to arrange a consultation in Johannesburg, 30 miles away. I used to give the consultant or specialist personally a history of the case and the treatment carried out and then discuss with him the diagnosis, prognosis and treatment; in this way one usually arrived at a satisfactory conclusion. In the event of my being unable to be present at the consultation, I always sent in a written history of the case (as stressed in Dr. Campbell Watt's excellent book *A Guide to Medical Ethics*, published in 1923, when he was a general practitioner in Pietermaritzburg and President of the South African Committee of the British Medical Association). These two ways are the only satisfactory methods of consultation.

But what happens in the bulk of cases in these modern days? In my experience, the commonest form of letter accompanying a patient is, 'Herewith Mrs. So and So, please see and advise'—not a word regarding previous history or treatment or what the doctor has told the patient. In many cases there is not even a letter; the doctor has made the appointment with my receptionist by telephone and has told the patient to give me the history herself!

Now this behaviour is doing the general practitioner a great deal of harm; he would be surprised at the remarks made about him by the patients regarding his attitude and 'lack of interest'. He might be even more surprised to know how many specialists do their utmost in the circumstances to foster the faith of his patient in him.

2. *The patient who has a doctor but comes to the specialist direct*

This is the type of case which probably gives rise to most resentment on the part of the general practitioner. Often the resentment

is justified; on the other hand the attitude of the specialist who endeavours in such cases to play the game by his general-practitioner colleagues has not been fairly stated.

I have no sympathy with the specialist who says he will see any patient who wants to consult him direct. Like many of my specialist colleagues I always try to find out first of all if the patient has a general practitioner; and if I discover that she is being attended to at that time for the condition about which she is consulting me, then as a rule I refuse to examine her. In fact I consider that if I saw her I might lay myself open to disciplinary action by the Medical Council under Clause 14 (2) of the Ethical Rules (dealing with supersession). In such cases I usually spend a considerable time in trying to explain to the patient the reasons for my action, and in many cases it is most difficult to convince her that my action is a reasonable one; she puts it down to 'this stupid medical etiquette'. Needless to say, I tell her that I shall be only too pleased to see her in consultation with her own doctor and all she has to do is to tell him she would like him to consult me in connection with her case. In most cases I never hear of the patient again. I make exceptions in certain cases and that applies particularly to patients who come from the country—some distance from Johannesburg. If, for example, a patient has travelled 30, 40 or even hundreds of miles into Johannesburg to consult me, then it appears to me a very discourteous action simply to turn her away and refuse to see her. Under such circumstances I inform her that I shall only see her on condition that she gives me permission to communicate with her own doctor. In this way, I feel certain I do much to further the doctor-patient relationship, by satisfying the patient and by sending her back to her general practitioner with a renewed confidence in him, for many of these patients come to a specialist because they are not satisfied with the progress they have been making and they do not know what steps to take to satisfy themselves that everything is being done that should be done.

Often they think their doctor would be offended if they suggested a consultation. When I point out to the patient that I also do not wish to offend him, she usually sees reason and decides either to see her doctor first and then return to me with a letter from him or allow me to examine her and write him, giving him my reasons for seeing her.

This appears to me to be a reasonable, courteous attitude to adopt towards the patient and the practitioner. I am sure it has prevented many a general practitioner from losing patients.

That is one type of patient who has a doctor but comes direct to the specialist; but there are other types. There is the one who does not wish to consult the family doctor for a gynaecological complaint. All sorts of excuses are given. 'He is a personal friend of ours and I might meet him at dinner a few nights after consulting him.' 'He is a relative of mine and I should not dream of consulting him about this.' 'He is too young.' Thus the gynaecological specialist is often put in a difficult position, and I think the only thing to do is to treat each case on its merits. I usually try to persuade such patients to see their own family doctor, but in many cases it is impossible to get them to do so and I do not see how I can force them. In some cases I succeed in persuading the patient to allow me to write to her doctor, pointing out that he should at least be acquainted with all her complaints and diseases, and if any operation is required it is imperative that he should know.

In some cases I find the general practitioner is on holiday and the patient refuses to see a locum or assistant. In these cases I consider it is sometimes an advantage to the general practitioner to see the patient on the understanding that she allows me to write him.

Again I have seen cases on whom I have operated before, and the general practitioner has gone overseas for some considerable time, e.g. to specialize, or has retired or died. In such cases I usually examine the patient and advise her to make up her mind about having another family doctor.

Sometimes, however, it is difficult to play the game, as when the patient volunteers the information that she wanted to come to me in the first instance but that her general practitioner had insisted that she should consult some other consultant or specialist whose name she might not even know; or when the general practitioner has informed her that there is no need for a consultation as he is 'as good as any specialist'. Some of my friends may hardly believe such statements but I can assure them I speak from personal experience.

Fortunately I do manage to persuade most of these types of patients to allow me to write to their doctors. I regret to say, however, that I do not get an acknowledgment from one general practitioner out of ten. I often ask myself why. Is it merely lack of courtesy or is it resentment? I cannot understand this attitude. I have always acted on the principle that if one has a grievance against a colleague one should go to him and 'have it out' with him. In nearly all cases misunderstanding will disappear and thus what might become a constant grudge and even enmity may lead to friendship—instead of an opponent one may have a real colleague. Such is my teaching to students in my lectures to them on Medical Ethics and I feel certain that if such a spirit prevailed between individual general practitioners and specialists, much of the present trouble would disappear.

3. *The patient who comes direct and has no general practitioner*

This type of case includes the woman who has come to settle in a town from elsewhere, or the woman who has always been healthy and therefore has no general practitioner. If such a patient wishes to consult a specialist direct is it reasonable to take up the attitude that she cannot do so, that she *must* consult a general practitioner first of all or that she must get a general practitioner, though he knows nothing about her, to give her a letter to the specialist? In other words, is the 'free choice of doctor' (one of the profession's long-cherished ideals) to be restricted to 'free choice of general practitioner'?

Personally I cannot agree to this restriction and in this matter I believe we must very seriously consider the attitude of the public. I have been very interested in the reaction of several non-medical friends when I have discussed this subject with them. Invariably the answer is, 'Not on your life; if I think Dr. So and So is likely to give myself, my wife or my children the best attention and treatment in any particular instance, then I claim the right to go to him direct if I want to'. The analogous position regarding solicitors and advocates makes no impression on them. There is a sentiment about medicine which does not obtain in law.

The Medical and Dental Council must take a wide view of the subject and, as a member of that Council, I say quite frankly that I cannot recommend to the Minister that the public must have *no* right to go to a specialist direct. I cannot conceive of any Minister asking Parliament to consider such a measure. If, therefore, it is not practical politics, is there any need for us to discuss the matter further, or is there anything more we can do to improve the position? I think we, as a profession, can help only by trying to educate the public on the importance to every family of having its own general practitioner and I very frequently tender that advice to the particular class of patient which I am discussing now. Naturally such advice should carry with it the implication that every general practitioner will make a first-class family practitioner, an ideal probably difficult to attain. The profession would set a good example if every medical family had its own general practitioner.

4. *The patient who insists on having the services of a specialist obstetrician during pregnancy, labour and puerperium*

The general practitioner condemns the specialist wholeheartedly for having 'pinched' these cases from him, and holds that all maternity work should be left to him and that the specialist should be called in only in consultation or emergency. Now could we enforce such a regulation? Would the public tolerate it? I do not think so. Can we tell a worried husband who comes along to say that he wants a certain specialist obstetrician to attend his wife that she cannot have his services but that she must go to a general practitioner? His answer is likely to be 'I am determined that my wife shall get the best treatment possible. Dr. So and So is the doctor we want and we are going to him'. Sometimes he adds, 'I know that many general practitioners always send their wives to a specialist for their confinements, and why should I not be allowed to do the same?'

Do not imagine that I think all specialist obstetricians are better than some general-practitioner obstetricians, many of whom are excellent but, by and large, it is difficult to refute the preference for a specialist. Many of us who were in general practice for years and then devoted ourselves to specialist obstetrical practice probably realize better than others what our shortcomings were.

CONCLUSION AND SUGGESTIONS

These remarks have expanded beyond what I had intended when I started, and although much more could be added, I have said enough to show that the question of specialists and/or consultants, the

relationship between general practitioners and specialists and/or consultants, and the relationship between doctors and patients, are all problems which bristle with difficulties. These difficulties will not be overcome by our quarrelling, calling each other names, and refusing to see the point of view of the other fellow. The first necessity is courtesy and honourable conduct on the part of all parties towards each other. Without this I despair about the future relationship between colleagues in different spheres of medicine—for I refuse to admit that any one branch of medicine is on a higher plane than another.

Also, I must confess that, as a result of experience, I have little faith that the present state of affairs will be remedied by regulations to be made by Medical and Dental Council. Law will not make people honourable and courteous. We must recognize the frailty and weakness of human nature, and that it applies to general practitioners, consultants, specialists and the public. Many of us admit that while we have tried to play the game, we have sometimes, perhaps often, fallen far short of the ideal we had set ourselves.

Is it too late to get together in an amicable way and try to settle our differences amongst ourselves? Surely it is largely a family problem and a family misunderstanding, and as such it should be settled amongst ourselves behind closed doors. Can we not agree on certain fundamentals? For example:

(1) That every specialist who receives a patient from a fellow practitioner will return the patient to the practitioner and will not carry out treatment except on the express desire of the practitioner.

(2) That when a practitioner refers a case to a specialist he will either have a proper personal consultation with the specialist or at least send him a full history of the case.

(3) That, where the practitioner is not able to be present at the consultation, the specialist will write a full report to the practitioner, who will duly acknowledge the report.

(4) That where a patient comes direct to a specialist and the specialist discovers, after proper enquiry, that the patient is being treated by another practitioner, the specialist will not see the patient except in circumstances where not to see the patient might be detrimental either to the patient or the practitioner. In such circumstances the specialist must communicate with the practitioner, who should duly acknowledge the specialist's communication.

(5) That where a patient comes direct to a specialist and the latter learns that the patient *has* a general practitioner even though he may not be treating the patient for the particular condition for which the patient has consulted the specialist, the specialist will do his utmost to encourage the doctor-patient relationship by endeavouring to send the patient back to the practitioner.

(6) That where a patient who has no general practitioner comes direct to a specialist the latter will point out to the patient the importance of having a family doctor.

(7) That specialists as a rule should do no domiciliary visits (certain types of cases, e.g. obstetrical, may require discussion).

These suggestions might form the basis for an amicable discussion in the hope that mutual agreement will accomplish more than can ever be attained by regulations.