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The referral system

Introduction

THE government's discussion document *Review of restrictive trade practices policy*[1] threatens to make established restrictive practices, including those in the professions, illegal unless an exemption is applied for and obtained. The document takes a precedent from article 85 (3) of the Treaty of Rome, which deals with exemptions. This states that each exemption must satisfy each of the following criteria. The exemption must:

- contribute to improving the production or distribution of goods, or promote technical or economic progress;
- allow consumers a fair share of the result in benefits;
- not entail restrictions which go beyond what is indispensable to attain those objectives;
- not allow competition to be eliminated.

These principles make it clear that if the College, or the profession as a whole, is to argue for the preservation of the near monopoly of general practices on primary medical care, the arguments must be persuasive. To underscore the seriousness and urgency of the problem, the Director General of Fair Trading has referred the issue of advertising by medical practitioners to the Monopolies and Mergers Commission. Although advertising may be the first target of those who question restrictive practices in medicine, it is unlikely that the referral system will not come under scrutiny. Further, although we may well be able to call on the support of a majority of our colleagues in specialist medicine in the defence of the referral system, we cannot assume this. The defence of the referral system will be taxing intellectually, morally and politically.

History

At the beginning of the nineteenth century medical care was provided by three groups of doctors: physicians, surgeons and apothecaries. The status of surgeons had risen progressively during the second half of the eighteenth century, and by and large physicians and surgeons attended the well to do, expecting the apothecaries (who looked after what we now think of as the lower middle and working classes) to refer difficult cases to them. Nonetheless the roles of all three categories of doctor were not clearly defined, and there was a great deal of rivalry and bad feeling between the groups and their professional organizations.

Reforms in the mid-nineteenth century were aimed at creating and regulating a unified medical profession. Much of the impetus for these reforms came from the newly emerging general practitioners — apothecaries whose route to professionalism had been the licentiateship of the Royal College of Surgeons. The Medical Acts of 1815 and 1858 resulted in the unification of medical education. The postgraduate split into consultants and general practitioners therefore went against the grain of this reform, and indeed in the mid-nineteenth century the British Medical Association appeared to be in favour of fusing the general practitioner and the hospital 'honorary' into one kind of doctor. In her classic *Medical practice in modern England,*[2] Rosemary Stevens points out that had this taken place, the pattern of medical care in England would now be akin to that in the United States of America. What appears to have been at stake in the second half of the nineteenth century, was the wish of physicians and surgeons to exclude general practitioners from the hospital. The price they paid for this was the referral system. Stevens writes '... the physician and surgeon retained the hospital, but the general practitioner retained the patient'.

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These arrangements became increasingly entrenched in medical etiquette in the first half of the twentieth century, and were enshrined in the arrangements for the National Health Service. What had begun as a restrictive practice, brought into being largely in order to protect the livelihood of the doctors, came to be seen in the late twentieth century as the basis (perhaps the only rational basis) for planned pre-paid medical care, whether financed by taxation or by private insurance.

The referral system can now be shown to have benefits which relate to medical logic, to cost effectiveness, to the development of a rational hospital service, to medical ethics and to the place of general practice in UK society.

Medical logic

Our present system permits a generalist in the community to act as a gatekeeper to expensive high technology specialist care. This gatekeeper role has two functions: to contain the majority of care within general practice, and to choose discriminately what specialist advice may be required. These functions require the highest professional skill. Self referral to a specialist simply relegates these professional tasks to the untrained layman.

Tiredness, for example, is a common complaint about which laymen have a variety of health beliefs. To which specialist would patients complaining of tiredness refer themselves? Diagnoses like depression, anaemia, cardiorespiratory disease, endocrine disease, neurological disease, musculoskeletal disease and much else must all be considered by a clinician. Further, the general practitioner is aware that most cases of tiredness can be related to the vicissitudes of life, and will not be explained by a classical diagnosis. In reaching such a diagnosis the general practitioner is trained in a rigorous approach to clinical problem solving — particularly rigorous because the process depends primarily on a skilfully taken history, an economical physical examination and a minimal use of low technology investigation. The general practitioner is in a position to reduce both over-investigation and undesirable medicalization. In this the UK general practitioner is further aided by his background knowledge of the patient, the patient's family, past patterns of behaviour and social context.

Further, the NHS model of general practice and hospital referral results in the creation of a single comprehensive life-long record of the patient's health and care, collated and kept by the general practitioner. Such a record is indispensable for logical medical management. Much emphasis is now placed on the standards and use of this record as a marker of quality in care. In the absence of the referral system it simply could not exist.

A woman with a breast lump might reasonably demand immediate access to a surgeon. It might seem self evident that a patient suffering from a hernia should similarly seek to self refer to a surgeon. But even here there are dangers in taking the argument too far. Contrary to popular belief research has established that the prognosis of carcinoma of the breast (at the stage of breast lump) is little affected by delay in confirming the diagnosis. There are many cases of hernia where surgery may be feasible, but neither necessary nor desirable. Of course the opinion of the surgeon in such cases is important and should be sought early: but there is no advantage in direct access.

The advantage of the referral system is that when a patient requires to see a specialist, there are always two opinions. The whole thrust of the College's view on medicine in general practice suggests that both opinions have independent value, and that the view of the specialist, even in relation to a disease in his own specialty, will not necessarily override that of the general practitioner who has special knowledge of the patient and the context of the problem.

Already the medical profession in this country permits and encourages direct access to specialist services for trauma and sexually transmitted diseases. Here the arguments for abandoning the referral system are strong, but it is as well to look at the reasons because they are by no means easily extrapolated to other branches of medicine. The direct referral of significant trauma to an accident and emergency department is logical — any delay in the arrest of haemorrhage and the relief of pain, for example, may be life threatening. The primary care of patients with sexually transmitted diseases in special clinics has in the past been a feature of the NHS, and thought desirable — but not necessarily because of the technical complexity of diagnosis and treatment. There are two other reasons which make this a special case. First, the social stigma of sexually transmitted diseases might discourage patients from approaching their family doctors. Secondly, the need to trace contacts and pursue an active programme of prevention requires an epidemiological approach which goes beyond the boundary of the practice population and the competence of primary health care teams. These exceptions, trauma and sexually transmitted diseases, therefore, do not seriously invalidate the general rule about referrals.

There have been representations from cardiologists that patients with chest pains should have direct access to their service, and similar suggestions have been made by paediatricians in relation to children suffering from asthma. Although the College should concede the power of some of these arguments, there are important opportunity costs in abandoning the referral system here. General practitioners would soon become clinically de-skilled, with serious results for the overall quality of their care. The immediate evaluation and management of chest pain and of respiratory distress in children remains within the competence of the general practitioner. If there are problems with the quality of care in these cases, the remedy is better medical education and a better organized service, not a removal of responsibility.

Cost effectiveness

Outpatient departments generate greater cost per consultation than general practice — hospital premises are more extensive and elaborate, the clinical and clerical work is more labour intensive and the use of high technology facilities is much more frequent. Moreover the indications for resorting to high technology investigation are less discriminating in hospital medicine than in general practice.

Such data as exist suggest that the cost of an outpatient consultation is some four times that of a consultation in general practice. In the 1986 hospital costing returns the Department of Health and Social Security gave a figure of £27.00 per outpatient visit in district general hospitals. If the total cost of general medical services for 1986 is divided by the number of consultations in general practice which took place in that year, we arrive at a figure of £5.80 per consultation. The basis for this calculation is clearly cavalier, but the order of difference remains impressive.

The effect of self referral to specialists would probably result in a geometric progression in the number of patients seen. Each self referral would generate follow-up appointments, and in the case of patients with chronic conditions these could become very long term indeed. Further, cross-referral would probably escalate. Specialists who judged that the patient's problem fell outside their own sphere of competence would be unlikely to refer the patient to a general practitioner. Since direct referral to specialists would create a totally different view about the competence of general practitioners, the likelihood is that these patients would be referred to other specialists. The financial cost of helping a patient whose tiredness was caused by marital conflict and the need to hold down two jobs would be considerable if the journey to this conclusion was routed through the departments of endocrinology, rheumatology, neurology and psychiatry.

We should note that both health maintenance organizations in the USA and the NHS in the UK depend on a gatekeeper function in primary care, in order to contain cost. In the UK, it is the NHS general practitioner's gatekeeper function on private referrals to hospital specialists, which limits the cost of cover

by BUPA and PPP. Without such controls, the cost of these insurance schemes would be prohibitively high.

Development of specialist hospital services

The values and skills of generalist medicine are integrative, and achieve a balance between different body systems, between the physical, psychological and social components of the patient's problem, and indeed between those problems which are amenable to health care and those which require help from outwith the health care professions. Metcalfe has pointed out that the exclusion of serious likelihood of disease is a major task in almost every general practitioner consultation (personal communication). In contrast, the clinical task of the specialist is the diagnosis of disease within his or her own field of expertise. This vitally important specialist task in modern medicine is not only different from that of the generalist, but cannot be safely accomplished in the absence of a primary generalist appreciation of the problem. Just as general practice requires the additional expertise of specialist medicine in the care of patients, so specialist medicine requires the discipline of general practice.

Few specialists can function without ready access to expensive hospital technology, even on an outpatient basis. If specialists offered primary care, they would only be able to do so as specialists, deploying a high technology approach to diagnosis and management. The likely effect would be an escalation of the use of this technology, and since this use would of necessity be less discriminating the efficiency of the service is likely to deteriorate. The specificity and sensitivity of specialist care would both decline. The erosion of the referral system is likely to slow the development of specialist medicine and make it less effective, less efficient and less innovative.

Ethical considerations

Four principles of medical ethics should be considered: beneficence, non-maleficence, autonomy and justice. The arguments previously adduced in this paper in relation to medical logic have suggested that the referral system is beneficient and non-maleficent (it enhances the probability of doing good and diminishes the possibility of doing harm).

It may be argued that by restricting access to specialist care, by making it contingent on a referral by a general practitioner, the patient's autonomy is diminished. However, to exercise full autonomy the patient's choice must be informed. Despite the College's wish that patients should be as fully informed as possible about health matters, and about their own condition of health, the general practitioner will almost inevitably be much better informed. It is the quality of the general practitioner's performance in detecting the need for a second opinion, and in helping to choose the relevant specialist, which ensures the relevance and quality of that specialist opinion. Self referral to a specialist therefore gives only the illusion and not the substance of true autonomy.

Finally, the abolition of the referral system by de-skilling general practice, perhaps even eventually by destroying it, will have a heavy opportunity cost for society. In this sense, abandoning referral will damage the principle of justice.

Survival of general practice

The intentions of government in attempting to limit restrictive practices and to dismantle monopolies are generally admirable and clear. They are to allow market forces to operate in the interests of the client/consumer, by encouraging competitive pricing and discouraging unfair collusion to keep costs up and so artificially to inflate the rewards of monopolistic suppliers. By abandoning the convention that patients for the most part can only gain access to specialist care as a result of a referral by a general practitioner, government might hope to give people greater freedom of choice, to contain costs of medical care and to augment quality.

It has indeed been argued that 'supply side competition' between general practices might result in all these benefits, although powerful arguments have been advanced against this thesis. Competition between general practitioners and specialists (even if it were contained within the NHS) would not only fail to achieve these benefits, but would guarantee the reverse. This paper argues that real choice depends on informed choice: that far from containing costs, such competition would increase them; that the effect on the quality of care would be deleterious.

Once the present convention about referrals is set aside, new and distorting financial considerations may come to affect the general practitioner's decision to refer. The general practitioner may come to see that when he refers a patient to a specialist on clinical grounds, he is in fact giving up a part of his livelihood. Specialists might take over the primary care of the young, the relatively fit and the employed. General practitioners (whose clinical skills would then be eroded) would be left with the care of the old, the chronically handicapped and the disadvantaged.

One of the great strengths of UK general practice, a tradition which predates the NHS, has been the cohesive function of the general practitioner. Richard Hoggart, describing his childhood in a northern working class neighbourhood,[3] wrote that the general practitioner was the only representative of the middle classes in his town who was really able to relate to the lives and families of working class people. What was true in the 1930s remains true in the 1980s. Support for the NHS in the UK spans the political spectrum. There may be party political differences about how to support the service, but there is no major body of political opinion which opposes its continuation and further development. Abolition of the referral system would be likely not only to damage general practice and the quality of health care; it would erode the foundations of the NHS.

Conclusion

How can the College frame its defence of the referral system in relation to the four criteria set out in article 85 (3) of the Treaty of Rome? In framing its response, the College will meet a problem which it has already met elsewhere in the current debate about the future of the NHS. We live in an age of consumerism, and the vocabulary of consumerism and the market dominates current thinking about reforming and developing health care. These economic arguments are important, and the College is on record in commending explicit and quantified standards of care, in welcoming audit and indeed a performance sensitive contract for doctors. But the doctor is something more than simply a supplier, and the patient is something more than simply a consumer of a commodity called health care. Medicine is more than an exercise in health economics; it is part of the fabric of social life, and it enshrines an age-old obligation to heal the sick. In the words of Ashley Montagu,[4] medicine is neither an art or a science in itself, but a relationship between two people, a doctor and a patient.

The relevant passage in the Treaty of Rome, however, is concerned primarily with goods and services which have the quality and quantities of commodities. Even in these terms it is possible to argue that the referral system is a necessary exemption which would satisfy each of the stated criteria.

1. The referral system contributes to the improvement of the quality of care by limiting over-medicalization, over-investigation and over-treatment. It permits an appropriate division of tasks between generalists and many specialists ('the distribution of goods'). It promotes technical progress (by freeing specialists to develop their services further) and ensures economic progress (by containing the costs of medical care).
2. If, for the purposes of this argument, the term consumer is taken to be synonymous with patients, it is essentially the consumer who benefits from the referral system. However, we cannot deny that at the same time there is benefit to the general practitioner as 'supplier'.

3. The College does not argue for any retention or extension of the referral system beyond what is indispensable to attain these objectives.
4. The maintenance of the referral system does not eliminate true competition. The dismantling of the referral system would set up quasi-competition between non-equals. This paper does not argue that general practitioners should not compete in quality and cost effectiveness with one another, or that cardiologists should not compete with one another, or general surgeons — only that there can be no true competition between 'suppliers' of totally different 'goods'.

Legislation to remove restrictive trade practices, to limit monopolies and regulate mergers are means by which any government, however committed to the benefits of a free market, seeks to regulate the market for the good of society. In this instance, what makes sense in a market, makes no sense whatsoever in medicine.

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Medical indemnity — a collective responsibility?

THE advertisements in the medical press offering professional indemnity to general practitioners are enticing. These new schemes offer cover to general practitioners at rates which are likely to undercut substantially the subscriptions to the traditional medical defence organizations. These developments seem to be in the spirit of the age which encourages competition as the most effective method of reducing costs giving direct benefit to the general practitioner and indirect benefit to the government through a reduction in overall practice expenses.

It is probably too late to stop the fragmentation of arrangements for providing medical indemnity in this country but serious thought must be given to the consequences. For over a century the medical profession itself has assumed responsibility for covering the costs of legal actions and settlements. The new schemes are able to offer insurance cover at relatively low rates because they only offer policies to those doctors who are considered to be at low risk of litigation. They are thus divisive both in their intent and in their operation. In comparison with surgeons and obstetricians, general practitioners are considered to form a low risk group. However, many general practitioners deliver babies and many work in anaesthetics. In future, is the range of activities undertaken by general practitioners to be determined by insurance considerations rather than the needs of patients?

If the new schemes are successful in recruiting low risk doctors, the traditional defence organizations will have to adopt similar selective policies or be left with only high risk members. The Medical Protection Society is already reported to be replacing the present flat-rate subscriptions with differential rates.

The virtues of the existing defence organizations are in danger of being over-looked as some general practitioners pursue short term financial gain. The new schemes provide cover on a short-term basis and there is no guarantee for the individual doctor that cover will continue to be provided at the same attractive rates. In contrast, the defence organizations have demonstrated that they can provide cover on a long-term basis for generations of doctors. They provide legal advice as well as insurance cover and have built up a wealth of experience and expertise in defending doctors. They have regard for the need to defend the reputation of doctors and decisions to defend legal actions rest on the merits of the case and not on purely financial expediency.

The defence organizations can be criticized for not making more use of their experience to help doctors avoid the pitfalls in practice which result in legal actions. Even here, welcome developments have taken place in recent years, with publications from defence organizations drawing attention to trends in litigation and areas in which clinical practice should improve.

The widening gap between the subscriptions for the Medical Defence Union of Scotland and the other two defence organizations, the Medical Protection Society and the Medical Defence Union, is of interest. Membership of the Scottish society is limited to medical and dental graduates of Scottish universities and doctors who complete at least one of their preregistration house officer posts in Scotland. Scotland has a long tradition of exporting doctors to the rest of the United Kingdom. The separate legal system in Scotland is unlikely to account for the increasing discrepancy in subscription rates. The selection and education of undergraduates in Scotland would seem to be the major factors responsible for the relatively low number of claims made against Scottish graduates. It is important that this difference in claims experience is analysed in detail so that the lessons for medical education can be learned.

Changes in the arrangements for medical indemnity cannot be seen in isolation from the general picture of medical litigation. The number of cases brought against doctors has doubled over the past three years and major individual awards made against doctors can now be expected to exceed one million pounds. This rapid rise in the number of actions may be good news for lawyers but it is not necessarily in the best interest of patients. In legal contests lasting several years both the patient and the doctor are likely to be the losers. Patients and their relatives may have to endure a series of hearings with awards made by lower courts rescinded by higher courts on appeal. The initial injury which stimulated the action is compounded by the anguish and uncertainty of prolonged legal proceedings even if the case is ultimately successful. For the doctor similar anxiety and anguish will be experienced during the years of court hearings.

Changes are necessary in the way in which compensation for medical accidents is awarded. Sweden has shown that a system of 'no fault' compensation can work satisfactorily. There is widespread support for the creation of such a scheme in the UK but the present government has shown no interest. Without radical reform of this kind the number of legal actions against doctors is likely to increase further and subscriptions to the defence societies or insurance premiums will continue to rise.

'No fault' compensation is often misunderstood. An excellent analysis of existing schemes is given in the booklet *Medical negligence: compensation and accountability.*[1] 'No fault' compensation does not remove a patient's right to sue a doctor for medical negligence but is a separate procedure whereby a patient can apply to a board for injuries resulting from a medical accident. In Sweden there are two boards. One determines the amount of compensation to be awarded and the other investigates the background of the accident and any avoidable factors. The prime role of the second board is educational. Whether or not the medical profession continues to be collectively responsible for medical indemnity, for a system of 'no fault' compensation to have any chance of implementation we need to be united in campaigning for it.

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