The case for widening the referral system

ABSTRACT—General practitioners (GPs) in the United Kingdom are vigorous in their defence of their sole right to refer a patient to a specialist. However, a strong case can be put for allowing access to specialist services through other channels of referral such as open access clinics, direct referral by district nurses, residential and nursing home managers or social workers. GPs and hospital consultants have long-established work patterns and are likely to be reluctant to change. But if all patients are to receive the level of expertise to which they are entitled, the barriers at the hospital/community frontier will have to come down.

The general practitioner’s (GP’s) primary duty, some say, is to protect patients from hospital medicine [1]. However, most hospital doctors and many GPs would argue that the true skill of a GP is to ensure that patients who need specialist attention are referred promptly and appropriately. There is nothing more galling to a hospital doctor than to see someone arrive in the final stages of a potentially treatable disease, or to learn of a death in the community under similar circumstances.

Referral systems vary in different countries [2], but in the United Kingdom (UK), medical etiquette prevents a consultant from intervening except at the request of a GP, unless the patient is seen as an emergency or attends certain open access clinics. The UK referral system limits patient access to specialists and amounts to a restrictive practice [3]. The UK population receives less medical care from specialists than the population of most Western European countries, and much less than people in the USA [4]. As Coulter has noted, referral rates hide failures to refer, which can lead to patient harm, and too great an emphasis on reducing referral rates may be counterproductive [3]. The interface between primary and secondary care has been identified as a priority area for research and development in the NHS because of concern about variations in GP referral rates and the appropriate use of specialist services [5].

At times, issues related to medical practices are referred to the Monopolies and Mergers Commission, provoking a vigorous defence of the present referral system by GPs [6,7]. This paper presents the opposite case, for debate.

The GP’s role as gatekeeper

The primary/secondary care interface sometimes seems like a frontier between the hospital service and the community. Most patients need a visa, issued by their GP, to obtain access to hospital services. Consultants are not free to move into the community in response to a patient’s need, but require an exit visa for domiciliary visits or outreach clinics. The latter can, for the purpose of discussion, be regarded as outposts of the hospital service. The community is GP territory and hospital doctors trespass there at their peril. Community paediatricians, community psychiatrists and occasional community geriatricians do work on both sides of the frontier, but their hospital base is usually limited.

In my view this situation is neither ideal nor necessary. As a profession we need to ask ourselves—like the character in Robert Frost’s poem—‘What are we walling in or walling out?’ [8]. It is not sufficient simply to reply ‘Good fences make good neighbours’ [8].

The benefits of the GP’s gatekeeper role are said to include restriction of access to high technology hospital care, use of the most appropriate specialist at the most appropriate time, maintenance of a single GP medical record, and overall reduction in health costs [6]. However, as Coulter comments, ‘we need reassurance that the British system does not result in underinvestigation and undertreatment’ [3]. Such reassurance is lacking.

Good medical practice includes readiness, where circumstances warrant, to consult appropriate professional colleagues [9]. Yet many of the public’s complaints about GP services relate to failure to visit, or to examine adequately, or to refer for a specialist opinion [10]. This being the case, changes in the referral system could prove beneficial. Widening the system may be particularly important in specialties that have lost many hospital units in recent years, namely, psychiatry, geriatrics and psychogeriatrics. It is essential to enable consultants in these specialties to use their skill across the hospital/community barrier for the benefit of the public.

Possible reasons for variations in GP referral rates

Variations in GP referral rates of at least three or four fold have been reported, but there is little information about the distribution of referrals between specialties [11]. Attempts have been made to explain variations between GPs in terms of patient variables, provider variables and health care system variables, but no clear pattern has emerged [11]. Researchers are now looking at psychological factors, such as attitudes to risk and tolerance of uncertainty, that may affect a doctor’s threshold for referral [11]. Psychiatrists have found that the development of relatively autonomous com-
munity-based units encourages rivalry between them, and hinders appropriate transfer of patients [12]. Issues of personal autonomy and interpersonal rivalry can hinder referral from primary to secondary care [13]. In general a doctor’s personal feelings, attitudes, knowledge base and past experience will all play a part.

External factors are also involved. Doctors may be influenced by patients, their relatives, district nurses, or the staff in residential or nursing homes. Financial considerations, or the old workhouse image of a local hospital may contribute, and acute beds may not be available. Ready access to laboratory tests and X-rays can encourage GPs to hold on to patients too long while they search in vain for a diagnosis, and limited exposure to a specialty during training may lead to a false sense of expertise. Some medical problems present as social emergencies, and medical aspects may be overlooked. Regrettably, the need for expert geriatric assessment of all elderly people admitted to residential and nursing homes is not yet accepted [14].

Doctors differ widely in their views about treatment and investigation, particularly for the elderly. Some consider hospital doctors too enthusiastic and favour an undisturbed decline at home. If the problem is one of failure to recognise the potential for treatment, patients or relatives who insist on a second opinion may be vindicated. Ready access to a second opinion is a safeguard when normal channels fail.

Arguments used in defence of the status quo

- Open access to a specialist opinion, without the need for referral by a GP, is seen as a threat to general practitioners [7] since ‘The strength of general practice in the British medical hierarchy can be said to depend, at least in part, on the existence of the referral system’ [3]. Status issues are involved for consultants too.
- There are fears about fragmentation of care but the present referral system does not prevent this. Patients are often known to several consultants in different hospitals and to several GPs in a group practice.
- Widening the referral system need not devalue the GP medical records, providing that reports are sent to the GP in the usual way, duly considered and filed.
- There are concerns that outpatient clinics will be overloaded with apparently trivial referrals. This already occurs in some specialities. A screening process could be devised, as has been suggested for orthopaedic clinics [4]. Non-urgent medical patients presenting in the casualty department could be seen by medical registrars in a medical sorting room, and, if necessary, referred for a consultant opinion.
- Some argue that the GP has a unique role as a generalist [7]. This is not entirely true; most consultant geriatricians are still general physicians who treat the patient holistically, support carers and, to quote Sweeney, ‘unravel the diagnosis from nonspecific and disorganised symptoms’ [7].
- The argument that self-referral does not enable the patient to select the most appropriate specialist advice has some merit, but referral by a GP does not guarantee that the ball will be in the right court. A person with indigestion may well have an endoscopy before his coronary thrombosis. Medicine is an art, and few get the diagnosis right all the time.
- There is concern that self-referral would slow down the development of specialist medicine [7] but this could prove to be an advantage. In some specialities, clinics already resemble factory production lines. It is not in anyone’s interest for a doctor to have to specialise too much.
- Defenders of the status quo argue that the present system gives the patient the benefit of two opinions—their GP’s and a consultant’s. This is true only if the GP chooses to refer; if not, the patient has only one opinion, which may not be helpful, and could be wrong.
- It is argued that referred patients may be subjected to unnecessary procedures, but specialists with long waiting lists do not readily take on unnecessary work. Moreover, accurate diagnosis at an early stage can reduce the number of inappropriate investigations. Concern is also expressed that referral may increase the potential for iatrogenic, drug-induced disease, but in my experience the reverse is the case [15].
- Finally, the present system is said to reduce overall health costs. While this may be true, any financial savings must be balanced against the cost to the patient of a delayed or missed diagnosis, needless anxiety or pain. As Marinker wrote: ‘Medicine is more than an exercise in health economics: it is part of the fabric of social life, and it enshrines the age-old obligation to heal the sick’ [6]. All doctors would surely subscribe to this view, and none should be prevented from exercising their art by outdated restrictive professional practices.

Precedents that have been set

Some precedents have been set without disastrous results. Many casualty departments function as open access self-referral departments, and many self-referred patients need admission. The current pressure on casualty departments may be due in part to real or perceived imperfections in primary care. Open access also operates in the field of venereal disease, in the provision of family planning services, and in some clinics for drug or alcohol abuse. GPs are not the only
ones who have rights to refer [3]; community clinical medical officers refer patients to paediatric, ENT and eye clinics, and there is cross referral between consultants; health visitors can refer to hearing clinics, eye clinics or child psychiatry, orthoptists refer to eye clinics, social workers can refer to child psychiatry, and some consultants allow former patients to re-refer themselves to outpatient clinics [3]. In some districts social workers refer elderly people to community units where medical advice is available: this may be given by a GP, not necessarily the patient’s own, by a clinical assistant or staff grade doctor linked to the local geriatric or psychogeriatric department and/or by a consultant visiting on a regular or domiciliary basis. These units, which are the exception, rather than the rule at present, can work well.

The need for change

With the closure of hospital wards, new patterns of care are evolving, and more frail and ill people are being cared for in the community. There is cause for concern [16]. Psychiatrists [12], geriatricians [17], palliative care specialists [18] and paediatricians recognise the need for programmes of care that cross the hospital/community interface, but innovative schemes may generate fears about erosion of the traditional referral system [14]. At least one government advisory committee recognises that specialist services may need to be accessible through channels other than the patient’s GP, with the knowledge of the primary care team [18]. Such channels might include referral by district nurses, residential and nursing home managers, social workers or teachers. Many patients and their carers could benefit from a relaxation of medical protocol. Providing that the primary care team and consultants treat each other with respect, cooperate and liaise effectively, the medical profession need have little to fear.

Changes in the referral system are likely to be resisted by GPs, for reasons already mentioned. Government pressure for a primary care-led health service will also reinforce the GP’s gatekeeper role, and fundholders could decline to pay for patients referred through other channels, necessitating alternative sources of funding. As the winds of change buffet the NHS, most professionals will tend to cling to traditional work patterns. Cooperation between professional groups may be most difficult when it is most needed [19]. However, none of these points negates the need for the profession to consider and debate the issues raised in this paper. In my view it is time to take down the barriers at the hospital/community frontier, and if this means widening the referral system, then so be it.

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