The Virgil Role

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The referral of a patient for subspecialty consultation and examination is but one facet of the primary care physician's involvement with his patient. Using examples from my practice, I argue that the term "gatekeeper" is an inadequate term for describing what the primary care physician does, or should do, for his patient. "Virgil Role" is offered as an alternative expression based on a proposed parallel between Dante's passage through the Inferno accompanied by his mentor-guide, Virgil, and a sick person's journey through his personal Hell of illness and the labyrinthine medical care system, guided by his physician.

Gatekeeper. When I hear the word, I picture the splendidly dressed doorman at a posh hotel, his uniform a spotless scarlet with sparkling yellow epaulets; the bare-chested, gold-chained thug at the disco door; the swaggering young guy at the entrance to my hospital parking lot, bloated with self-importance as he repeats the daily check of my parking tag for the 334th time this year. I picture someone who says yes or no, you can enter or you can't, like the guard at our local bank who opens the door for the impatient crowd at precisely 8:30 each morning. Whether or not the term is condescending or pejorative can be argued, but there is no argument that it is a grossly inadequate, inaccurate description of the process of patient referral.

A 45-year-old man has a large meningioma of the tuberculum sella encasing major blood vessels. He requires referral to one of the few neurosurgeons with adequate experience in removing such tumors. The referral

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involves discussion with neurologists, neurosurgeons, radiologists, arguments with the insurance company, a literature search for outcome data, and meetings with lawyers. The insurance company insists on a local surgeon with far less experience than the choice neurosurgeon; and although my colleagues agree with me, none are willing to put this in writing. To whom should he be referred? How far does patient advocacy go?

A 64-year-old man is considered by his cardiologist to be a success story after repair of an acute aortic dissection, but in fact has an ongoing dissection, intermittent neurological deficits and progressive aortic insufficiency. Referral for further surgery involves multiple examinations, discussions with subspecialists and the sorting out of occasionally contradictory advice to convince the cardiologists and cardiac surgeon that the initial surgery was not the end of the story and that urgent further surgery was necessary.

A 21-year-old visitor at the kibbutz complains of lower abdominal pain and a discomfort in his left testes; ultrasound (US) examinations of his testes and abdomen confirm a malignant mass with nodal spread. Referral to his native country involves breaking the bad news to him, writing letters to his consulate and to the airline company, translation of documents, and multiple telephone calls overseas.

A 72-year-old man is seen for an inguinal hernia. Referral for this "bread and butter" problem requires a delicate explanation—a forewarning—that the local surgeons have recently been doing laparoscopic hernia repairs with occasional disastrous results and are not in the habit of giving the patient the option of a standard hernia repair. The referral which he is given specifically advises against laparoscopic repair.

A 31-year-old woman requests referral to an orthopedist for upper and lower back pain, almost certainly related to her chronic poor posture and to multiple serious insoluble current personal worries, none of which she wants the orthopedist to be aware of. Referral requires preparing her for what is likely to be an inappropriately aggressive orthopedic evaluation.

I could list a dozen more examples just from this past month's primary care experience, but these few examples make the point. The process of patient referral is rarely a simple gesture of opening a gate and letting the patient pass on to a subspecialist.

The referring physician must have sufficient medical knowledge to know when and why to refer and then to assess the reasonableness and plausibility of the consultant's advice. He should know enough about the consultant to judge his level of knowledge, skill, judgment and his behavior with patients.