The Consultation Process and its Effects on Therapeutic Outcome

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There is little in the literature dealing with consultation from the point of view of patient care. Since one of the major elements in the definition of family practice deals with the synthesizing role and the responsibility of the family physician to help guide patients through the complex health-care system, it is entirely appropriate to take a critical look at the consultation process. This will allow more appropriate teaching of the family practice resident, so that he may use consultation and referral in a more productive manner in the future. This paper defines and discusses six common problems in the consultation process. Classification of pitfalls in the consultative process can serve as a starting point from which a more critical and systematic study of the consultation can be made, to the end of making the consultant and the referring physician both more skilled and more comfortable with their coordinated tasks.

It has long been appreciated that the *manner* of prescribing, the doctor's spoken and unspoken expectations that accompany the prescription, and the follow-up exchange between patient and physician affect the therapeutic outcome of a drug regimen.[1] The technique of prescribing and delivering a medical consultative referral, however, has received little attention. There exists a traditional mechanical (terse note on a standard hospital form) or offhand ("Call Dr. Jones, tell him I sent you") method of making such referrals. At the other end, the consultant's answers come back in a variety of nonstandardized ways ranging from secondhand messages sent through the patient to scholarly treatises worthy of textbook publication.

The problems of referral that lie beneath the consciousness of the medical profession are many. Six common problems relating to referral and consultation will be discussed, accompanied in some instances by illustrative cases. It is hoped that this paper will focus interest on the therapeutic value of the consultation process itself.

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Problem #1. Resistance to Referral on the Part of the Family Physician

The greatest stumbling block here has been, of course, the threat to the physician's ego. This should become less of a problem as a generation of medical humanists takes the field. No longer does our culture tell us that we should be the ultimate in everything, or even in anything. Physicians are not expected to be gods even by their most adoring patients (unless such claims are made verbally or nonverbally). Physicians will gain as much respect from their patients by knowing when a specialized opinion is needed as by making an astute diagnosis followed by a startling cure.

In some areas, family physicians resist referral because they fear losing the patient to the consultant.[2] However, if the consultant is truly a consultant, he cannot very well provide a family or primary medical service. He cannot remain competitive as a consultant by serving as a primary or family physician.

It is dangerous to act out of pride against a family's initiation of a suggestion for consultation. If the primary care physician honestly feels it would be a waste of resources to consult or refer, he has the obligation to say so. However, if his protestations are not well received, or have failed to calm fears, he is foolish not to acquiesce. At best, an unhappy result may be followed by the family surreptitiously consulting someone on their own, perhaps someone who was not of the physician's choosing and with whom he has no opportunity to exchange information. At worst, litigation may result.

Problem #2. Resistance on the Part of the Patient to Consultation

There can be many causes of this problem, most of which are related to dependency by the patient upon the primary care physician. In these instances the physician is in control and the situation should be remediable. The following causes can be briefly outlined:

1. *Apprehension of the unknown.* The solution here is obviously a rational explanation of the need for consultation. It must be pointed out that referral is in the patient's best interest. Some description of what the consultant might do is often needed to allay fear. The physician must be alert to non-verbal signs that may indicate resistance in this area.
2. *Failure on the part of the patient to take his illness seriously enough.* If the illness is real and the patient is mature, simple, direct education is usually effective. Other subtypes of this problem, however, may be involved:
   a. The person with an "A" personality[3] (usually a male) may ambivalently harbor dependency while abhorring and denying weakness or dependence. Resistance to consultation is just another proving ground for his ego. The physician must fight him, not only on rational grounds, but by strength of personality, head to head.
   b. Two kinds of manipulative patients exist. The sheltered hysteric, who is usually a female, uses deep-seated denial and requires persuasion that must

accelerate from gentle tact to hard salesmanship.

c. At a more conscious level, the seductive patient (usually a female dealing with a male physician but could be vice versa), may use apparent failure to take a need for consultation seriously as a pitch to the physician's ego, portraying him as omniscient. "After all, Doctor, I am sure you can handle it." The doctor must then decide if her reaction is a signal to "cool it, my symptoms aren't real anyhow." Whether he decides for or against referral, his demeanor will be most successful if he maintains professional firmness in a nonjudgmental manner.

3. *Financial.* There may be legitimate fear in this area. It behooves practitioners to be aware of public assistance programs and to be ready to reduce fees and to request consultants to do likewise.

Problem #3. Failure to Follow Through

Following through is a three-way transaction between primary care physician, patient, and consultant. Some cases need little follow-through; whether in hospitals or in outpatient settings, and some cases are appropriately managed by turning the primary responsibility for care over to the consultant for a certain period of time. However, when a patient has multiple problems, often requiring many medications, or when there is emotional overlay, or when the patient has difficulty forming new relationships, the family physician should continue to be actively involved in the care of the patient.

The primary care physician is naive or shirking if he expects his consultants to review all the medical aspects of his cases. Even when the consultant does so, he will sometimes not be on the scene when the patient needs attention, and then the family physician is likely to be replaced by yet another specialist who must invest expensive time to bring himself to an adequate level of knowledge of the case. In that event, aspects of the patient's medical and personal situation may or may not be treated in a balanced perspective. Failure by the family physician to follow through when it seems appropriate, may be seen as sloughing by consultants and as rejection by patients.

Problem #4. Failure to Adequately Interpret the Patient/Family Complex to the Consultant

In the case history that follows, the problem can be restated as a corollary: *failure to match consultant and patient.*

Mrs. D., a 55-year-old woman, had epicondylitis refractory to repeated steroid injections, and was referred to an orthopedist. She had been known to the family physician during the previous five years when he had cared for her elderly aunt who had resided in the patient's home. A keystone of the treatment of the aunt's ulcer disease had been to move her to a hospital milieu and away from the tension-provoking double messages which had emanated from Mrs. D. Mrs. D. was a rigid, anxious person who used denial as a prominent defense mechanism. She had resented her aunt's presence, and therefore, the aunt's illness more so. The doctor gained what at the time seemed the dubious distinction of becoming her own physician but managed to earn her trust. This had come mainly through giving her permission to admit her difficulty in dealing with her aunt.

Referral to the orthopedist came after the family physician had ordered hospitalization to evaluate a possible radicular component to the pain of her tennis elbow. This was effected in the classic way, using a terse medical inquiry at the top of a standard hospital consultation form.

The match between patient and consultant was a case of "divorce before the recessional ended." He told her on the first hospital visit that she needed surgery for the epicondylitis, and acknowledged that she had osteoarthritis of the cervical spine, but that surgery would not correct that. She quoted him as saying before he departed, "and surgery won't correct a vaginal discharge." The last was interpreted by the family physician as the consultant's response to demands and entreaties, some of which he felt were threats by the patient lest he fail, and others that were irrelevant to the case.

The family physician spent much time giving explanations and calming the husband, who had angrily upbraided the orthopedist and the family physician as well. The decision by the family to submit to surgery was finally made, but not without needless travail and delay. The surgery was successful. The pain was alleviated, but the patient refused to see the surgeon in follow-up, preferring to return to the family physician.

Many problems of referral are exemplified here. First, however, was the matching of the consultant and patient by personality. Many orthopedists were available. One who was more tolerant and less defensive might have accepted the patient's nature as her own problem rather than his and been able to deal with her in a more professional manner. Having chosen his consultant with that in mind, the family physician would have done well to have prepared the consultant in advance by letter, outlining not only the medical and past histories, but also what he knew about the patient's rigid, anxious, and hysterical makeup. In this case the family physician might also have better handled his end of the referral by remaining more actively involved. His failure to do so was, in part, his unresolved feeling of being "one down" in dealing with the "specialists."[4] If he had assumed a stronger role, he might have entreated the specialist to explain himself better to the family, at least regarding the technical explanation of the surgery and its indications. The family physician's failure to solve the status dilemma may lead to substandard care. Consultation must be a total person management problem rather than a parcelling off of part of the patient for specialists to handle for a while.

Problem #5. Failure to Define for the Consultant Objectives Hoped for in the Consultation

The case report that follows also illustrates the personality matching difficulties described in the preceding problem.

A family physician discovered hypertension with blood pressure readings consistently over 150/105 mm Hg in an aggressive, somewhat sullen and hostile 34-year-old Caucasian man. Attempts to have him submit to complete physical examination and renovascular work-up met with passive resistance. The patient, Mr. E., radiated hostility but verbalized little of it. He failed to keep appointments for a

thorough physical examination, laboratory, and radiological evaluation. The physician, therefore, attempted medical management which met with some success over a two-year period.

Referral to a urologist was effected only after the patient consulted the family physician for an infertile marriage of two years, resulting in the family physician's finding of azospermia. The mechanics of a consultative referral were a few words addressed to the urologist in long-hand mentioning: (1) the azospermia, and (2) the hypertension, alluding to the fact that it had been incompletely evaluated. The patient was instructed to call the urologist, make the office appointment, and hand carry the note from the family physician.

In the course of the work-up, the urologist obtained an intravenous pyelogram. He told Mr. E. that the azospermia could not be helped and hence the infertility was incurable, but that the I.V.P. showed a non-functioning left kidney. The urologist strongly recommended left nephrectomy for a chronically infected kidney which he felt probably caused the hypertension.

Much later, Mr. E. announced gruffly that the urologist had charged a big fee after investing unnecessary time and ordering unnecessary procedures, "without taking care of what I went to see him about." The family physician tried to use the opportunity to reinforce what he had attempted previously to tell the patient about the gravity of the hypertension and the importance of a complete work-up. However, the patient would not be mollified, and his remarks implied an unwillingness to pay the urologist's fee.

Only after still another year of sporadic blood pressure tests and hard work by the family physician, did Mr. E. soften his view. By that time, there had been much talk about Mr. E.'s frantic life style, which included staying up late into the night drinking beer in front of the television set and a general restlessness born of his free floating hostility and lack of direction. He also exhibited a fierce independence born of denial of any dependency needs, in short, the attributes of the "A" personality.[3]

One day when his blood pressure was 140/80 mm Hg for the third consecutive month on medication consisting of Hydropres 50 daily, Mr. E. suggested that maybe he should consider the urologist's advice and seek the recommended nephrectomy. At the time of this writing, however, he has not yet done so.

The family physician might have worked better with the forces of collision had he prepared the patient for the probable content of a visit with the urologist. This would have included an interpretation of the consultant's position as being necessarily the last word morally and legally for all problem solving that enters his sphere of specialization. It also would have included a description of procedures that were likely to take place in the urologist's office. Further, he might have prepared the urologist in a letter or telephone call for the type of patient Mr. E. was. This should have included a warning of the patient's hostility, resentment of authority and inability to express his fears of emasculation, the basic ingredients of the "A" personality.[3] In this, he should have taken the lead as an equal colleague and made positive suggestions as to ways in which Mr. E. could be best approached in order to gain trust and compliance. Also, he might have clearly stated both the patient's and his own expectations of the consulting situation.

As with other therapeutic tools in the physician's armamentarium, a consultation will serve no purpose if the patient is not encouraged to be an active and positive participant.

Problem #6. Reticence Toward Critical Evaluation of the Consultation by the Referring Physician

The case that illustrates this pitfall was born of respect and admiration by the primary care physician for the consultant, which delayed expression of doubt in the family physician's mind and made him hesitate to contradict the consultant's diagnosis. The case in point is that of an infant who had the appearance of Down's syndrome, complete with hyperglossia, umbilical hernia, and heart murmur. A consultation was arranged for confirmation. After seeing the infant on two occasions three months apart, the consultation provided this confirmation as well as an in-depth explanation of future expectations to the family. In addition, the consultant expressed the opinion that chromosome testing for absolute confirmation was not in order.

This diagnosis was accepted by both the family and the referring physician, and long range plans were made to keep the child in the home and provide support as necessary. As time passed, the child developed an anemia unresponsive to iron therapy. She also failed to grow. It was not until several years later that the referring physician saw these latter two findings as inconsistent with the first diagnosis. A T-4 test was then found to be abnormally low, and a chromosome test was normal. Thyroid therapy was begun and the child experienced an acceleration of growth and motor development, closure of the umbilical hernia, disappearance of the heart murmur, and decrease in tongue size, with accompanying improved eating patterns. The latter, no doubt, was a significant factor in the resolution of the anemia.

Besides illustrating the need for the referring physician to have a thorough knowledge of the natural history and evolution of the problems of his patients, this case points up another pitfall of patient management. No matter how highly one regards the consultant, he or she is not infallible. The consultation does not relieve the referring physician of further diagnostic considerations in the course of time. The mimicking of Down's syndrome by a cretin is not a common differential diagnosis in daily practice. Nevertheless, the referring physician might have been suspicious of the slow growth pattern earlier, and sought further consultation to test this suspicion or ordered the T-4 earlier. Another safeguard might have been to develop, with the original consultant, a list of parameters to follow by the use of a flow chart, and to have discussed what developments might suggest a repeat consultation.

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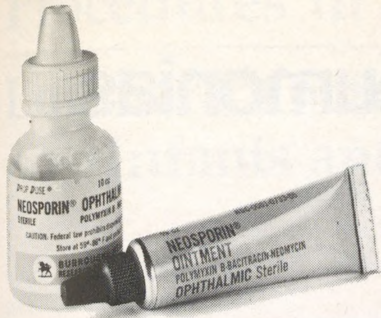

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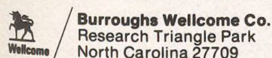

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(U.S.), $13.25 (Canada).

This small book is Volume 17 in a series entitled *Major Problems in Clinical Surgery,* and with the aid of nine distinguished contributors seeks to define the problems of treating patients of advanced age who require surgical intervention. It quite properly points out that this has become an increasingly larger portion of the health dollar and of increasing concern to those individuals whose surgical practice places them in a position of having to deal with the patients who, because of age, may present with unique hazards.

The book is organized into ten chapters, each of which is written by a contributor and attempts to deal with one aspect of surgery in the aged. The initial evaluation of physiology of the aging provides a good, albeit restricted, overview of the aging process in regard to the these patients, and is well complemented by a chapter on wound healing and inflammatory response, particularly as it relates to aging. The other chapters deal with anesthesia, fluid and electrolyte therapy, and specific respiratory, cardiovascular, or other organ system problems. There is a chapter on management of surgery in a patient with psychiatric problems and, finally, a chapter on the results of surgery in the aging.

The book is well organized, easily readable, and small enough to be of considerable practical interest. There are no illustrations, and no loss from their absence.

A family practice physician certainly is asked in many instances to deal with problems having to do with surgery in an aged individual, and it is of considerable value to counsel the family concerning the advisability or inadvisability of surgery. The specific details of management may be of some interest to the physician who is charged with pre and post-operative management of surgical cases. The specifics of techniques are of overall interest but are not considered in sufficient detail for the individual who would like to pursue these matters in depth. However, reference material is appended to each chapter to allow for further evaluation should it be desirable.

It certainly is the objective of this book to give an overview rather than a more detailed picture and this is easily accomplished. The one area in which there may be some difficulty is the attempt to exploit the uniqueness of surgery in the aged individual after one has said that it is particularly important in *any* poor-risk patient to pay meticulous attention to careful preoperative assessment and treatment, a well-conducted general anesthetic, expedient surgery, and meticulous postoperative care with early mobilization. These seem to apply not only to aged patients but to any poor-risk patient. Therefore, there may be some limitation as to the objectives of this particular volume.

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Manual of Medical Care of the Surgical Patient. *Solomon Papper (ed), James F. Hammarsten and John A. Schilling (consulting eds). Little, Brown and Company, Boston, 1976, 347 pp. (spiralbound), $8.95.*

This handy book is relevant to family practice in that many of our patients do, of necessity, undergo further surgical procedures, and this type of book certainly is helpful for our house officers in the evaluation of their patients. It is easily readable and well organized; however, as in almost all manuals which are a compilation of many subjects, the topics are treated superficially, and really, the book is of very little value for the actual treatment of the particular problem.

This book provides an excellent cataloging of the problems, and presents a concise compilation of the various problems of the surgical patient. It may be useful for some house officers in their day-to-day treatment of their ward patients, but overall, I believe that it is of very little value for the actual treatment of the patient.

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