The Development of a "Statement of Policy Regarding Consultations"

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The use of consultations in family medicine has often been misunderstood by both the persons seeking the consultations and the persons acting as consultants. A policy regarding the use of consultants has been written by the Department of Family Medicine and Practice at the Center for Health Sciences, University of Wisconsin. The statement includes a definition of "consultation," the reasons and goals for consultation, and the manner in which consultations are obtained. The policy includes the family practice residents, faculty, and patients in the decision-making process prior to all consultations.

The family physician "evaluates the patient's total health needs, providing personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of care."[1] It became apparent in 1974 that some sort of document defining the University of Wisconsin's Department of Family Medicine and Practice policy on consultation was needed. The traditional policy, that the consultant assume the total care of the referred patient, did not lend itself to the department's basic policy of the family physician maintaining "continuous care" of a patient.

As experienced clinicians in family medicine, several of the faculty members felt that a proper manner of instituting change called for a written statement of policy regarding consultations. A primary "rough draft" was completed in April 1975, and was submitted to both faculty and resident members of the department, and subsequently to approximately 80 consultants, including the chiefs-of-departments of the University Medical School and the Dean of the School. Eight replies were received from persons outside of the department, and their suggestions were used in preparing the final draft of the consultation document. The final document was approved by the faculty in June 1976 and was then distributed to approximately 140 family physicians, medical school faculty, and private consultants of the department. It has been a useful document in our relations with our consultants and it is presented here so that other family practice training programs may benefit from these endeavors.

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References

1. Meeting the Challenge of Family Practice. The Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, American Medical Association, 1966

2. Stedman's Medical Dictionary, ed 22. Baltimore, Williams and Wilkins Company, 1972, p 281

Appendix 1

University of Wisconsin
Family Practice Clinics

Patient Referral Form

Referral to:

_____

_____

_____

From:

Family Practice Clinic
777 South Mills Street
Madison, Wisconsin 53715
Phone: (608) 263-3111

Date of Referral: _____

Physician: _____

Patient's Name: _____

Patient's Number: _____

Problem:

Subjective findings:

Objective findings:

Assessment:

Medication or Procedures already utilized:

Note: See attached *problem list* for complete listing of current and chronic problems and medications. Please add new problems you identify to the list and return it with your summary.

Requested Disposition

_____Please evaluate this problem.
_____Please administer appropriate management for this problem.
_____Please refer patient back to the Family Practice Clinic for management, if appropriate.
_____Please send report of results and progress to the Family Practice Clinic.
_____Other: _____

_____
(Signature)

Statement of Policy Regarding Consultations
The Department of Family Medicine and Practice
University of Wisconsin

The Department of Family Medicine and Practice at the University of Wisconsin is dedicated to understanding the health needs of the people of Wisconsin and to developing, fostering, and promoting innovative programs related to meeting these needs. The primary Department mission is the training of family physicians who are interested in and adequate to the task of providing primary care to persons living in areas of need. Since the definition of a family physician includes the statement that he/she "evaluates the patient's total health-care needs, providing personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care,"[1] we feel that a basic understanding among ourselves, our residents, and our consultants would be mutually beneficial.

Consultants are vital to meeting one of our major objectives, that of providing a teaching program which specifically prepares physicians to continue lifelong learning in the areas of family medicine. Another major objective is that of developing the techniques of patient care and information management required to make family physicians most competent and productive. This includes the responsibility to effectively and efficiently relate to other resources in the health-care system. In order to accomplish these goals, each resident in the program accepts responsibility for his/her patient's total health care within the context of the patient's environment which includes the family, community, and other applicable social units. A primary concept of the family practice department is that the *patient* is the primary person in the health-care team and that the family physician (or other primary care physician) is the patient advocate, directing the patient's care within the health-care system. We feel that it is essential that the primary physician, with informed consent of the patient or responsible person, be the person who makes overall decisions in patient care. The role of the consultant is that of working with the primary physician and the patient to address a specific problem. Further problems which may become evident should be considered by the primary physician and the patient prior to further consultation.

"Consultation" is defined as "a deliberation between physicians on a case or its treatment."[2] We look upon consultation from three different points of view. (1) A consultation is obtained as a *service* to the patient for the best medical/surgical care the patient can receive. (2) A consultation is a source of continuing *education* on the parts of both the resident and the faculty person involved (and we appreciate consultants acting in the role of educator). (3) This department is interested in areas of *research* on how best to use consultants for the mutual benefit of all concerned.

Consultations may be requested with a variety of goals in mind. A clear understanding as to each request for consultation by all persons involved, including the patient, is essential. Examples of different reasons for consultation are as follows:

1. Consultation for a diagnostic opinion only.
2. Consultation for management advice only.
3. Consultation for diagnosis *and* initiation of management.
4. Consultation for diagnosis and complete or extended management of one or more specified problems.
5. Consultation and request to have the consultant take over entire management of a patient's problem or problems on an ongoing basis.
6. Consultation for a surgeon's advice with contemplation of a surgical procedure.

The consultation request form will clearly specify which of the above goals is requested (see Appendix 1).

In light of these assumptions our policy is as follows:

1. The resident, with supervision of a faculty member, has charge of the individual patient. He/she calls upon the consultant either by written request, telephone call, or direct personal request.
2. The resident, with supervision of the faculty member, will continue to maintain overall charge of the patient whether the patient is in the hospital or is seen by the consultant in his/her office.
3. If the consultation is of the nature of a total referral or complete care by a surgeon, psychiatrist, etc, the time period during which the consultant is totally responsible will be determined with the patient's understanding and concurrence.
4. If further consultations by other specialists are indicated, these consultations again will be sought by the resident and faculty member. These consultations may or may not be at the suggestion of the first consultant.
5. A consultant is requested not to refer patients to other consultants without the knowledge and consent of members of the family practice department, except in emergency situations.
6. The consultant is expected to submit a written report of his/her findings on the hospital chart, or, for nonhospitalized patients, directly to the referring physician in the Family Practice Clinic where the referring physician is located.

Members of the family practice department appreciate being called upon as consultants by other departments of the University Medical Center when general comprehensive and continuing health care is in the patient's best interest.

In summary, the effective use of consultants is a major concern for the Department of Family Medicine and Practice. Goals in the training of residents are to aid them in learning how to most effectively use medical and surgical consultants while adding to their individual knowledge. The ultimate results will be advantageous for the family physician, the consultant, and the patient.

As questions arise regarding this policy, they should be directed to department faculty members.

Faculty
Department of Family Medicine
and Practice