Consultation-Referral Among Physicians: Practice and Process

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Consultation-referral is a part of everyday family practice. Although the process is taken for granted, it is a complex phenomenon. Neither the practice nor the process always meet the expectations of the referring physician or the consultant, and the patient may be the worse because of this discrepany. Studies of the practice and the process support this view. A model of the process is elaborated which can be used for the teaching of medical students or residents and which the practicing physician may use to improve his/her consultation-referral practices.

The words "consultation" and "referral" reflect the complexity of medical practice and imply that a physician cannot be all things to his/her patients and community. Fifty years ago a physician may have been able to fulfill such a role, depending upon the physician's degree of isolation, skill, and knowledge. Nowadays, communication technology and the availability of air travel make possible startling examples of compression of time and distance. For example, a man suffering chest pain while working on a drilling crew in the Canadian Arctic, having the benefit of a paramedic who is able to communicate with a physician, is in an intensive care unit in a hospital close to his family within a few hours of his attack. These conditions—the increasing complexity of medical practice, the ease of transportation, and the technology of communication—also serve to highlight the problems of communication between health-care professionals. This paper will review the literature of one aspect of this communication—the practice and process of consultation and referral between physicians—and will propose a model for the teaching of both.

The term "referral" is usually used to denote the practice whereby one physician gives over the care of a patient to another physician who has particular expertise, knowledge, or use of a facility. The term "consultation" usually denotes the practice whereby one physician consults with another about a patient with the implication that the first physician will continue to care for the patient during and after the consultation. In some parts of the world the term "consultation" is also used to denote any physician/patient encounter, but this is not the sense in which the word will be used here. In this paper, these terms will be used interchangeably in the belief that they represent the extremes of a spectrum of activity, the underlying process being very similar throughout the spectrum.

Present Practice

Family physicians consult with all other physicians and the rate of referral is fairly constant in different areas of the world. Geyman, Brown, and Rivers[1] compared referral patterns of family

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physicians in the eastern and western United States, rank ordering the referrals according to specialty. General surgery, orthopedics, and obstetrics /gynecology were the first three in each area, followed by a number of subspecialties. Internal medicine and pediatrics were well down the list. Geyman et al suggest that differences in the rank order and the absolute number of referrals to some subspecialties may be a function of the availability of those specialists. The average referral rate in each area was around two percent.

Morrel[2] studied the practices of three general practitioners in suburban London, England (United Kingdom general practitioners do not usually have hospital appointments in urban centers) and found rates of 15 percent for the older physician, and 22 percent for the two younger physicians. This suggests that age and experience may be factors in referring fewer patients, but the younger physicians used more laboratory and x-ray assistance and examined more systems, both factors that had been previously correlated with higher referral rates. There was also evidence that the physicians had higher rates in their particular interest areas, or in specialties in which they had extra postgraduate training.

Collyer[3] studied the treatment of emotional and psychosomatic illnesses provided by eight family physicians in southern Ontario. He found that 93 percent of the patients with these illnesses were treated by the family physician, 12 percent were sent for consultation, and eight percent required consultant care for all of their treatment. Riley[4] obtained 103 completed interviews from 146 general practitioners in the 11 counties surrounding Rochester, New York. The sample included 34 percent of the urban practitioners and 23 percent of the rural practitioners. The rural practitioner referred patients at a rate of three percent versus five percent for his urban counterpart. Riley found no difference between the referral rates of the older and the younger physicians in either setting. Greenhill[5] studied two urban general practitioners in Elberta and found that the physician without hospital affiliation referred 6.3 percent, while the other general practitioner referred 3.4 percent and admitted 5.9 percent of his patients to hospitals. At another general hospital in Alberta with a department of family medicine, the average consultation rate of the 50 patients admitted to that hospital by family physicians has remained around 45 percent over the past seven years.* Thus, if about one half of a family physician's hospital admissions have a consultation, then Greenhill's two physicians probably refer the same number of patients.

Clute[6] estimated that 30 percent of the physicians in his study saw and treated patients who should have been referred to specialists. This opinion seems to be at variance with Geyman's study, which suggests that family physicians provide definitive care in 98 percent of the patient visits in daily practice. Geyman correctly points out that the quality of care issue has not been addressed in his as in most studies about consultation-referral. The College of Family Physicians of Canada,[7] (which commissioned Clute's study) describes how a certified family physician ought to behave in "using the ancillary and consultant service to insure exemplary health care." The objectives which cover this area state that "(a) the physician shall suggest and arrange an appropriate consultation if he has not established a satisfactory definition of the problem in his or the patient's mind, (b) the physician shall obtain suitable consultation indicating to the consultant his reasons for the consultation and his expectations, (c) the physician shall demonstrate his knowledge of a health professional's ability in tailoring the choice of health professionals to suit the needs of a specific patient and family, (d) the physician shall tactfully and ethically obtain another consultation when dissatisfied with one consultant's opinion, insuring that both are aware of the circumstances, (e) the physician shall continue to follow closely patients whose supervision he has referred to other health professionals."[7]

This emphasis on the importance of consultation in the provision of high quality health care receives support from society as well as the profession. Williams[8] interviewed a random sample of physicians in North Carolina to determine the reasons for referral to a university center. He found

*Physician Activity Study data, Foothills Provincial General Hospital, Calgary, Alberta. 1970-1976. Available from author.

that 48 percent of the referrals were initiated primarily by the patient. Of the remainder, 30 percent initiated by the physician were for nonspecific reasons and only 22 percent were for specific reasons.

Larsen[9] surveyed a random sample of 1,000 residents in Calgary on Patient's Expectation of the Family Physician. Nine hundred seven questionnaires were completed by the head of the household, either male or female. Less than 25 percent (range 12 to 25 percent) said they thought it of little or no importance that their family physician used the community health care resources which were available.

How society in general thinks about the importance of consultation-referral practice in health care is best illustrated by a study by Price.[10] He developed a set of criteria for physician performance in the patient care area. To arrive at this set of criteria, he asked a large number of practicing physicians what they considered to be the basic factors of success in their specialty and what characteristics they felt to be most important in providing outstanding patient care. This list was then submitted to over 100 selected individuals: medical educators, college and medical students, administrators, clergymen, other professional people, and patients recuperating in or recently discharged from the hospital. The respondents were urged not only to evaluate the list, but to add to and modify it. As a result, the list underwent a series of refinements until the final list consisted of 87 positive or desirable qualities and 29 qualities of negative or undesirable nature. A questionnaire was constructed with a five-point scale from "of no importance" to "of extreme importance," and, for the negative attributes, "extremely undesirable" to "of no importance." The questionnaire was submitted to 1,604 people, including a general public subsample obtained at redemption centers of a large trading stamp company in the Salt Lake City-Ogden-Provo area. The sample included health-care personnel, college students, lower socioeconomic multi-ethnic groups, blacks (sampled across socioeconomic strata), and hippies. The results were analyzed by computing means within groups and then using the average of the means as the rank so that no one group could dominate the ranking.

Ranking fourth in the positive qualities behind "clinical judgment," "up-to-date knowledge of medicine," and "ability to study patients," was the quality "readily refers patients when it is to their advantage to do so." Ranking tenth from the most undesirable quality, which read, "is negligent in handling of patients," was the quality "holds on to patients to undue degree: disinclined to suggest or seek consultation; apt to be offended if patients request consultations or a transfer to another doctor."

The decision to refer is the key to the practice, but how well the process of consultation or referral is carried out is also important. Cummins and Smith[11] received follow-up information in 75 percent of 200 referrals, after a waiting period of 60 days. Sixty-five percent of university-based subspecialists provided the information, whereas 90 percent of private subspecialists provided follow-up. In making the referrals, the referring physicians provided a letter and contacted the consultant by telephone in each case.

Kunkle,[12] a consulting neurologist at a university hospital in the southeastern United States, kept data on 100 consecutive referrals of private patients by local physicians, taking note of the presence and the extent of the information supplied to him about the patient. Sixteen of the patients had illness of recent origin. Forty were seen as office patients and the remainder were referred for admission to the hospital. In nearly one half of the 100 consecutive referrals, the referring physician supplied either no clinical information or sent along a brief note of introduction of little practical help. In 23 of these, the information withheld was of potential value to the consultant. When such critical information was not supplied, the referring physician was reached by letter and useful information was received from 11 of 13 requests made. Kunkle comments on the uncertain fate of the referred patient when communication is faulty, and on the obligation of the consultant to report back. He then observes that "...a triple loss to consultant, to referring physician, and to patient results from the breakdown of referral communication...."

Long and Atkins[13] found similar problems in their study. The reasons given by the physicians, ie, heavy workload, poor-quality house staff, lack of secretarial help, seem to this writer to be simplistic solutions to a very complex communication problem. Support for this view comes from a number of studies of the process of

consultation-referral.

The Process

McWhinney,[14] writing about the process of consultation, voices the commonly held opinion that there is a referral threshold for each physician which varies with age and experience. Rawnsley and Loudon[15] noted that differences in rates of referral among six general practitioners in Wales could not be accounted for by variations in clinical severity, diagnosis, or type of patient. Interviews with the physicians suggested that they were influenced by social and attitudinal factors in their decision to refer. Bergen's[16] findings were similar and he makes the observation about psychiatric consultations (which can be generalized to all consultations) that "...the present relationship between psychiatry and the community physician must be seen as a special case of intraprofessional tension. Although considerable attention has been given to the relationship of communities to the larger society, relatively less attention has been paid to special types of problematic relationships within professional communities. The most critical of these for understanding the consultation process is how one member of a profession is able to seek help from another about something of which he is ignorant without losing his professional demeanor. This is regulated by largely nonrational factors...."

Shortell and Anderson[17] analyze the referral process in terms of exchange theory which attempts to explain human social behavior by focusing on the rewards and costs to individuals who choose to interact with one another. This theory would explain the behavior of the referring physician and consultant in this manner: the referral of a patient reflects the feelings of the referring physician towards the consultant, who responds in such a way as to reward or punish the referring physician. The diagnostic and treatment skills of both are required, and both must make correct responses if the interaction is to have a positive outcome for the patient.

Each physician may feel rewarded in several ways, and also may experience various costs. The referring physician's rewards may include having his patient receive proper treatment, receiving a prompt report, having the consultant refer patients to him, and increasing his prestige in the medical community. The consultant's rewards may be the gratification of being chosen to exercise his special skills; the satisfaction of receiving a cooperative, well worked-up patient; income from the consultation; etc. The referring physician may experience the cost of acknowledging to the patient his inability to diagnose or treat the illness, the possible loss of the patient, the risk of improper treatment by the consultant (thus reflecting on the referring physician), or the cost of the criticism by the consultant for his work-up. The consultant's costs may include receiving an uncooperative patient, poor communication from the referring physician as to the purpose of the consultation, or being in the position of not wishing to develop a relationship with the referring physician. The trade-off between the values that each physician places on the rewards and costs produces a positive or negative outcome. This theory suggests a number of hypotheses about the practice and process which can be tested by research. It also provides a theoretical background for learning, since it views the process as rather more complex than does the idea of a referral threshold.

Teaching the Practice and Process

Skills in the arranging of consultation-referral, although emphasized in the College of Family Physicians of Canada objectives, are not evaluated in their certification examinations. Yet consultation-referral is a part of every family practice residency program, since every family physician consults with all other disciplines. Similarly, acting as a consultant must be a part of every specialty resident's training. Perhaps, because it is a part of everyday experience for residents, the process is not emphasized and the practice depends on the practice of the preceptor or hospital, thus accounting for the variation and the problems noted in the studies.

The author believes that the consultation-referral process ought to be taught more formally, not left to be learned as a part of one's experience.

Weed[18] has pointed out the dangers to the patient if communication between physicians is loose and unstructured, and emphasizes the importance of the problem-solving approach in recording patient information in a structured manner. Problem solving lends itself to the development of a model for the teaching of the process of consultation.

Problem solving consists of five steps: problem sensing, problem formulation, search for solutions, selection of one solution, and implementation/evaluation. Consultation-referral can be a part of all five steps but is more likely to be concerned with the search for solutions. The teaching model proposed is elaborated from the problem-solving approach and consists of six steps as shown in the following diagram:

Problem → Assessment → Plan →
(consultation is indicated)
Communication with Consultant →
Consultation itself → Follow-up

1. The problem itself may dictate consultation as in multiple trauma in an Emergency Room, when several disciplines may be involved from the beginning in formulating the patient's problems. It is more likely that the possibility of consultation and referral is involved in the next two steps.
2. Consultation in a complex situation may be indicated to fully assess a problem or to help formulate all of the patient's problems. This is the step in which a problem-solving physician begins to think of the possibility of the help of a consultant: the physician focuses on the problem and is better able to develop a dialogue with the consultant, rather than focusing on his own competence—the threshold above which he refers patients.
3. Assessment of the problem may dictate a plan, as when a patient is referred for major surgery. This step helps to focus on who should provide the treatment or do the investigation, when the consultation or referral should take place, and the fact that patient education is also important. The problem-solving physician becomes more flexible in his search for solutions.
4. As the studies quoted indicate, communication among physicians about patients is not always done well. Weed[18] emphasizes this in his advocacy of the problem-oriented medical record (POMR) to facilitate communication, even suggesting that the patient be the custodian of his own record. This structured record does provide the consultant with a summary of all of the patient's problems and allows the consultant to focus on the problem for which he is consulting. But more importantly, it provides the consultant with a logic diary of the referring physician's work with the patient. It would be as wrong to provide the consultant with only a POMR as it would be unfair to ask a consultant to rely on memory after asking him to see a patient in consultation. A formal written request for consultation is a necessary part of the process. The referral letter should include:

a. a brief statement of the problem and the reason for the consultation;

b. information about symptoms and physical findings relevant to the problem. Other problems which might have a bearing on the particular problem should also be included;

c. the master problem list;

d. the patient profile;

e. information about the patient's and the referring physician's preferences if further consultation is necessary. Information about the referring physician's skill, his available facilities, and his interest might be important in helping to decide on follow-up treatment or investigation;

f. arrangements for the consultation should be spelled out, ie, as the responsibility of the patient, of the referring physician, or of the consultant, dehending on circumstances.

5. The consultation itself: in former times this was often carried out in the presence of the referring physician and was very formal. This rarely happens now, but a consultant friend of the author's dintates his letters to the referring physician in the presence of the patient, a practice which must assist the process of communication!
6. Follow-up. This can be a delicate matter since it involves physician-patient and physician-physician relationships; however, if all the steps in the process are followed, and if the focus is on the problem, then the stage is set to allow for the best solution.

The method of teaching will depend on local practice and curriculum. Two methods might be considered. Signall[19] has used role playing in teaching community health consultation to school teachers, a method which might be most useful for students of different disciplines where feelings of status might be involved. Focal problem teaching,[20] which uses paper simulations of cases and small group instruction, would lend itself to teaching this problem-oriented model and in this

method practice in the writing of a referral letter with peer evaluation is possible. Group problem solving is an excellent format in an area in which there is no single right or wrong answer.

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