Editorial

Consultation among physicians: conflict or complimentary purposes ?

The essential unit of medical practice is the occasion on which, in the intimacy of the consulting room or sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it. James Spence¹

All physicians, regardless of their specialty, turn to another physician at some time for advice. This process necessarily became formalised as physicians focused their training and limited their practice to a particular segment of medicine; at the same time, the total care of the patient cannot be met by a single physician. When more specialised care is needed, the continuum of care extends into the arena of consultation and referral.

The referral system is a means of communication between two physicians, and it is one of the indicators of the quality of a healthcare services. So, good communication between two physicians is essential for the smooth running of any health system.

Consultation and referral

Consultation is the practice of one physician asking another for an opinion or assistance, and the term consultant in this context means a person who is consulted, and implies no particular office; referral is the transfer of responsibility to another physician for the care of a specific problem.¹ Referral usually involves one physician requesting the services of another for a particular problem and for a limited time. Regardless of this distinction, the physician initiating the process is spoken of as the referring physician, and the physician to whom the patient is referred is called the consultant.

Responsibilities of the consultant and referring physician

The referring physician is responsible for the selection of the proper consultant for a particular patient. Care must be taken to select a consultant who has knowledge and skills appropriate to the patient's need. Also, he must be sure that the referral contract is clearly understood by the consultant, and he should state the reason for the request and the action desired, so that the consultant knows clearly whether the request is for an opinion only or also involves management. Patient preparation and compliance is one of the most important responsibilities of the referring physician. The informed patient understands what will occur and that the referring physician will remain in charge or will resume responsibilities at the conclusion of the referral. The understanding is important if the patient is to avoid feeling rejected or 'sent away'.

The consultant is expected to provide a prompt and concise report to the referring physician. The specific questions passed on the consultation request should be addressed and action limited to the amount of involvement requested. When the consultation involves a hospitalised patient, the consultant should see the patient promptly, provide an opinion and give therapeutic suggestions in a concise note on the consultation sheet, and in general, should not write orders unless requested to do so by the referring physician. The consultant also has a responsibility

to the patient and the referring physician to avoid unnecessary expense through duplication of studies recently obtained by the primary physician, unless there is a good reason to doubt the results or there is sufficient need to repeat the test. When a patient is referred for care, the consultant should remain in contact with the referring physician throughout the period of care and return the patient with a full written report when the problem is resolved or when no further involvement by the consultant is warranted. A consultant should not refer patients to other consultants without the knowledge and consent of the primary physician, who should coordinate or at least be closely involved with this process.

The most common reason for discontinuing referrals to a particular consultant is failure to receive adequate reports or failure of the consultant to return the patient for continuing care. The latter occurs most frequently when physicians who also function as primary physicians are used as consultants. The patient may 'stay on' for continuing care if the consultants does not encourage his return to the referring physician.

The teacher–pupil relationship

The consultation process works best when two physicians work together as colleagues to solve a difficult patient problem. Since the process is usually a learning opportunity for the referring physician, it is easy for the consultant to assume the role of teacher and the referring physician the role of pupil.

If the referring physician places the consultant in the role of 'teacher', the consultant may feel obliged to make comments or recommendations that may not be necessary. Balint¹ felt that this teacher–pupil relationship interferes with patient care if the referring physician is dissatisfied with the consultant's report but follows the advice solely out of respect for the consultant as the 'expert'. The consultant may have formed an opinion based on insufficient information or without total knowledge of the patient's emotional and medical background, or the opinion may have been generated, or even manufactured, as a result of having little additional information to offer.

Collusion of anonymity

A 'collusion of anonymity' exists when neither the referring physician nor the consultant accepts responsibility for the patient.¹ Inappropriate decisions regarding patient care can be made when neither physician accepts full responsibility. The problem is amplified when the referring physician turns to a variety of consultants for advice, yielding to each, with no one person accepting ongoing responsibility for the patient. If the consultant does not provide meaningful or useful information, then additional consultation, must be obtained until the problem is satisfactorily resolved.

Conclusion

A failure of communication can be as harmful to the patient as a missed diagnosis or an error of treatment. Communication breakdown must be considered the

primary cause for consultation failure. It can occur at all stages of consultation, between physician and patient, consultant and patient, or consultant and referring physician. The consultation process is more successful when there is a personal interchange between two physicians rather than when communication is solely by letter. When the referring physician responds only to recommendations made in a report, without the opportunity to discuss them with the consultant, inappropriate assumptions may be made. The more personal the interchange between the two physicians, the more effective the consultation.

The consultant should not enter into a series of exotic tests merely because it is thought to be 'expected' or for fear that his prestige as a consultant will be jeopardised. The referring physician may have requested another opinion primarily to confirm the diagnosis, perhaps wishing to

obtain reassurance before telling the patient he has a permanent and incurable disease.

The consultation / referral process can be more formally taught instead of being left to be learned by experience.³ Teaching may be by didactic conferences, chart review with discussion of possible future consultation, or even on site specialty consultation by the consultant.

Finally, it is of great importance to keep in mind that open communication is the cornerstone of a successful consultation.

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1 Rakel RE. Use of consultants. In: *Textbook of family medicine*. WB Saunders, 1990; pp 247–58.

2 Balint M. *The doctor, his patient, and the illness*. London: Sir Isaac Pitman and Sons, 1964.

3 Buckingham JL, Jacott EPDE, Rosen MG. Primary care, consultation and referral. In: *Family medicine, principles and practice*. New York: Springer Verlag, 1983; pp 465–9.