Communication Between Primary Care Physicians and Consultants

Ronald M. Epstein, MD

Optimal communication between primary care physicians and consultants includes transfer of relevant clinical information, including the patient's perspectives and values, and provides a means of collaboration to provide meaningful and health-promoting interventions. Communication difficulties arise because of lack of time, lack of clarity about the reason for referral, patient self-referral, and unclear follow-up plans. Also, primary care physicians and consultants may have different core values and may have little day-to-day contact with each other. Poor communication leads to disruptions in continuity of care, delayed diagnoses, unnecessary testing, and iatrogenic complications. Changes in the health care system offer the opportunity for improved collaboration between physicians by creating smaller administrative units within large health care systems that facilitate contact between primary care physicians and consultants; incorporation of discussions of uncertainty, patient preferences, and values into referral letters; adoption of a friendlier consultant letter format; and the improvement of the transfer of clinical data.

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Effective partnerships between health care practitioners are essential in providing high-quality medical care. Patients want to know that their health care practitioners work together effectively, involve the patient in important decisions, are in meaningful dialogue about the nature of the problem, and communicate a consistent therapeutic approach. Health care practitioners want to know that their input into patient care is used and valued; they want to be treated with respect and to foster collaborative relationships.

Optimal communication between physicians is characterized by the accurate gathering and sharing of information about the patient, taking the time to communicate expeditiously information that will be useful to the other health care practitioner, indicating what the patient has been told, planning who will take ongoing responsibility for the patient, and keeping the door open to further communication. Despite these ideals, communication between health care practitioners is sometimes problematic. Consider the following example:

Mr Norman, a 70-year-old man with coronary artery disease, had experienced worsening dyspnea on exertion and orthopnea during the previous 4 weeks. He had undergone coronary artery bypass surgery 5 years previously after a myocardial infarction.

His wife had died of arrhythmia at home 13 months previously, a year after a large anterior myocardial infarction. Coronary angiography had demonstrated inoperable severe coronary artery disease. She had been under my care and had also consulted the hospital cardiology group several times after her initial myocardial infarction.

I suggested to Mr Norman that he might need further evaluation of his heart disease and discussed the possibility of consulting a cardiologist. His initial response was that he preferred that I take care of him because he trusted me. After further discussion, he expressed reluctance to consult the hospital cardiology group because it brought up bad memories of...
his wife's illness. I arranged for him to see a cardiologist in a different office, to which he agreed. The appointment was scheduled for 3 days later. I called Dr Ruben, sent a referral letter, and faxed relevant records to him.

Dr Ruben performed echocardiography, prescribed a regimen of digoxin, and suggested that a thallium stress test be performed with "delayed images." Mr Norman was contacted by the cardiologist technician, and the test was explained to him, including the need to remain at the hospital for 10 hours. At that point, he indicated that he did not wish to have the test. Before I received a consultation letter, the technician called me to notify me that the patient refused testing, without specifying the reason.

I called the patient, and he expressed willingness to adhere to the recommended medication regimen but adamantly refused to have the thallium stress test performed. He believed that the inconvenience was not worth the therapeutic benefit that might result. I called Dr Ruben, who believed that the test was optional and most probably would not result in a change in management.

This story reports some challenges for the primary care physician in the referral process and some successful communication between the patient's primary care physician and a consultant. However, the patient's values and wishes were lost in the communication between health care professionals in regard to performing the thallium stress test.

THE CONTEXT OF THE RELATIONSHIP BETWEEN PRIMARY CARE PHYSICIANS AND CONSULTANTS

Communication between primary care physicians and consultants does not occur in a vacuum. Often, there are more than three parties to consider, including a primary care physician, one or more consultants, psychotherapists, nonphysician health care professionals, and patients' family members. All have as their primary goal improving the patient's health. Although this article focuses on relationships between primary care physicians and medical consultants, many of the same principles apply equally to other parts of this complex web of relationships.

Although some authors use the terms referral and consultation interchangeably, I favor Nutting et al's characterization of a referral to imply a transfer of care for the ongoing management of a specific problem, whereas a consultation involves another physician for a specific time-limited therapeutic or diagnostic task. Referral and consultation make up a broad spectrum from "curbside consultations" to a formal transfer of care; when the system works well, the patient's needs are served, all parties are informed, and there are no redundancies or omissions in care.

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A variety of intrinsic and extrinsic factors influence communication between primary care physicians and consultants. Among primary care physicians, there is considerable diversity in referral patterns. Type of insurance (or lack of insurance) may restrict patient access to some physicians and demand certain kinds of communication between physicians. Financial incentives may promote or discourage diagnostic testing or referral. In addition, psychological characteristics of physicians, such as risk aversion, tolerance of ambiguity, perceived confidence, fear of exposure of their own lack of knowledge, and fear of malpractice, may influence physicians' referral patterns, style of communication, and need for information.

Aside from consultation and referral, primary care physicians and consultants interact in other forums. In the political arena, primary care physicians and consultants promote agendas, some of which are complementary (such as vertical integration of services, ensuring a referral base) and some of which come into direct conflict (such as salary discussions). In the academic setting, with a push toward generating more primary care physicians, there has been increasing contact between community-based physicians and tertiary care-based consultants in discussions about curricular time, funding, and space allocation.

The relationships among primary care physicians, consultants, patients, and their families will evolve along with changes in the US health care system. Patient self-referral to consultants will become less common to reduce medical costs. In this context, effective collaboration between consultants and primary care physicians will be necessary and must be supported by the larger health care system to provide high-quality care.

COMMUNICATION BARRIERS

Communication between primary care physicians and consultants takes place in person, over the telephone, and in writing. Virtually all the research that exists on communication between primary care physicians and consultants has studied the content of letters exchanged, leaving the nature of other forms of communication poorly understood.

The majority of this research has been conducted in Great Britain, Australia, and the Netherlands.17-21 Letters from general practitioners were often found to be lacking critical information, explicit statements of the reason for consultations, or plans for follow-up.22-23 Letters from consultants were sometimes absent, delayed, discourteous, or overly detailed. A Dutch study24 indicated that there was often disagreement between primary care physicians and consultants about the necessity of referrals.

In a large US city hospital, McPhee et al12 analyzed request forms from primary care physicians in the hospital-based general internal medicine group practice to consultants within the same hospital. Of 464 consultations from 27 practitioners, the reasons for consultation were provided for only 77%, and only 76% of the referring physicians indicated that they wished to learn of the consultant's findings. Appropriate clinical information about patients was provided in 98% of the cases. The referring physician contacted the consultant directly by telephone in 9% of the cases and tended to telephone when the request was urgent. Consultants did not provide information on the results of their
consultation in 45% of the cases when the referring physician requested them. Most often the results were communicated via a shared medical record.

In 1982, Hansen et al. reported that of 141 consecutive referrals from family physicians to consultants, consultation reports were returned from 88% of community-based consultants, from 75% of university faculty, and from 43% of university outpatient clinic physicians. The quality of the reports, as judged by the referring physician, varied directly with the amount of referral information provided to the consultant.

In 1975, a two-physician general practice generated 233 referrals within a 6-month period, all accompanied by referral material and a request for follow-up information. The overall rate of receiving follow-up information from consultants was 62%. Communication from the consultant to the primary care physician was more common when the consultant was in private practice than when he or she was from an academic medical center. In an older study of 100 consecutive private patients who were referred to one consultant, 47 were accompanied by no or minimal clinical information. In half of those cases, the clinical data that were available to the primary care physician would have been of significant value to the consultant.

A recent study by Williams and Peet surveyed 200 family physicians and 200 consultants in Ohio. Both family physicians and consultants placed a high value on information, most preferred that both written and telephone contact be used for chronically ill patients, and there was variation in preference for written or oral communication. The family physicians often commented that they wished that consultants would ask the patient to return to the referring physician, indicate to the patient that communication would occur between physicians, avoid cross-referral (referral from one consultant to another without the knowledge of the primary care physician), and avoid negative comments about the referring physician. The following narrative from a primary care physician illustrates some of the difficulties when this does not happen:

A 55-year-old truck driver was referred by his primary care physician to a neurologist for evaluation of dizziness and paresthesias. Dr. Wall, the primary care physician, sent a letter summarizing the patient’s medical history and the consultation question. After the initial visit with Dr. Klein, the neurologist, the primary care physician received a consultation letter that summarized again the patient’s history, along with a diagnostic workup plan.

After several months, the patient returned to Dr. Wall’s office. The patient indicated that he had undergone magnetic resonance imaging scanning, electroencephalography, nerve conduction studies, electromyelography, and a lumbar puncture. None of these results had been sent to the primary care physician. Dr. Wall (uncharacteristically) wrote a letter to Dr. Klein and gave the patient a sealed envelope so that he could deliver it personally to the neurologist in 3 days when he had an appointment. It was an angry letter, noting that this lack of communication had occurred not only with this patient but also with other patients in the past. Dr. Klein responded immediately by letter and gave results of the diagnostic workup. However, Dr. Wall described further communication with Dr. Klein as obsessive. Of note, Dr. Klein was the only neurologist in the closed-panel health maintenance organization to which the majority of Dr. Wall’s patients subscribed.

In the study by Williams and Peet, consultants were uncomfortable when their roles were not specified by the referring physician, when referring physicians made changes in management without informing them, and when patients were referred too late in the course of illness.

In London, Ontario, a questionnaire and in-depth interviews were conducted with primary care physicians and consultants (M. Bass, MD, unpublished data, 1991). Problems identified by the family physicians and consultants are listed in Table 1. A follow-up questionnaire indicated that both family physicians and consultants considered it important that the patient understand the reason for referral, the patient be informed of the consultant’s opinion by the consultant, the family physician’s continuing role be supported, the consultation be psychologically therapeutic, and relationships between primary care physicians and consultants be cooperative.

The only study relating communication to clinical actions was a 1989 prospective study of patients who received screening mammograms. Written reports were sent and primary care physicians’ offices were called when the findings of the mammogram were abnormal and biopsy was recommended. After 2.5 months, only 37% of the patients had had a biopsy performed. Only after additional phone calls and another month did 84% of the patients undergo the indicated proce-

Table 1. Communication Problems Between Primary Care Physicians and Consultants

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
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<tr>
<td>Patient does not follow through with recommendation to see consultant</td>
<td>84%</td>
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<tr>
<td>There are delays in obtaining a consultation or procedure</td>
<td>75%</td>
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<tr>
<td>Patient refers himself or herself with or without the knowledge of the primary care physician</td>
<td>62%</td>
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<tr>
<td>There are multiple providers (especially in clinic settings)</td>
<td>50%</td>
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<tr>
<td>Consultant refuses to care for patient</td>
<td>40%</td>
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<tr>
<td>Consultant views referral as inappropriate</td>
<td>30%</td>
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<tr>
<td>Reason for referral is unclear or inappropriate</td>
<td>25%</td>
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<tr>
<td>There is a lack of information on referred patient</td>
<td>20%</td>
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<tr>
<td>No referral letter or phone call</td>
<td>15%</td>
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<tr>
<td>Missing relevant laboratory results</td>
<td>10%</td>
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<tr>
<td>Phone calls are not returned</td>
<td>5%</td>
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<tr>
<td>Diagnostic tests are repeated by consultant</td>
<td>3%</td>
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<tr>
<td>Response from consultant is absent or delayed</td>
<td>2%</td>
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<tr>
<td>There is cross-referral (from one consultant to another)</td>
<td>1%</td>
</tr>
<tr>
<td>Consultant “steals” patients from primary care physician</td>
<td>0%</td>
</tr>
<tr>
<td>Response does not answer question</td>
<td>0%</td>
</tr>
<tr>
<td>There is a lack of discussion as to who will follow-up with the patient</td>
<td>0%</td>
</tr>
<tr>
<td>Primary care physician does not carry out consultant recommendations</td>
<td>0%</td>
</tr>
</tbody>
</table>
dure. However, it was unclear from the study whether those recommendations were actually made to the patients who initially refused, whether the primary care physician disagreed with the need for biopsy, or whether the primary care physician simply did not make the recommendations.

Of note, to my knowledge, there have been no studies on the impact of the development of vertically integrated medical care systems and managed care on communication between physicians.

WHY ARE THERE COMMUNICATION DIFFICULTIES BETWEEN PHYSICIANS?

Table 2 lists reasons communication may be poor between family physicians and consultants.

From an anthropological perspective, primary care physicians and consultants pertain to different subcultures. The intellectual bases, site of practice, type of patient concerns, and prevalence of disease are different. The core values of primary care physicians may differ substantially from consultants. Primary care physicians are likely to be more person oriented, that is, they value long-term relationships with patients and experience more distress when dealing with complex medical problems and technology. By contrast, consultants are often more disease oriented, that is, they enjoy complex medical problems, feel more comfortable with technological interventions, and place relatively less importance on getting to know their patients as people. As such, misunderstanding, stereotyping, and prejudice would be expected, resulting in uncommunicated expectations, unmet needs, and frustration. Problems might include primary care physicians’ unwillingness to refer unless for a specific diagnostic test or consultants’ ordering tests that they do not think are necessary in the belief that that is what the referring physicians want. Because primary care physicians commonly encounter undifferentiated illness, they may be more accustomed to dealing with uncertainty and may pursue diagnostic certainty less vigorously than consultants. Primary care physicians may place a higher value on patient preferences, especially in longstanding patient-physician relationships.

The cultural gap is exacerbated by the fact that primary care physicians and consultants often have little contact. This is especially true between community-based primary care physicians and university-based specialists. Because the practice settings and clinical management styles of primary care physicians and consultants differ substantially, each may be judgmental of the other’s style unless they are more familiar on a personal basis. Some consultants may view primary care physicians as unnecessary and may believe that consultants can provide “primary care” for a problem within their domain (such as a dermatologist treating a patient with acne). These relationships are likely to change with the advent of managed care; most likely there will be more contact, with more opportunities for healthy collaboration.

In fee-for-service health insurance plans, it may be more convenient for patients to self-refer to consultants, especially if the primary care physician is not immediately available. This problem, accompanied by the problem of cross-referral, excludes the primary care physician, as well as other consultants, from the communication loop. In addition, some patients seek multiple medical opinions without the knowledge of the other physicians involved. Consider the following situation, and the difficulty in trying to communicate with multiple consultants:

Ms Brown has been a patient in our practice for 15 years, and I took over her care 8 years ago. She has multiple medical problems, including peptic ulcer disease, osteoarthritis, major depression with a prior suicide attempt, chronic headaches, facial pain, back pain, and bunions. When I first met her, in her chart there were letters from two gastroenterologists, three psychiatrists, three orthopedists, a chronic pain clinic, a podiatrist, and two neurologists with whom she had consulted in the previous 2 years. It became evident that there were other physicians, chiropractors, and therapists whom she had seen as well, either via self-referral or cross-referral from other health professionals. She had in her home at least six different nonsteroidal anti-inflammatory drugs, three histamine blockers, a variety of migraine preparations, and narcotics, which were prescribed by different physicians who were often unaware of all of the medications she was receiving. Ten years ago, she had an episode of severe upper gastrointestinal tract bleeding due to the simultaneous use of four nonsteroidal anti-inflammatory drugs. After a few months, she requested referral to a surgeon for partial gastrectomy because of an episode of recurrent ulcer pain.

Although the delay when having a patient see a consultant was the most commonly cited problem in family physician–consultant communication in a Canadian study (M. Bass, MD, written communication, 1991), this problem has a different character in the United States. Among well-insured patients, prompt access to care is the rule rather than the exception. The delays encountered by some patients in managed care settings may improve with increased competition. There is not yet a plan that will

**Table 2. Reasons for Poor Communication Between Family Physicians and Consultants**

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<th>Reason for Poor Communication</th>
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<tr>
<td>Physicians are busy</td>
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<td>Good communication takes time</td>
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<tr>
<td>Communication is an undervalued activity</td>
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<tr>
<td>There are cultural differences between primary care physicians and consultants</td>
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<tr>
<td>There is a lack of familiarity between primary care physicians and consultants</td>
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<td>Some referrals may be for nonmedical reasons, such as physician anxiety</td>
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<td>Physicians may believe they have “ownership” of patients</td>
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<td>Patients and physicians may view referral as abandonment</td>
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<tr>
<td>Patients refer themselves directly to consultants, bypassing the primary care physician</td>
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<tr>
<td>Some patients lack adequate insurance</td>
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<tr>
<td>There is concern that a referral will reveal inadequacies in care</td>
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reduce the often intolerable delays in finding appropriate care for uninsured patients or patients with Medicaid.

Inadequate communication between primary care physicians and consultants appears to be more common in tertiary care clinic settings than in private practice and is compounded by the involvement of multiple practitioners in the patient’s care. A patient may be seen by a physician assistant, a resident, and/or an attending physician, raising the question of whom to contact and who is ultimately responsible for the patient’s care. Inadequate secretarial and clerical staff can make the process of sending letters, copying records, and answering return phone calls difficult or impossible.

A 33-year-old woman infected with the human immunodeficiency virus (HIV) was hospitalized at the primary care physician’s community hospital for Pneumocystis carinii pneumonia. She had an initial evaluation at an acquired immunodeficiency syndrome (AIDS) clinic after her initial diagnosis 1 year ago and had a 1-year follow-up visit scheduled soon.

The patient improved enough to go home and was seen the next week for a visit at the AIDS clinic. The patient was found to be severely dyspeptic and she was admitted directly to the university hospital. The AIDS clinic physicians attempted to contact the primary care physician, but he was on vacation, and the covering physician was unfamiliar with the case. The primary care physician returned to find his patient intubated in the intensive care unit at the university hospital, at which he did not have admitting privileges, on the “staff” service, under the care of a physician who was not the usual caretaker in the AIDS clinic. Chart notes were written by a series of residents. The primary care physician had had some therapeutic suggestions and had discussed end-of-life issues with the patient, including her wish not to receive “heroic” care, but was unclear with whom to share that information. The patient’s family was confused as to who was in charge.

Good communication between physicians takes time and involves skills they may not have developed during training. Physicians are busy, and they may undervalue the importance of a clearly written letter or a phone call. Also, there are economic considerations; some of the time spent communicating between physicians and patients (and all communication between health care practitioners) is not directly compensated.

Some referrals and consultations may be for nonmedical reasons, which may not be communicated clearly to the consultant. Patients and physicians may need reassurance from a consultant that the diagnostic and therapeutic measures under consideration are in the patient’s best interest. Difficult problems may generate significant physician anxiety, raise medico-legal concerns, and may appear to challenge the physician’s authority. In these cases, the reason for the consultation may not be made explicit to the consultant; referral may be an attempt for physicians to get psychological support in dealing with patients with whom they find it difficult to communicate for a variety of personal reasons.

Physicians’ feelings of connection to patients form the sustenance of work that is otherwise stressful and demanding. In the course of seeking consultation, physicians may fear losing some of that connection, just as patients are afraid of being abandoned by their physician in the process of referral. A primary care physician may also face embarrassment or shame if a consultant discovers inadequacies in the care that he or she has given the patient.

**CONSEQUENCES OF POOR COMMUNICATION**

Poor communication between primary care physicians and consultants may result in disruption of continuity of care with the primary care physician and/or consultant, missed or delayed diagnosis, repeated or unnecessary testing, increased iatrogenic morbidity, polypharmacy, increased risk of litigation, and, in some cases, unwillingness to care for the patient.

With poor communication, data may be lost in the referral process between primary care physicians and consultants, patient expectations may be unclear or unrealistic, and there may be erosion of the physician-patient relationship. Inadequate communication among multiple practitioners increases the likelihood of repeated and unnecessary diagnostic testing and, consequently, increases the number of false-positive test results. These, in turn, lead to more diagnostic workups, some of which may contribute to iatrogenic morbidity. At the opposite extreme, if poor communication results in patients’ not attending recommended consultations, diagnoses may be missed or delayed. The prescribing of medications by multiple practitioners can leave patients confused about medication regimens and can increase the risk of drug interactions and adverse effects.

One consequence of poor communication, disruption of continuity of care, is associated with increased medical morbidity and poor outcomes independent of patient age, disease, status, and the number of medical visits. Furthermore, there are many intangibles about a patient that cannot be adequately communicated through a medical chart, including the patient’s response to illness, the patient’s communication style, and family and social supports, making effective oral and written communication more crucial. Lack of explicit discussions about whether the consultation implies a

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**Table 3. Possible Solutions**

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<th>Possible Solutions</th>
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<tbody>
<tr>
<td>Facilitate personal knowledge and contact between the primary care physician and the consultant</td>
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<tr>
<td>Participate in explicit discussions regarding uncertainty, continuity, patient’s understanding of illness, patient’s values, and patient’s preferences</td>
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<tr>
<td>Include a clearly stated reason for the consultation in the referral letter</td>
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<tr>
<td>Participate in explicit discussions of roles and follow-up plans</td>
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<td>Use the telephone for urgent or sensitive matters</td>
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<td>Improve the transfer of clinical data</td>
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<td>Use a friendly consultant letter format</td>
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<tr>
<td>Conduct outcomes research on the consultation and referral process</td>
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<td>Conduct seminars on consultation and referral for trainees</td>
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transfer of care, who will follow up with the patient, and with what frequency may result in inconsistent messages to the patient, physician concerns that patients may be "stolen" from them with little or no follow-up, and patient concerns about abandonment.

Finally, primary care physicians may be unwilling to care for some patients unless adequate specialty backup is available. This has been dramatic in the case of HIV infection; physicians express more willingness to care for HIV-infected patients in locations where subspecialty support is more available and of high quality.38

POSSIBLE SOLUTIONS AND DIRECTIONS FOR FURTHER RESEARCH

Table 3 lists some possible solutions.

The increased emphasis on understanding the organizational design and process of care, coupled with movement toward creation of vertically integrated health care systems offers the potential to move from a consultation model to a collaborative relationship between generalists and subspecialists. This has important implications.

Discussions of uncertainty, continuity, values, patient perspectives, and patient preferences that occur between physicians and patients should also be part of the communication between physicians.8,39 Physician, patient, and family expectations of the consultation should be addressed explicitly. Mutual understanding of core values will align all parties providing care around the patient's needs and create a respectful, collaborative working relationship. Specialty consultations that are primarily to address the needs of the primary care physician are not necessarily inappropriate and may facilitate patient care. Especially in these situations, the reason for referral needs to be communicated clearly to guide consultant input into the patient's care.

Strong patient-physician relationships will facilitate communication between physicians. It is crucial to elicit the patient's understanding of his or her illness, to respond to his or her concerns about the management of the illness, and to explore together the reason for referral and the potential benefits (and risks) of seeking a consultant's opinion. A patient who is psychologically invested in the outcome of the referral process is far more likely to follow through with the recommendation for consultation and to become an active participant in his or her care.

Personal knowledge and personal contact between the primary care physician and the consultant can transform an otherwise anonymous professional relationship into a working partnership. This now happens more readily in small, contained health care systems such as community hospitals, multispecialty groups, and small health maintenance organizations. Some of the features of these systems can be applied to larger, more complex health care systems. For example, creating smaller, vertically integrated administrative units within a large health care system could provide more opportunities for consultants and primary care physicians to interact. By placing offices in close proximity, the casual oral communications that form the basis for relationships and discussions of values and practice styles may occur more readily. Written communication could be facilitated by using standardized referral forms, and electronic networks could transfer data more efficiently. There are already innovations in some parts of the United States that serve to improve communication between physicians; these need to be developed further and disseminated.16

Referral letters and phone calls from primary care physicians need to include clearly stated reasons for consultations, the patient's expectations, what the patient has been told,40 and who will take primary responsibility for further management of the problem. The telephone should be used when an urgent response is required25 and when there are sensitive topics, such as mental illness, HIV-risk behaviors, and family information that practitioners would not want to include in a letter.41 Letters from consultants might be written in a friendlier, more respectful format. The letter would begin with a restatement of the consultation question followed by an answer and specific recommendations. This then would be followed by a more traditional recording of the history, physical examination, and diagnostic test results and discussion to substantiate the recommendations. Incorporation of seminars on how to consult and refer along with critiques of actual referral letters by experienced preceptors should be incorporated into medical training.

Finally, there is a need for well-conducted outcomes research on the consultation and referral process.9 Actual face-to-face communications, letters, telephone calls, and electronic media17 need to be examined in greater detail to determine other ways in which communication between primary care physicians and consultants can be improved. Intervention studies should examine whether improved primary care physician-consultant communication results in better patient outcomes.

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REFERENCES


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