Differences In The Value Of Clinical Information: Referring Physicians Versus Consulting Specialists

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Background: We investigated differences in the value of clinical information communicated between referring physicians and consulting physicians in the setting of shared care of patients who had chronic problems.

Method: An 18-item questionnaire included items that measure the value of information received from the other physician, referring and consulting physician roles, preference for method of communication, and content of communication. Questionnaires were mailed to a study sample consisting of 200 referring family physicians and 200 consulting specialists. The overall return rate was 44 percent.

Results: We found that both referring physicians and consulting physicians assigned high value to all categories of information, but (1) consulting physicians value information received from referring physicians less than referring physicians; (2) both referring physicians and consulting physicians rank the value of definition of roles and specific monitoring procedures below other aspects of the consultation process; (3) both referring physicians and consulting physicians assign equal priority to information about current medications, health beliefs and attitudes of patients, drug details including sensitivities, and matters that the patient is not likely to discuss with consulting physicians; and (5) consulting physicians assigned less value than referring physicians to reasons for referral, chief symptoms and symptom chronology, referring physician findings, and referring physician diagnosis, though both rate all these items relatively high.

Conclusion: There appears to be a need for referring physicians to improve the quality of information provided to consultants. New educational strategies must be addressed to enhance quality medical management in the setting of shared care. (J Am Board Fam Pract 1994; 7:292-302.)

Dissatisfaction with the consultation process is a familiar topic of discussion whenever physicians gather. It is not uncommon to hear referring physicians complain of not receiving reports from consultants and to hear consulting specialists complain that referring physicians seldom supply patient information. Studies of the consultation process consistently show that communication between referring and consulting physicians leaves something to be desired. The lack of effective communication poses a serious threat to the quality of medical management. There has been little investigation of the referral process in the setting of shared care between referring and consulting physicians of patients with chronic illness.

Literature Survey

Williams, et al.¹ described five steps in the consultation-referral process: (1) referring physician defines the need and purpose and creates an understanding with the patient, (2) referring physician communicates these needs to the consultant, (3) consulting physician addresses the purpose and problem as requested, (4) consulting physician communicates findings and recommendations to referring physician, and (5) referring physician, consulting physician, and patient develop a clear understanding of responsibilities for continuing care. Effective communication is essential to four of these five steps. These investigators found adequate communication to be seriously wanting in each step.

In another study Phillips, et al.² convened referring physicians and consultants to discuss mutual concerns. Communication was the major

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concern of each participant. Consultants defined the following data they considered essential to receive from referring physicians:

- 1. Level of urgency
- 2. Relevant history (especially that not available from the patient)
- 3. Natural history milestones (stages or specific steps in the disease progression that the patient has experienced)
- 4. Disease- or condition-specific discriminating data or history
- 5. Treatment that might mask symptoms
- 6. Current medications

Saunders³ proposed the problem-oriented record as a framework for communications and described six areas of content to be communicated: (1) statement of problem and reason for referral; (2) relevant symptoms, physical examination findings, and potentially related problems; (3) master problem list; (4) patient profile; (5) preferences should further consultation be necessary; and (6) expectations of responsibilities for consulting and referring physicians. Few reports, however, have studied the relative value that each participant in the consultation process places on different elements of information.

There is little agreement in the literature as to the preferred method of communication. Bates found a preference for written communication and specified the components of the consultation process.⁴ Burnside reported a preference for personal communication by telephone.⁵

Bates,⁴ Burnside,⁵ and Marshall⁶ defined the responsibilities of referring and consulting physicians, many of which indicated roles to be accepted or avoided. These authors agreed that referring physicians should define the question to be addressed by the consultant, indicate responsibilities expected of the consultant, convey to the consultant what has transpired to date, enclose study reports, and make appropriate explanations to the patient. No study determined the degree of compliance with any category of information content exchanged between referring and consulting physicians.

Byrd and Moskowitz⁷ found referring physician satisfaction with consulting physician reports to be related to the degree to which consultants aided management, addressed specific questions, wrote with clarity, responded promptly, and provided information of educational value. Hansen, et al.⁸ and McPhee, et al.⁹ found quality of the consulting physician's reports was related directly to the amount of information provided by referring physicians.

In a study of referrals from family physicians, Geyman, et al.¹⁰ found 59 percent of consultants favored sharing of care as opposed to one-time consultations.

In a preliminary study, the first author (PTW) co-managed 15 patients with 20 different physician consultants using worksheets designed to define roles and monitoring plans and flow charts to determine data for communication. At the end of 2 years, individual interviews were held with each of the consultants. Information derived from these interviews was used to formulate questions for a pilot study that preceded this investigation. In this pilot study 30 referring and 27 consulting physicians in Columbus, Ohio, were mailed a questionnaire consisting of 10 questions assessing the method of communication, satisfaction with communication content, physician role, and the patient-monitoring process. An overall response rate of 57 percent was obtained from the 57 questionnaires mailed. Analysis of the data indicated that consulting physicians were not satisfied with the quality or quantity of information received from referring physicians. Referring physicians appeared to be relatively more satisfied with reports they received from consultants. Consultants were more satisfied with role expectations, the criteria for monitoring, and the referral process in general when there was greater structure to a plan for shared care. Respondents indicated agreement with the statement that there is a direct relation between patient satisfaction and quality of communication between involved physicians. Although the sample in the pilot survey was too small to claim significance for these findings, the findings seemed to indicate a need to assess the relative value that referring physicians and consulting physicians place on different categories of clinical information when patient care is shared in continuity between referring and consulting physicians. The pilot study was useful for framing and validating the questions of the present study.

Purpose

Our study focused specifically on issues of shared care between referring and consulting physicians to determine the following:

- 1. Value referring physicians and consulting physicians placed on information received from each other
- 2. Importance of designation of the role of each physician
- 3. Relative preference for written versus telephone communication between referring and consulting physicians
- 4. Priority for different elements of information content of both referring and consulting physicians and level of congruence between referring physicians and consulting physicians regarding the value of each of these elements

Methods

The method selected for this investigation was a mail survey in preference to personal interviews with a select number of referring physicians and consulting physicians. A mailed questionnaire was determined to provide more power for the analysis of data, given the sample size needed to conduct this study. An 18-item questionnaire based upon the preliminary study was developed and mailed to 400 practicing physicians. The sample comprised 200 family (referring) physicians and 200 consulting specialists. A response card was enclosed with the first mailing for respondents to indicate their intention about participation in the study. Sample size was necessarily limited by available resources.

The sample of 200 family physicians was randomly generated from the 1990 roster of members (about 2500) of the Ohio Academy of Family Physicians. The sample of 200 specialists was randomly generated from the 24th edition (1989-1990) of the *Directory of Medical Specialists*.¹¹ The consulting physician sample was determined in the following manner:

Number for given specialty= $200 \times \frac{\text{number of listings in specialty (estimated)}}{\text{total of all specialty listings (estimated)}}$

The relevant population was defined as the total (estimated) number (about 11,000) of specialty physicians in Ohio. The resultant sample consisted of 31 percent medical specialists, 41 percent surgical specialists, 9 percent obstetrician-

gynecologists, 9 percent psychiatrists, 8 percent pediatricians, and 2 percent other. Physicians' names were examined for duplication, and participants in the pilot survey were deleted. Randomly selected replacements were assigned before the first mailing. Questionnaires returned as "undeliverable" were replaced with ones sent to randomly selected new subjects to maintain the 200 sample number for each group. A follow-up mailing was sent to nonresponders 1 month after the initial mailing. Completed questionnaires were coded and recorded into a data file on a mainframe computer. There were ten duplicate returns from the two mailings. These duplicates were deleted from the data pool.

The questionnaire contained five demographic items: age, specialty, practice load, type of practice, and community size. Additionally the physicians were asked what percentage of referred patients they expected to share care. The instrument contained 18 items requesting responses on a Likert-type scale of 1 to 5, ranging from important to not important or strongly agree to strongly disagree. The Appendix contains the questionnaire sent to family physicians. The counterpart sent to consulting physicians was reworded to be comparable with the referring physician questionnaire. Instructions explicitly directed that answers be addressed to the setting of shared care. The domains examined were the value of information received (2 items) physician roles (5 items), communication method (3 items), and content of communication (8 items). Value of information was rated on a scale of 1 to 5 (poor to excellent). All others were rated on a scale of 1 to 5 (strongly disagree to strongly agree).

Responses were recorded numerically, and the data were analyzed on SPSS/PC+¹² at The Ohio State University. Student t-tests were used to detect any significant differences between the responses of the referring and consulting physicians for the first five demographic questions and all of the questionnaire responses. Narrative comments were summarized and categorized.

Results

Analysis of the duplicate returns showed no significant difference between responses of the matched duplicates (P<0.05). The overall survey return rate was 44 percent for medical specialists, 30 percent for surgical specialists, and 55 percent for family physicians. Medical specialists contributed 44 percent of the consulting physician responses and were 31 percent of the consulting physician sample. Surgical specialists contributed 30 percent of the consulting physician responses and were 41 percent of the consulting physician sample. Psychiatrists contributed 5 percent of the consulting physician responses and were 9 percent of the consulting physician sample pool. Obstetrician-gynecologists and pediatricians both contributed 8 to 9 percent of the consulting physician returns and were 8 to 9 percent of the consulting physician sample.

Demographic Profile

The geographic locations of family physician and consulting physician practices are displayed in Table 1. Sixty percent of referring physicians were located in rural to medium-sized urban communities, and 69 percent of the consulting physicians were located in large urban centers. More family physicians than consultants were in solo and partnership practice. Thirty-nine percent of referring physicians had been in practice for fewer than 5 years, compared with 17 percent of the consulting physicians.

Value of Information

Eighty-eight percent of the consulting physicians expected a shared-care relationship in care of referred patients compared with only 39 percent of referring physicians. Referring physicians and consulting physicians rated the information they provide as between adequate and good with no significant difference between the two groups.

Table 1. Community and Practice Characteristics of Referring and Consulting Physicians.

Characteristic	Referring Physician Percent	Consulting Physician Percent		
Community				
Rural	15.5	1.5		
Small and medium urban	44.5	21.5		
Suburban	12.7	7.7		
Large urban	27.3	69.3		
Practice				
Solo	43.6	30.8		
Partnership	30.0	12.3		
Single-specialty group	21.8	35.4		
Multispecialty group	10.0	21.5		

Table 2. Physician Responses to the Questionnaire Regarding Value of Information Shared, Roles, and Communication Methods (Mean Scores on a Likert Scale from 1 to 5).

Question	Referring Physician	Consulting Physician	P Value
Information provided*	3.74	3.91	0.22
Information received*	3.55	2.75	0.00†
Prefer written report	4.25	3.95	0.02†
Prefer verbal report	2.25	2.58	0.02†
Prefer written and verbal reports	4.07	3.92	0.26
Roles defined	3.70	3.75	0.72
Monitoring criteria estab- lished	3.45	3.52	0.65
Future decision points dis- cussed	3.98	4.00	0.88
Intellectual discussions	4.07	4.16	0.44
Communication is excel- lent and promotes good outcomes	3.86	3.80	0.66

*1=poor, 2=needs improvement; 3=adequate; 4=good; 5=excellent. All others 1=strongly disagree; 2=disagree; 3=neutral; 4=agree; 5=strongly agree. *Significant=P<0.05.

-Significant = P < 0.05.

Overall, consulting physicians rated information they receive from referring physicians significantly lower (2.75, which falls between "needs improvement" and "adequate") than referring physicians rated the information they send (3.74, between "adequate" and "good"). Referring physicians seemed quite satisfied (3.55, between "adequate" and "good") with information they in turn receive from the consulting physician (Table 2).

Communication Method

Both referring physicians and consulting physicians valued the need for written reports. This preference, however, was significantly greater for referring physicians. While both rated verbal reports as less preferred than written reports, referring physicians preferred verbal reports significantly less than consulting physicians. More importantly, both referring physicians and consulting physicians equally valued the combination of written and verbal communications (Table 2).

Roles

With the exception of responses pertaining to content of communication, there was no signifi-

cant difference between groups for the role characteristics measured (define roles, establish monitoring criteria). Rank order of the items dealing with physician interrelationships was identical for both groups of physicians. Intellectual discussion was rated highest. Discussion of future possible management changes was next in rank order, followed by agreement that quality of communication related to outcome quality. Defining the roles and responsibilities of each physician and defining monitoring criteria received the lowest priority of this group of issues, though both were valued above neutrality (Table 2).

Communication Content

Table 3 displays average ratings by physician group of content items. There were statistically significant differences in ranking of four content areas. Consulting physicians assigned significantly less value than referring physicians to reason for referral, chief symptoms and symptom chronology, referring physician findings, and referring physician diagnosis. Both referring physicians and consulting physicians agreed that the three most important areas of communication were current medications, reasons for referral, and details the patient is not likely to supply to consulting physicians.

Narrative Comments

Narrative comments of respondents provided a rich view of the consultation and referral process. Sixty percent of family physicians and 52 percent of medical and surgical consulting physicians contributed narrative comments. Sixty-four per-

cent of family physician responses and 76 percent of consulting specialist responses were encompassed by three of the categorical areas of this study (communication, roles, content). The remaining responses fell into three broad categories: (1) interpersonal characteristics, (2) mutual respect, and (3) secondary referrals (Table 4).

Generally narrative responses indicated great variation in the behavior and expectations of individual physicians, a reminder of the heterogeneity of both groups. This heterogeneity was not appreciated when we defined the study population and should be considered in future studies. The following comments might be useful in informing future investigations. Consultants appeared to be most uncomfortable when referring physicians neglected to clarify the exact role they were to perform: a physical medicine and rehabilitation consultant expected "a clear explanation to the patient about what I'm expected to do." Referring physicians criticized consulting physicians if they assumed follow-up care of patients: "The consultant should not try to take over the patient permanently to enhance their practice to the detriment of mine," and "Beware of gynecologists, dermatologists, and endocrinologists. They steal patients and notoriously fail to communicate."

We have been impressed with the frequency of referral process problems found in cases reviewed for malpractice litigation, and we were surprised to find no reference in this study to liability risks in narrative responses of either referring physicians or consulting physicians. Are consulting physicians to be concerned with their liability risks when they lack feedback regarding the ful-

	Referring Physician		Consulting Physician		
Information Content	Rating*	Rank	Rating*	Rank	P Value
Current medications	4.65	1	4.71	1	0.52
Reason for referral	4.64	2	4.38	3	0.02†
Details patient unlikely to supply	4.41	3	4.55	2	0.27
Chief symptoms and chronology	4.11	4	3.80	6	0.04†
Referring physician findings	4.05	5	3.58	8	0.00†
Referring physician diagnosis	3.91	6	3.60	· 7	0.04†
Health beliefs and attitudes of patients	3.78	7	4.03	4	0.09
Drug details, including sensitivities	3.75	8	4.02	5	0.08

*Mean score of importance on a Likert scale from 1=very unimportant to 5=very important. †Significant=P<0.05.

Table 4. Frequency of Narrative Responses, SixCategories by Physician Group.

	Referring Physician No. (%)	Consulting Physician No. (%)
Communications	46 (41)	26 (35)
Roles	16 (14)	22 (30)
Content	10 (9)	8 (11)
Interpersonal	` 17 (15)	7 (9)
Mutual respect	20 (18)	10 (14)
Secondary referral	2 (2)	1 (1)
Total	111 (99)*	74 (100)

*Does not equal 100% due to rounding.

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fillment of their recommendations and subsequent outcomes? When referring physicians do not clarify the roles they expect consulting physicians to assume and roles that referring physicians are prepared to fulfill, are liability risks increased for both? In the only reference to liability and the referral process, Green¹³ described a framework for defining mutual expectations with the avowed purpose of minimizing malpractice risks. Liability risk reduction should be given more consideration in studies of the referral process.

Reason for referral was emphasized by consultants. A consultant wrote, "Accurate identification of wishes of referring physician, delineation of role of consulting physician, delineation of communication needs . . . [and] when referring physician takes time to explain referral, the reply is always at least in kind." Family physicians emphasized educational content and the desire for longrange planning assistance, e.g., "Follow-up letters to me about changes in management or about things I need to be alerted about following", "In the future what work-up do you want me to do?" "Help in formulating long-range plans for dealing with patient's health care."

Consultants appealed to referring physicians for information about changes that might have been initiated by referring physicians, e.g., "Importance of notification if new problem arises." Are referring physicians managing chronic medical problems without the assistance they might desire or not know they need from consultants? Rheumatologists and orthopedic surgeons were especially sensitive to this issue. These specialists reported, "Most referring physicians (primary care docs) don't refer . . . thus no comprehensive care is rendered until LATE"; "I never get anything from the primary physician My patients are patient referred, not physician referred"; and "I only occasionally receive an introductory letter." Is such assistance not sought because past efforts have demonstrated consulting physician lack of understanding of how they might be helpful? Is it reflective of the lack of a clear request to the consulting physician by the referring physician? Has medical technology progressed faster than referring physicians and consulting physicians can decide which tasks to assign each other? Perhaps some of the difference is indicative of the greater desire of consulting physicians to participate in shared care reported in this study and their frustration with the failure of an invitation to do so.

Repeated themes from referring physicians included the expectation that consultants should do the following:

- 1. Indicate to the patient that the consulting physician would be in contact with the referring physician.
- 2. Be supportive of the referring physician; "No negative comments about my hospital or its services."
- Notify the referring physician before making a secondary referral: "Consultant should *never* send patient to another consultant"; "No secondary referrals"; "I prefer conservative consultants who do not interfere with care outside their field of expertise."
- 4. Return the patient to the referring physician.

Mutual respect and the ability to discuss differences were often cited as important by both referring physicians and consulting physicians. Consultants usually couched their comments in respect to knowing personally the referring physician and the physician's "style" and usual expectations: "Prior experience in the way the referring physician operates." The rules of etiquette undergirded many of the comments: "Straightforward expressions of dissatisfaction with me by either patient or referring doctor," and "Courtesy should be extended to me by the referring physician."

Discussion

For statistical significance the sample size should have been more than 200 for each group. Logistic and resource limitations, however, dictated using

a sample size of 200 for each group of physicians. Follow-ups to nonresponders were not made because of the same limitation. Nevertheless, an inspection of nonresponders according to specialty and location seemed to indicate representativeness. No assessment can be made of differences between groups within each category, e.g., demographic and geographic differences in both referring physician and consulting physician groups or specialty differences within the consulting physician group. The return rate was lower for the surgical specialists and psychiatrists, possibly introducing bias into the consultant total responses. Shared care between referring physician and surgical specialist is unusual. Surgical referrals are usually made for acute problems that are resolved by the surgery and do not require postsurgical continuity of care beyond the time required for surgical healing, which perhaps explains the lower return rate from surgical specialists. Although a 44 percent response rate is not optimal (50 to 60 percent is more acceptable), the randomized sample design, with randomized substitution of nondeliverable questionnaires, reduced the possibility of sample bias. Additionally, some studies have reported that nonresponders generally do represent responders, especially in relation to questions of patient care.^{14,15} A potential bias exists from the 39 percent of family physicians who had been in practice less than 5 years (compared with 17 percent of consulting physicians), because they have had less time to establish consultant panels and consequently referral patterns. Experienced family physicians change consultants until they establish a panel that meets their needs, whatever those needs might be.

Demographics

Demographic characteristics of the responders were comparable with the profile of Ohio physicians. Rural physicians constituted 15.5 percent of the sample, 22.3 percent of Ohio family physicians,¹⁶ and 13.3 percent of nonmetropolitan (non-MSA) family physicians nationwide.¹⁷ Respondents' specialty representation differed little from their representation among Ohio specialists and seems unlikely to introduce selection bias.

Some differences observed between the two groups of physicians in the demographic profiles could be expected by the inherent differences between family practice and consulting specialty practices, e.g., size of community of practice location, practice setting (e.g., solo, partnership, group). Consulting specialties require a larger service population and are more likely to practice in multispecialty groups. Primary care physicians more frequently locate in smaller communities and are more likely to choose solo practice.¹⁷ Even though solo practice is less widespread,¹⁶ it does contribute to relative professional isolation and is possibly related to the preference of referring physicians for written communication. Further study of the possible relation between communication preference and solo and rural practice settings should be undertaken.

Value of Information

Consultants' relative disregard for the value of referring physician findings and diagnosis and symptom chronology might be explained by the finding of Hansen, et al.⁸ that referring physician communications with consultants were less comprehensive than those of consultants to referring physicians. Because action begets reaction, as suggested by 1 of our specialist respondents, is it any wonder that low rates of referring physician provision of information to consulting physicians (46 percent)¹ is followed by the low rates of reporting responses from consultants found by Curry, et al. (28 percent),¹⁸ McPhee, et al. (55 percent),⁹ and Ruane (76 percent)¹⁹?

The high value of referring physicians for the reports of consulting physicians in our study was also reported by Hines and Curry.²⁰ Lee, et al.²¹ found that referring physicians and consulting physicians did not agree on either the purpose of the referral or the disease in question in 14 percent of referrals studied. Good outcomes in the consultation-referral process, therefore, should be considered to be dependent upon amount and quality of information provided to the consulting physician by the referring physician.⁷⁻⁹ Good performance by referring physicians in this regard constitutes a prompt to responding by consulting physicians. Referring physicians who experience a low rate of consulting physician consultation reporting should look to their performances in providing information to their consultants.

Roles

Interestingly, referring physicians were much less likely than consulting physicians to express an expectation of shared care in a high proportion of referrals. Future studies should attempt to discover the reasons for this difference and whether this finding changes as the prevalence rate of chronic disease increases with the graying of the population.

Communication Method

Both referring physicians and consulting physicians indicated a strong preference for written reports, whereas referring physicians expressed lower preference for verbal communication than consulting physicians. The narrative comments again underscore the strong preference of both for a combination of verbal and written reports. This seeming ambiguity is clarified as preference for initial verbal reporting, supplemented by subsequent written reports, which is proposed as the ideal in narrative responses. Other studies found similar preferences. Byrd and Moskowitz⁷ found 99.6 percent of referring physicians preferred reports written on forms provided for the purpose. They also found consulting physicians to be divided: 44.2 percent preferred to write reports on forms provided, 35.7 percent preferred to provide letters, and 23.6 percent preferred to report by telephone. Studies conducted in the hospital environment found personal contact (face-to-face or by telephone) to be preferred for communication in both directions.²²

Content of Communication

Knottnerus²³ observed that differences in disease prevalence rates between the practices of referring physicians and consultants resulted in differences in level of bias in assessing the relation between symptoms and disease. Therefore, usefulness of a specific clinical finding in decision making changes from the undifferentiated patient to one screened to be referred. This observation provides a logical explanation for different values assigned to categories of clinical information by referring physicians and consulting physicians. The high value placed upon intellectual discussion by both referring physicians and consulting physicians seems to reflect the educational role of the consultation-referral process.

There is need for further study of the referral process and for standardization of definitions of its elements to afford comparability of future studies. While methodologic problems limit generalizing the results of this study, there are some practical findings. If these differences between the views of consulting physicians and referring physicians can be shown to compromise patient care, strategies for dealing with these differences to enhance the quality of patient care should be sought through the education of referring physicians.

Conclusions

There appears to be a need for referring physicians to improve the quality of information provided to consultants. Both referring and consulting physicians prefer initial verbal communication followed by a written report. Referring physicians and consulting physicians both give high value to each of the content areas studied, and both assign top priority to current medications, reason for referral, and information the patient is not likely to give to consulting physicians. Consulting physicians, however, value the findings and diagnosis of referring physicians relatively less than do referring physicians.

The rich narrative comments of respondents could inform further studies of the referral-consultation process. Without a better understanding of existing communication problems in this process, such problems might worsen as the anticipated increase in managed care occurs.

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Appendix

Please respond to the following questions/statements based on your personal experience with the referring physician/consultant process.

It is important that your responses reflect SHARED-CARE in CHRONIC CASES.

Check one for each question.

		EXCELLENT	GOOD	ADEQUATE	NEEDS IMPROVEMENT	POOR
1.	How would you rate the workup infor- mation you provide for the consultant when requesting a referral?					
2.	How would you rate the information you receive from the consultant through- out the referral/consultant process?		-			• • •
3.	Rate the following in terms of their level of requesting a referral. Circle one number for unimportant.	importance a r each questio	s neces n, 5 bei	sary workup ing the most	information who important to 1 b	en being

Appendix continued on next page

		IMPOR	TANT		UNIMPO	ORTANT
a.	Drugs and treatment patient is having	5	4	3	2	1
b.	Details patient is unable or unlikely to supply	5	4	3	2	1
c.	Your problem or specific requirement from referral	5	4	3	2	1
d.	Other details about drugs, sensitivities, or steroids	5	4	3	2	111
e.	Main symptoms and their chronological development	5	4	3	2	1
f.	Your own diagnosis and opinion	5	4	3	2	1
g.	Your clinical findings	5	4	3	2	- 1
h.	Attitude of patient toward illness, knowledge of seriousness, type of reassurance required, and what	-		2		
	they expect from referral	5	4	3	2	1

Please indicate your level of agreement or disagreement on the following statements. Check one for each question.

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
4. In your relationships with consultants, your role of responsibility is clearly defined at the beginning and through- out the process.		· · · · · · · · · · · · · · · · · · ·			
5. The criteria to be used for monitoring a patient are clearly established between yourself and the consultant.					
6. I prefer written over verbal communi- cation for extended shared-care of chronic patients.					
7. I prefer verbal over written communi- cation for extended shared-care of chronic patients.		, 			· · · · · · · · · · · · · · · · · · ·
8. Both written and verbal communication are essential for extended shared-care of chronic patients.					
9. The referral/consultant process should deal with changes in the natural history of the problem at issue which will require a change in the management strategy. For example: for an HIV+ patient, if his or her					
T4 count drops below 500 cells/ μ L, then the institution of AZT should be consid- ered. This decision should be discussed and made prior to its occurrence.					

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	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
10. It is important that intellectual discus- sions about future decisions take place in the referral/consultant process when dealing with extended shared-care of the chronic patient.				· · · · · · · · · · · · · · · · · · ·	
11. Communication between myself and consultants in chronic cases is excellent and promotes better patient outcomes.					

Please list some of the factors that you feel are important for an excellent relationship between yourself and a consultant which result in positive patient outcomes.

Please provide the following demographics to the best of your knowledge.

- 1. How many years have you been at your present practice? _____0-5 _____6-10 _____11-15 _____ more than 15 years
- 2. What is your specialty?_
- 3. Approximately how many patients do you see in a half-day office session? _____1-4 ____ 5-8 ____ 9-12 _____ 13-16 ____ more than 16
- 4. Approximately what percentage of your consultant/referral patients do you expect to be sharing the management of for an extended period of time?

_____0_10% ____11_20% ____21_30% ____31_40% ____41_50%

____ 51-60% ____ 61-70% ____ 71-80% ____ 81-90% ____ 91-100%

5. Which of the following best describes the community where your practice is located?

_____ rural _____ suburban _____ small urban (5,000 to 50,000)

_____ medium urban (50,000 to 100,000) _____ large urban (>100,000)

6. What type of practice do you have? Check those that apply to you.

_____ Solo practice

- _____ Self-pay
- _____ Partnership practice _____ Group (single specialty)
- _____ Fee-for-service _____ Prepaid (HMO, PPO)
- ____ Group (multispecialty) ____ Medicare/Medicaid