with detecting all possible abnormal patients. I hope researchers in family practice will lead obstetrical care to a more practical and specific approach to the diagnosis of gestational diabetes.

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Adoption

To the Editor: In the April–June 1988 issue, there is an article entitled "The Physician's Responsibility in Adoption, Part II," written by Carl and Lois Melina. I thought the article was very well written and pertinent.

The issue of informing an individual that he/she has been adopted still seems of great importance to me. I cannot understand why there is such a rush by so many these days to let individuals know that they have been adopted. It seems reasonable to me either to not inform the person or to delay the information until the child is at least 18 and more able to withstand the typical confusion and dismay that such news brings. I know of two cases in which children, who were told at an early age that they were adopted, suffered considerably because of the distrust and wonder that this information caused. Furthermore, unless there is some clearly important information about a person's genetic or other background to relate, I doubt that we should inform someone that he/she has been adopted.

Ignorance can indeed be bliss in some matters.

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Consultation/Referral Patterns

To the Editor: In a recent article, Vogt and Amundson[1] reported the results of their survey of North Central members of the American Academy of Family Physicians about referrals to internal medicine and pediatric generalists versus subspecialists. With regard to internal medicine consultation/referral, they documented a strong preference for referral to subspecialists as opposed to generalists. This was particularly true for residency-trained family physicians.

As a general internist who has taught full time in family practice residencies for the past 9 years, I am somewhat dismayed by these results. The role of the general internist has been widely debated in internal medicine circles. On the one hand, the general internist is viewed as an "adult medicine specialist" who would be better prepared to deliver primary care (in concert with pediatricians and obstetricians) than would the family physician.[2] On the other hand, the general internist is viewed as a diagnostic consultant who would have special and intensive training in the wide variety of technical procedures currently being performed by subspecialists.[3] I have previously participated in this debate and have suggested that there are at least three categories of adult patients who would be best referred to a general internist.[4] These categories are:

1. Patients who have multiple medical illnesses involving several organ systems, all of which are important and interrelated. The general internist's impartiality may be an advantage in looking at the total internal medicine picture.
2. Patients whose presenting complaints are nebulous or not easily categorized by organ system. This is a surprisingly common occurrence and once again benefits from the perspective of an unbiased generalist.
3. Patients in whom the family physician identifies a leading medical problem, possibly in a particular subspecialty, but in whom a more measured and less aggressive approach is desired. The generalist's cognitive skills may be more helpful than the subspecialist's procedural imperative.

There are other advantages of referral to a general internist. In complicated cases, three or four individual referrals to different subspecialists may be necessary to answer all of the family physician's clinical questions. This is difficult and confusing for the patient and his/her family, not to mention quite expensive. No reasonable physician would use several different drugs when one would suffice. Why should the principle be any different when choosing consultants? I suspect that initial referral to a subspecialist (who may feel insecure in evaluating questions outside his/her narrow field) is more likely to result in a pattern of secondary and even tertiary referral, often completely unknown to the originating physician. Such patients frequently become lost in a complex medical system for months at a time, returning to their family physician only after multiple aggressive interventions. This phenomenon resembles Michael Balint's *Collusion of Anonymity*. I believe that an initial referral to a general internist would less likely result in such fiascoes.

The authors correctly identify some of the factors influencing the referral choices of family physicians in