The Consultant Family Physician

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Abstract: Family physicians frequently consult and refer to other specialists, both generalist and subspecialist. Less commonly has the family physician been used as a consultant. A randomized questionnaire survey of family physicians in five midwestern states was used to consider the frequency and reasons for other specialists collaborating with the family physician as a consultant. Fifty percent of the respondents consult and refer to as well as receive consultations/referrals from other family physicians. Thirty-five percent of the respondents receive consultations and referrals from other generalist specialists, and 28 percent receive theirs from subspecialists. Most often these occur because the patient has no family physician, but family physicians are also used for their procedural skills and coordination of patient evaluation and management, including preoperative evaluation of patients. This study confirms that the consultant family physician is an important part of the health care team. (J Am Bd Fam Pract 1989; 2:34-6.)

For a number of years, the need for more collaborative relations among physicians has been noted.[1,2] Numerous studies have looked at family physician consultation/referrals to other specialists, both generalist and subspecialist.[3-13] However, the literature is sparse in considering who consults/refers to family physicians, and why these consultations/referrals are made.[14,15] In the current environment of controlled fiscal resources (Medicare, DRGs), and with an awareness that quality care can be provided and is available in an ambulatory setting, another look at how other physicians use family physician resources seems appropriate. This study considers these issues.

Methods

A questionnaire was developed, pilot tested, modified, and then sanctioned for study by the Research Committee of the American Academy of Family Physicians. A 10 percent randomized sample of midwestern family physicians in five states (Region V, AAFP) was selected, and 350 of 506 physicians completed questionnaires (69.2 percent) to constitute the cohort for this study (see Vogt and Amundson[3] for a more complete description of the research design).

Results

Fifty-two percent of the respondents were residency trained, 85 percent were board certified, and a majority (59 percent) practiced in communities with fewer than 25,000 persons. Of these, 52 percent were in group family practice, 25 percent in multispecialty groups, 13 percent in solo practice, and the remainder represented academic and other practice settings. Ninety-one percent of the respondents had hospitals in their communities; 94 percent of the remainder admitted and cared for patients in hospitals in other communities that were located within 30 miles of the physician's office in more than 90 percent of cases.

Fifty percent of family physicians in this study consulted with or referred patients to another family physician; 53 percent received consultations and referrals from other family physicians. As shown in Table 1, most consultations and referrals were for a second opinion or for a procedure that the referring physician did not perform.

Other specialists also referred to family physicians. Thirty-five percent of family physician respondents received consultation requests and referrals from other generalists (general internists and general pediatricians); one-third were used two to four times a month. These collaborative efforts occurred in ambulatory (43 percent) and hospital (16 percent) settings or in both (41 percent). The most common reasons for these consultation/referral activities included serving the patient who did not have a family physician, performing a procedure the referring physician did not do, coordinating patient evaluation and management, or serving at the request of the patient (Table 2).

In a similar manner, 28 percent of the respondents were used as consultants by subspecialists; again, one-third of these family physicians were used two to four times monthly in ambulatory

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Table 1. *Consultations/Referrals to Family Physicians from Other Family Physicians.*

Reason	To Family Physicians (n = 172) Number of Responses	Percent	From Family Physicians (n = 180) Number of Responses	Percent
Second opinion	136	36.8	138	35.7
For a procedure I do not do (e.g., flexible sigmoidoscopy, vasectomy, etc.)	104	28.2	110	28.5
Patient request (other than due to a move)	59	16.0	71	18.5
To serve as "surrogate" family physicians for my patients who must travel to another community for further diagnosis and/or management	36	9.8	33	8.5
Psychosocial problems (including family counseling)	17	4.6	20	5.2
Other (please specify)	17	4.6	14	3.6
Total	369	100.0	386	100.0

(45 percent), hospital (7 percent), or both settings (48 percent). The most common reason was because the patient had no family physician. Other frequent reasons included coordination of patient evaluation and management and preoperative evaluation of a patient who had no family physician (Table 3).

Discussion

While the preponderance of consultations and referrals in which family physicians are involved occurs with the family physician as the referring physician, these data reveal that referrals among family physicians and from other specialists (generalists and subspecialists) do happen frequently.

The reasons for consultations vary. Fry said at the outset of our speciality (1971) that, "We have come to view our specialist colleagues more as expert 'technicians' than as consultants."[16] Respondents in this study show that this perception is now changing and that family physicians are used for their procedural skills by other generalist specialists and some subspecialists. Other skills that are recognized are coordinating patient evaluation and management ("captain of the ship"), offering psychosocial guidance (including family counseling), and providing second opinions. Also, these physicians serve as "surrogate" family physicians for patients who must travel to other centers of care for additional medical services. Consultant family physicians

Table 2. *Consultations/Referrals to Family Physicians from Other Generalist Specialists.*

Reason	Family Practice Respondents (n = 119) No. of Responses	Percent
Patient does not have a family physician	66	24.4
For a procedure I do (e.g., flexible sigmoidoscopy, vasectomy, etc.)	45	16.7
Coordinator of patient evaluation and management (i.e., "captain of the ship")	41	15.2
Patient request (other than due to a move)	36	13.3
Second opinion	32	11.8
Psychosocial problems (including family counseling)	24	8.9
To serve as a "surrogate" family physician for patients who must travel to our community for further diagnosis and/or management	16	6.0
Other (please specify)	10	3.7
Total	270	100.0

Table 3. *Consultations/Referrals to Family Physicians from Subspecialists.*

Reason	Family Practice Responsdents (n = 96) Number of Responses	Percent
Patient does not have a family physician	71	25.5
Coordinator of patient evaluation and management (i.e., "captain of the ship")	60	21.4
Pre-op evaluation (does *not* include on your own patient)	47	16.7
Patient request (other than due to a move)	30	10.7
Psychosocial problems (including family counseling)	21	7.5
To serve as a "surrogate" family physician for patients who must travel to our community for further diagnosis and/or management	18	6.4
For a procedure I do (e.g., flexible sigmoidoscopy, vasectomy, etc.)	15	5.3
Second opinion	13	4.6
Other (please specify)	6	2.1
Total	281	100.0

provide these and other services to specialty colleagues in both ambulatory and hospital settings, including those patients being cared for by a cadre of physicians, i.e., the family physician provides "dying care" for patients and families faced with terminal illness.

Fragmented tertiary care lends itself well to integration of the broad-based family physician as an appropriate consultant, often assuring that "touch meets tech" in an environment beset by a shrinking health care dollar while ensuring that comprehensive care is rendered in a cost-effective manner.[2] The use of the consultant family physician is documented, and patients will benefit as these physician collaborations become more formalized and frequent.

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