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PROCEDURES IN CONSULTATION AND REFERRAL*

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I AM deeply grateful for the honor of being thought worthy to join the parade of distinguished physicians who, almost every year for a century and a half, have delivered formal addresses on this occasion before the Society. So formidable are their names, and so striking are the contributions that many of them made in their orations, that one approaches this test of eloquence with some trepidation, and with a feeling that what one says here should not be merely an exercise in entertainment, but rather a statement of some important principle that concerns the medical profession in the Commonwealth. In keeping with this feeling, but still with trepidation, I wish to present today what can only be a humble personal interpretation of an age-old, traditional problem in medical practice — namely, that of professional conduct in the handling of consultations and referrals. I approach this problem from the viewpoint of a general practitioner, trained in surgery and industrial medicine. I choose this subject because I believe that increased courtesy in the conduct of consultations and referrals might, by improving the care of patients, win back some of the human respect lost by the profession in this modern generation. I believe that too assiduous pursuit of technical competence and medical economics and concentration on the disease process often dull awareness of the simple human aspects of the sick patient. The human being gets lost in the medical machinery. A symbol of the times was the young mother from Wellesley who complained about her doctors: "No one gets to know my family very well."[1]

The American Medical Association streamlined its *Principles of Medical Ethics* in June, 1957, reducing its section on consultation to the simple statement: "A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby."[2] This is, of course, the fundamental ethical principle, with which no one is likely to quarrel. When, however, one examines the *Traditional Concepts* that the Judicial Council holds are included in the fundamental principle, such matters of etiquette as the following appear: "When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient, he should address the physician in charge and advise him of the results of the consultant's investigation."[2] And furthermore: "When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation."[2] These statements are "not laws, but standards by which a physician may determine the propriety of his conduct in his relationship with patients and colleagues, with members of allied professions and with the public."[2] Furthermore: "There is but one code of ethics for all, be they group, clinic or individual and be they great and prominent or small and unknown."[2]

How well the profession measures up to official statements of principle is difficult to determine. I have an impression that it falls far short of some of them. To bring into focus some of the current problems in the Massachusetts handling of consultations and referrals, I mailed a questionnaire in January, 1959, to 70 practicing physicians. Equally divided among general practitioners and specialists, this was necessarily a hand-picked group of personal friends, as widely distributed over the State as I could make it and as representative as possible of differing types of specialties, communities and hospital staffs. All are members of this society, and all are men of outstanding integrity as physicians and citizens of their

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communities. This was not, therefore, an average cross-section of physicians but, rather, an especially observant and articulate sample of the profession who might be asked to render frank opinions on the basis of long experience in practice. I am gratified to report that 58 of the 70 returned this rather complicated, 7-page questionnaire, thoughtfully completed and usually accompanied by a letter or notes further amplifying their views, often with extreme frankness. Although I have already written personal letters of thanks to these doctors, I wish today again to express my grateful appreciation for their substantial contributions to this address.

Of the 58 physicians who responded, the average doctor had been in practice for twenty-five years, the sample varying from six to fifty-two years. About 20 per cent were from the immediate environs of Boston, and the others were irregularly distributed over the North and South Shores, the Framingham–Worcester area and western Massachusetts. Although it was not deliberately so planned, there happened to be almost equal representation among population areas of five sizes: above 500,000; 100,000 to 200,000; 50,000 to 99,000; 25,000 to 49,000; and under 25,000. The specialists who answered included 18 general surgeons, 4 internists, 3 orthopedic surgeons, 2 each obstetricians, genitourinary surgeons and ophthalmologists, and 1 each neurosurgeons, gynecologists, dermatologists, pediatricians and otolaryngologists. Three of the specialists considered themselves also in part-time general practice. Since more specialty-trained men than general practitioners answered the questionnaire, these part-time men almost brought the responses into equilibrium between the two groups, as originally intended. No truly statistical significance can be derived from these hand-picked groups in any case; the intent has been only to collect opinions and experiences from a variety of sources. Such figures and proportions as are quoted in this address must therefore be regarded only as evidence of trends rather than as numerical samplings of the profession. I wish also to make it clear that neither overtly nor by implication are any individual physicians identified in this oration, except to themselves as they hear or read what they have written.

About three quarters of those answering report that 80 per cent or more of their referrals are to consultants in their own area or hospital staff. Only a sixth limit themselves to local consultants, and a twelfth say they refer more than 50 per cent to outside consultants. In each of these fractions the division is about equal between specialists and general practitioners. To a question whether "limitation of referral to physicians within a group or hospital staff lessens the quality of care the patient receives," 24 answered, "yes," 11 said, "no," and another 16 qualified their answers by comments such as "depends on quality of group or staff" and "availability of certain specialists." Perhaps the numerous blanks and question marks further suggest that it was difficult to answer this question by "yes" or "no." One gains the impression that physicians, at least of the sort who responded to this study, are concerned about the competence of their consultants, and are usually utilizing the skills of other clinics and hospitals as well as their own.

A question that aroused a marked difference of opinion was, "Do you believe it is ever justified for a consultant to re-refer a patient to another consultant without talking with the original referring physician?" The affirmative answerer was further asked, "If so, under what circumstances?" Seventeen flatly replied, "no," this group being made up almost entirely of specialists, most of them surgeons. There were 5 surgeons, however, who answered, "yes." One of these was an obstetrician who requires a second opinion before certain operations can be performed; 2 orthopedic surgeons pleaded the need for prompt team consultation when the referring physician is out of town, a neurosurgeon likewise needed help in emergency or when the proper care of the patient demanded consultation, and 1 general surgeon insisted that he must control the choice of his consultant on the basis of competence. Eleven other specialists, mostly surgeons, thought there were occasional emergencies that required further consultation without waiting to consult the referring physician. It is interesting that 12 general practitioners left this question blank, and only 3 gave a "no" answer, whereas 2 gave a qualified "yes" answer. A part of these differences of opinion probably arises from the current confusion in definitions between the terms "referral" and "consultation." Bornemeier,[3] in 1954, emphasized the point that "referral is generally understood as a transfer of the full responsibility of the patient to another physician" whereas, "a consultation implies cooperation." He also pointed out that "one of the chief reasons that referrals and consultations have been confused is that we lack terms describing the recipient of a referral, and the physician seeking consultation."[3] "Consulter" and "referee," which he suggested, have not come into general use, and the confusion therefore continues. But semantics aside, I believe the clear differences of opinion, in response to this question of re-referral, represent a slowly appearing change in the attitude of the profession toward the so-called "ownership" of a patient by a referring physician, in cases in which the immediate safety or survival of a patient depends on quick re-referral in a hospital situation. Legalistically, this is a violation of the already-quoted excerpt from the *Traditional Concepts* of the American Medical Association, which states that the consultant "should not become the physician in charge of the course of that

illness except with the consent of the physician who was in charge at the time of the consultation."[2] There certainly seem to be times in modern hospitals when patients must be transferred from one service to another without the knowledge of the referring physician, and these times are characterized by a situation in which the welfare of the patient transcends the formalities of medical ethics. One small-town general practitioner makes this candid note: "When I refer a patient to a specialist, I expect him to call in any other specialist he needs without wasting his time telephoning, trying to locate me. In this way, my patient gets a better work-up and surer diagnosis."

A corollary to the observations presented above appears in another of the queries in this questionnaire: "How many patients do you think you have lost to a physician to whom you have referred them?" Thirteen specialists and 7 general practitioners report no losses or no "known losses"; 16 specialists and 8 general practitioners report "a few," or "1 per cent" or numbers of patients from 1 to 12. Thus, almost all the specialists and half the general practitioners consider the problem negligible or minor. Nine general practitioners report losses of 5 to 10 per cent, or numbers from 50 to 100 patients. One internist complains that he has lost patients to general practitioners whom he has left on call when he is not available, but 4 general practitioners complain of losses to internists or pediatricians. One of these complains also of obstetricians to whom he refers mothers for obstetric care, who then re-refer the babies to a pediatrician instead of referring them back to the general practitioner. Three surgeons and 1 general practitioner express the opinion that patients should have, and often do utilize, free choice of physicians, whether general practitioner or specialist. One of these surgeons writes: "I feel strongly that any of my patients may go to another physician without the necessity of notifying me. *I don't like it,* but that is their privilege." Another says: "As to losing patients to consultants, I think one is most likely to do that if he has tried to hang on to the patient too long . . . I am sure more patients are lost because of what the loser has done or has not done than because of the consultant." A general practitioner writes: "There are many patients today who seek out their own specialists rather than go to a general practitioner, and many who, when once referred, will go back to the specialist on their own. It seems to me that patients today are selecting their particular specialists and circumventing the general practitioner, to their own dismay when they need a physician in an emergency." Another general practitioner comments: "The difficult bridge for the consultant to cross is to behave in such fashion so as not to insinuate, by omission of some reassuring remark, that previous care was inadequate. The average patient is not able to return for constant care to a specialist, nor is it usually necessary, but he is very apt to feel he is accepting second-rate care in returning to his family physician, unless he has been reassured that his care has been adequate. It is, therefore, difficult and sometimes impossible to care for him during the long trek when no specialist wishes to 'hold his hand.' "

This line of argument leads quite naturally into another of the questionnaire items: "Do you believe that modern convalescent follow-up care, back to full rehabilitation on the job, is usually the responsibility of the consultant, or of the referring physician?" Here, only 9 considered rehabilitation the consultant's responsibility alone, and all these were surgeons. Eleven considered it the referring physician's responsibility, 6 of these being surgeons. Fourteen of the specialists believed the responsibility must be shared, and 11 of these were surgeons. No general practitioner thought that it was exclusively the consultant's responsibility, about 85 per cent voting for the referring physician as the solely responsible man and the other 15 per cent regarding it as a co-operative job. Thus, all the nonsurgical physicians and two thirds of the surgeons believed that the referring physician shares at least part of the responsibility for follow-up care and rehabilitation. Of all those who expressed opinions, half considered it solely the referring physician's responsibility, and a third a co-operative one.

To another question — "Do you think fee-splitting is common in your area?" — 3 surgeons in different geographic areas responded, "yes," and another in still a fourth area answered, "occasionally." Six other surgeons from three areas are concerned about Blue Shield's allocation of fees for aftercare as a legalized form of fee splitting. Thirty-nine answered, "no." Of the six who were critical of Blue Shield's policy, however, 3 believed that follow-up care should be a partnership between the referring physician and the consultant; 2 considered it the sole responsibility of the referring physician, and only one thought the consultant should alone be responsible.

A broader question than that pertaining to convalescent care was asked to get a survey of opinions on the family-physician problem: "Who do you believe best handles the over-all care of the total patient in the long run: (a) an internist? (b) an organized group or clinic? (c) a family physician (G.P.)? (d) an outpatient department?" An associated question was also attached: "If you have an opinion, indicate, in the second column above, proportions you believe are now so handled in your community." Not surprisingly, general practitioners voted universally for themselves as the best handlers of total care, but 5 of them admitted in the second column that from 1 to 10 per cent of patients in their communities were actually cared for by internists, groups or outpatient departments. Specialists divided about

2:1 in favor of the general practitioner over the internist on the first question, with only 2 votes for group care. But on the question of actual conditions in their communities, there was a slight shift toward internists and a marked shift toward clinics and outpatients. It is only fair to state that only 2 of those polled indicated that they were in group practice, both of them in offices for a single specialty. The only significance of the figures in the second question is probably that the specialists are usually practicing in cities, and the general practitioners in smaller communities. But in answers to the first question, the preference of specialists for general practitioners over internists as family physicians seems important. The only exception to this observation was in Framingham, where every vote cast was for the internist, with no internists or general practitioners among those polled. Elsewhere, the consensus is well expressed by a surgeon: "While a family physician is the best answer for each patient, this is predicated on his being a thorough and good one."

A question was asked: "Do you believe that a referring physician should set specific limits on what he wants a consultant to do, in requesting a consultation?" Among the specialists, 7 replied, "yes," and 23, "no," with 4 others modifying their "yes" by observing that the referring physician should inform the consultant whether he wants an opinion based on one visit, or a transfer for definitive treatment. The general practitioners produced 6 "yes" and 11 "no" votes. Here, again, the question is confused by the semantic problem already mentioned of consultation as opposed to referral. There are numerous modern situations, however, particularly when a third party is paying the bill, in which this question is important for either a one-visit consultation or a "take-over" referral. In elective cases financed by industry, by welfare departments or by private charity, decisions about the degree of diagnostic study or of corrective treatment often involve an economic problem of which the consultant should be aware. Under these conditions it is only fair for the referring physician to limit his consultation request to a degree commensurate with the wishes of the third party, so long as no immediate emergency exists. This may also be true when only the patient's relatives are involved, if they are subsidizing the investigation. One general practitioner suggests that a detailed mimeographed form be used to specify what limitations the referring physician requests in such problem referrals. Similarly, there are frequent situations in modern industry in which occupational impairment may be a determining factor in deciding what course to pursue, and frequently the industrial physician may be of assistance both to the referring physician and to the consultant in describing conditions in the working environment that may vitally affect a patient's rehabilitation to skilled employment. If so, the consultant will avoid embarrassment by conferring with the plant physician where the patient is employed, to clarify such limitations as may be imposed by the job.

A group of six questions was directed only to the general practitioners. The first of these was: "In what proportions do your referrals to other physicians result from: (a) your own suggestion? or (b) a request by the patient, a relative or friend?" Out of 24 who answered, 7 indicated that all referrals resulted from their own suggestion; 12 replied that the request originated with the patient or relative in 10 per cent or less of referrals, and 3 said 15 to 30 per cent and 3 more 40 to 50 per cent of referrals. A parallel question asked was, "In what proportions is the specialist chosen (a) by you, (b) by the patient or a relative?" The answers here were similar, 6 indicating 100 per cent their own choice, 12 indicating 10 per cent by the patient or relative, 5 indicating 15 to 30 per cent, and 3 indicating 40 to 80 per cent of referrals. Apparently, a few more patients choose their own consultants, once the suggestion is made, than the number who ask the physician for consultation in the first place. It is clear that an appreciable number of consultants owe both the idea of consultation and the choice of the particular specialist to the patient or his family rather than to the referring physician alone.

To another question — "In your practice, is a needed referral to a clinic or private consultant ever refused because of alleged prohibitive cost?" — 16 general practitioners answered, "no," and 10, "yes, occasionally," most of these indicating only 1 per cent to 5 per cent of such cases. No one considered this enough of a problem to comment further upon it.

To a question whether most consultants were ethical in the handling of referred patients, 23 general practitioners answered, "yes." Three others indicated that there were a few who were not. But when asked whether consultants were careless about reporting, only 20 answered, "no," and 6 indicated that they were not only careless but also late in reporting. One excellent and well trained general practitioner expressed himself as follows: "My chief complaint is against the larger hospitals . . . to which I have referred patients because they can't afford to go private. Nowadays you never hear from these hospitals either while they are in the hospital or even after discharge. Usually, they are referred on discharge to their Out-Patient Department. In the old days they used to call up the day before an operation was booked; they would call up when the patient was discharged to give you discharge diagnosis and treatment and follow this up with a written, detailed report. We don't get any of these courtesies today." A surgeon from an outlying town writes: "Getting an extract of a record from a hospital is rapidly getting to be a super-major operation." A man from the Connecticut Valley writes: "Specialists in the Boston

area, except for organized staffs or those who are well established privately, anger many western Massachusetts M.D.'s by lack of unqualified referral back of patient to referring physician . . . If nothing else is accomplished by your paper, get all consultants to *acknowledge in writing* and *promptly* the arrival of patients, with a complete report then, or as soon as conclusion is arrived at. The referring physician is in trouble with the patient's family if he is not informed *fully* until the patient is back home; the consultant is viewed as unsympathetic if not cooperating with the referring physician."

General practitioners were asked whether they give subsequent progress reports to their consultants. Fifteen replied that they do so regularly, and 5 that they do occasionally. Six answered that they do not.

A somewhat similar group of questions appropriate to consultants was asked of the specialists. Thirty-one said, "no," 2, "yes," and 1, "mostly," to the question: "Do you accept patients on referral only?" To the question whether estimated costs were discussed with patients before treatment, 12 said, "yes," 11 more, "usually," 2, "occasionally," and 10, "no." To the questions whether the nonreferred patient was asked the name of his family physician, and whether a report was then sent to him, 75 per cent answered, "yes," to both, with an additional 10 per cent responding, "sometimes." A few objected that the nonreferred patient often changed his family physician, and the report then created embarrassment all around. One surgeon comments: "Ever since I have been in this town, I have tried to drum into the people who are interested in coming into my office the advisability of having a family physician . . . they are getting so that they go to see their physicians."

The specialists were asked the percentages of their patients who arrived in their offices referred by general practitioners, referred by other specialists, by friends, by allied medical groups or at their own initiative or referred by a lawyer, insurance agent and so forth. The statistics are too complicated to be reported here fully, but some trends were observed. In most areas referrals from general practitioners were in the majority, with "own-initiative" cases next in frequency. Framingham again showed more from other specialists than from general practitioners, but in all other geographic regions the frequency of these was under 20 per cent, comparable with "friends," "allied groups," and "lawyers" and so forth. The pattern of origins of cases among Boston specialists did not greatly differ from that in smaller cities.

To still another question — "Do you think referring physicians are generally careless in their technique of asking for consultations?" — 24 specialists replied, "no," 3 said, "yes," and 4 qualified their affirmative answers. One of these, a surgeon, writes: "Not most, but some are [careless], and especially in the writing of hospital consultations: 'will you please see John Jones?' "

To a further question — "Do you think their preliminary work-up is adequate?" — 28 specialists say, "yes, " but 8 of these make minor reservations, and 3 quite serious reservations. Six answer, "no." As to whether the work-up is too prolonged, 10 say, "no," 12 say, "yes," with minor or major qualifications, and 13 do not answer. A characteristic surgeon's comment reads: "The family physician should send information to consultant. To do this he must keep office records. A too high percentage of general physicians do not (I think) keep records, and too frequently do not examine thoroughly and work up their patients." An internist speaking of adequacy of preliminary work-up comments succinctly: "From some men, excellent; from some men, poor; and from some men, lacking." On the "Too prolonged?" question, a neurosurgeon writes, "yes, in time; no, in quality," and a genitourinary surgeon writes, "yes, 50, no, 50."

On questions about whether they think the proper care of the patient often suffers for lack of referral or delay in referral to specialists, about half those answering, mostly surgeons, answer, "yes," often with qualifications like "sometimes" or "occasionally." These opinions need to be balanced by the recognition that sometimes it is the patient who refuses, or delays, the referral. When asked whether there is generally good follow-up care and reporting by their referring physicians, 22 specialists reply, "yes," 4 say, "no," 4 qualify by saying that the reporting is poor, and 2 do not answer because they do their own follow-up study until the patient is recovered.

Since it is obvious that paper work is an important factor in the proper handling of referrals to specialists and reports from them, a series of questions relating to this problem were asked of all those polled. The first of these was: "Do you have a paid secretary or nurse-secretary, part-time or full-time? Does your wife or other dependent assist with records or correspondence, part-time or full-time?" Forty-four, of whom 30 were specialists, reported that they had a full-time paid secretary, and 10 reported a part-time paid secretary — 4 of these in offices that have also a full-time one. In total, 31 specialists and 19 general practitioners had either full-time or part-time paid secretarial help. Three specialists and 5 general practitioners reported no paid secretary. In 18 offices, wives or dependents did part-time secretarial work, 15 of these supplementing paid secretaries. Five men reported that they had no secretarial help at all, all of these being in rural areas, 4 of them general practitioners. It is interesting that 3 of these 5 reported in subsequent questions that they neither refer by letter nor get consultants' reports by letter. In all justice, it is fair to mention that 1 rural surgeon,

whose wife is his part-time, and only, secretary, despite a large family, writes on this question, "between us we get it done somehow," and he later explains: "I think most referrals around here, in my work at least, are quite informal. I am sure I don't care whether someone to whom I have sent a patient reports back, since he and I and the patient are all at the local hospital, so I know what goes on as it goes on. This would be entirely different in a large city."

All those polled were asked: "In what proportion of your referrals is your request forwarded: (a) by letter; (b) by telephone; (c) by personal conversation; (d) by written request on a hospital record; and (e) by the patient himself?" I will confine myself to trends in reporting these answers, not to burden this paper with statistics. Specialists in all geographic areas of the State use the written word, by letter or hospital record, distinctly more frequently than general practitioners in referring patients. However, both specialists and general practitioners use the telephone more frequently than any other method, and in similar proportions. Referrals are made by personal conversation between the doctors more frequently by general practitioners than by specialists. Only about 25 per cent of the physicians polled ever use the patient himself as the referral messenger, and rarely in more than about 10 per cent of cases, these occurring slightly oftener among general practitioners than among specialists.

A similar question was asked about reports: "In what proportion is the report by your consultant provided: (a) by letter; (b) by telephone; (c) by personal conversation; (d) by written hospital record; and (e) no report?" In this instance letters are received by 90 per cent of the physicians polled and are the most frequent form of report to general practitioners. Specialists receive a higher proportion of their written reports by hospital record than by letter or telephone, but reports to general practitioners come by telephone oftener than by hospital record. Report by personal conversation between physicians is occasional in both groups, but more than a third never receive reports in this fashion. Thirty-nine men say that they have never failed to receive a report from a consultant in some form, but 19, including 12 general practitioners, state that with varying frequency, usually 5 to 15 per cent, they fail to receive any report. Two men, 1 in central and 1 in western Massachusetts, declare that they fail to receive reports on 50 per cent or more of their referrals. These seem to confirm the strong protests recorded above from a third man, who answers this question: "When report lags, contact is repeated until report is obtained." No doubt both long-distance telephone calls and secretarial help are expensive, but neither should be a serious obstacle to providing a prompt report to a physician who has sent his patient a hundred miles from home for special care. Such a patient frequently asks the referring physician whether he can go back to work, and with no report from the consultant, the question is unanswerable, often producing further economic loss to an already hard-pressed patient, until a hurry-up report is obtained.

One final question was asked of all those polled on the questionnaire: "Do you acknowledge or reply to letters containing reports from consultants?" Nineteen, of whom 13 were specialists, do so regularly; 28 others, of whom 18 were specialists, do so occasionally or frequently, and 10, including 8 general practitioners, reported that they never do. Here is a courtesy that the referring physician should pay to the consultant, to inform him that the report has been received and that the patient has been safely returned to his own physician. It affords the physician a chance to thank the consultant for referring his patient back to him, and to report on his condition after discharge. It is possible that consultants would feel a closer liaison with the general practitioner if the latter more generally observed this simple act of courtesy.

There are certain technical and special problems about consultations for which there is not space in a paper of this sort to discuss in full but that may be mentioned in passing. Among these is the mandatory consultation, already touched on in a remark above about obstetric situations. These consultations are usually a requirement of the Joint Commission on Accreditation of Hospitals[4] and are designed to divide responsibility in poor-risk surgical cases, or in operative interventions that may disturb a known or suspected pregnancy. The procedures in these matters sometimes vary from hospital to hospital, depending on staff organization and other factors in the local situation. I do not believe that any useful purpose can be served by attempting any broad statement of principle about these cases in this discourse other than to emphasize the desirability that all concerned follow sound basic ground rules within any hospital staff designed to carry out the purposes of the Accreditation Commission. Another especially technical problem that differs greatly from place to place is the handling of psychiatric consultations and referrals. Here, again, the variables of availability of psychiatrists, clinics and public or private facilities in different areas of Massachusetts make any general statement of procedure difficult. Each physician must of necessity work out for himself acceptable relations with the specialists and institutions accessible to him in his particular area. An interesting study of the whole problem of psychiatric consultation, by the questionnaire method, was made by Blain and Gayle[5] in April, 1954. I commend this article to any who have a special interest in this field.

I do wish to take the time, however, to emphasize the necessity of teamwork between specialists and gen-

eral practitioners. I quote a paragraph from A. D. Dennison, Jr., M.D.,[6] in a 1957 paper:

> Recently it was brought to my attention that a number of men were leaving general practice to return to residencies in the various specialties . . . because of interpersonal professional problems with specialists. It was stated that they are hurt, annoyed and embarrassed by being made to feel inferior, by the usurping of patients by specialists and by the direct or indirect restriction of the pleasurable challenges in medicine. They are sometimes made to feel like moronic purveyors of fascinating cases to their more gloriously endowed colleagues. For this they get little consideration, brief, late, or no reports at all, and perhaps a fleeting glimpse of their former loyal patient as she or he passes in review through the halls of the specialists. . . .

Against such a statement one must balance a comment like the following, from an eminent specialist, accompanying the questionnaire:

> My impressions are that there is never any trouble in the lines of consulting and referral when the consultant or referring physician is a really competent man. On the other hand, I believe that the frankly incompetent doctor who practices medicine as a business or for the money in it always causes trouble, and usually refers patients or employs a consultant only when the patient forces him to do so, runs out of money, or is about to die. In the middle are a larger group of doctors who mean to do well by their patients, but just do not know they are, or are about to be, in trouble. . . . More education, more recognition of what they *don't* know rather than self-adulation because of what they think they do know is today even more essential than it has been in the past.

These two declarations represent the poles of an argument that goes on every day in the staff rooms of most hospitals. In between there is a fertile ground for tolerance of the weaknesses all possess, for post-graduate education and for the courtesies and teaching through consultations that all need. All physicians could be advised, also, to improve paper work, both in the proper presentation of cases and in reporting on them.

In the long run it is what is best for the patient that is going to determine what directions consultation procedures, and indeed the whole conduct of medical practice, are going to follow in the coming years. Whenever specialists' competence in the great hospitals begins to override and neglect the human need for doctors who will make house calls, the great American public, which constitutes the patients, begins to complain. Whenever general practitioners become careless and routine and fail to utilize proper liaison with expert technics available through their specialist colleagues, public clamor is again raised. The profession is a team, and anyone who fails to maintain cordial relations with the other members of the team loses the respect of patient and colleague alike.

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In this paper I have attempted to bring together certain current factors in ethics and etiquette that I believe are as important as the new drugs, the laboratory facilities or prepaid insurance in maintaining the integrity of the medical profession in its care of the patient. I have tried to outline some of the current practices, through using the loyal co-operation of colleagues who subjected themselves to the analysis of a questionnaire. In certain instances variances have demonstrated that sometimes the care of the patient may have priority over strict adherence to formal traditional concepts of behavior under the *Principles of Ethics*. I hope I have opened up certain directions of thinking by which any physician may improve the courtesy and co-operative teamwork by which all may render better service to the sick, the maimed, the halt and the blind, who depend wholly on the medical profession for wise advice, rehabilitation or, hopefully, cure. My wish is that you take these ideas home with you, ponder them, and if they have any merit, use them for the better care of your patients.

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