# Family Practice Forum

# Family Physicians as Consultants

Lucy M. Candib, MD
Worcester, Massachusetts

Traditionally, family physicians serve as physicians of first contact for patients coming with previously undiagnosed and unsorted illness. Patients requiring specialty consultation may then be referred to the specialist best meeting the needs of the patient. It is rare for patients or families to be referred from specialists to family physicians for either consultation or ongoing care.

Situated in an urban neighborhood and serving low-income families, the Family Health and Social Service Center occasionally receives referrals of patients who are Spanish speaking because of the center's bilingual capability. Also, patients on Medicaid may be referred from an emergency room for follow-up of an acute illness. Ordinarily, these patients' problems do not subdivide well into the specialty clinics of the university hospital.

For example, the following are typical patients at this health center: a 58-year-old Spanish-speaking father of 16 children who presents with obesity, mild hypertension, mild osteoarthritis, headaches, and bronchial asthma and who needs a form filled out certifying him unable to work; a 19-year-old, mildly retarded woman, pregnant for the third time, unable to care for her first two children, who lives in an abusive relationship with her husband; and a 45-year-old alcoholic mother who persistently misses the appointments for her daughter's necessary surgery. Together with social workers, outreach workers, and counselors, the family physicians of the health center provide care for these patients.

It is not unusual for such families to enroll at the Family Health and Social Service Center. On several occasions, however, certain patients have been referred to the center who can be described as extraordinary. One example is summarized here.

Requests for reprints should be addressed to Dr. Lucy M. Candib, Family Health and Social Service Center, 875 Main Street, Worcester, MA 01610.

## Case Study

A call was received to see a 25-year-old Puerto Rican woman who had been an inpatient on the orthopedic service at the university hospital for the last five months. She had received a gunshot wound to her spine at the eighth thoracic vertebra six years previously, when she was 19 years old. Since then she had suffered from contractures of her hips and knees, severe decubiti, and subsequent osteomyelitis. Although she spoke English, she was considered a difficult patient by the nursing staff. At the time of the original consultation, she was in line to have a three-step repair: bilateral, high, above-the-knee amputations, a diverting colostomy and ureterostomy, and a major flap procedure to close the decubiti. If these were not successful, she would then go on to excision of her pelvis and the remains of her femurs (a hemicorpectomy).

Recommendations for social service consultations, upper extremity physical therapy, occupational therapy, patient education regarding ostomy procedures, and encouragement of control of specific aspects of postoperative care were followed. When she was seen again two months later, she was in good spirits, navigating the hospital in a wheelchair, and translating for Spanish-speaking patients. Her main problems at that time were restriction from a wheelchair because of a new decubitus and her desire for prosthetic legs when seated in the wheelchair. The nursing staff did not appreciate her embarrassment over the use of a mobile cart in the prone position instead of a wheelchair.

At this point, the center staff physician suggested specific behavior and time-oriented negotiations around wheelchair use, a shift in bed location so that the patient could see the doorway from the prone position, and English language tutoring to

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improve her proficiency in her new role as translator.

## Discussion

For this patient, the referring physician was requesting overall evaluation and management suggestions, perhaps because of the center's known abilities in taking care of Puerto Rican patients. The family physician's role here was to see the patient in consultation, without any expectation of transfer of the patient's care.

In other instances, center staff have been consulted as physicians willing to take on patients that the medical or legal systems were finding difficult to manage. This suggests that family physicians are beginning to be identified as physicians willing to deal with the health care system's problem patients. This trend would be a reversal of the current one-way consultations from family physicians to specialists.

If family physicians are to take on this role of being open to consultation for problem patients, some guidelines are in order:

1. The responsibility for ongoing and ultimate care of the patient must be established early in the consultation.

2. Hospital based consultations need to take place early so that coordination of hospital services is a real possibility and discharge plans can be made with the family physician's knowledge of community resources.

3. Family practice training programs must prepare residents for this consultative role through the use of faculty members as role models and with the development of formal consultative services within hospitals where residents rotate.

4. A payment mechanism for the time consuming nature of the office services must be devised in order to make it economically feasible for teaching and practicing family physicians to provide such services on an ongoing basis.

The expertise of family physicians in seeing the whole patient within the context of the health care system, the family, and the community makes them a logical choice for consultations on problem patients both in the hospital and in the office. Their skills in this process will earn family medicine respect as a valuable consultative discipline.