

## Guidelines for Physicians Regarding Referral and Consultation

### Note re. Guidelines and Policies

This document is a physician **guideline** approved by the Council of the College of Physicians and Surgeons of Nova Scotia.

**Guidelines** contain recommendations endorsed by the College of Physicians and Surgeons of Nova Scotia. The College encourages its members to be familiar with and to follow its guidelines whenever possible and appropriate. Note that guidelines may contain references to College policies.

**Policies** reflect the position of the College of Physicians and Surgeons of Nova Scotia. Physicians licensed with the College are expected to be familiar with and to comply with College policies.

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### Preamble

The College of Physicians and Surgeons of Nova Scotia recognizes that effective communication between referring and consulting physicians is essential to the quality and safety of patient care.

The following describes the College's recommendations regarding professional communications between referring physicians and consultants.

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## The College's Position

- A. Professional communication between physicians should always serve the best interests of patients and should be respectful, collegial, collaborative and courteous.**
- B. The referring physician should provide, sometimes verbally but more commonly, in a written letter, secure fax, or encrypted email:**
1. The specific reason(s) for the consultation request.
  2. Accurate contact information (including address and phone number), basic demographic information about the patient (such as gender and age) and the patient's Nova Scotia Health Card (MSI) number and/or insurance information.
  3. The referring physician's contact information (including address, phone number, and/or pager number).
  4. When possible, the referring physician's expectations of what the consultant will undertake. (e.g. Whether the request is for an assessment and advice only or whether there is a request to transfer some or all of the responsibility for care).
  5. A summary of pertinent medical history, examination findings, current medications (name and dosage used, including those on a PRN basis), known allergies, and the identification of other physicians currently involved in the patient's care, where appropriate.
  6. Copies or summaries of pertinent laboratory investigations, imaging and other consultant reports, where appropriate. The consultant should also be informed if additional investigations have already been ordered but are still pending or if results are not yet available.
  7. An indication of whether requests have been sent to other consultants to see the patient for the same complaint.

8. When referring or consulting with a diagnostic specialty such as diagnostic radiology or laboratory pathology, the following information should be provided:
  - a) Accurate contact information (including address and phone number), basic demographic information about the patient (such as gender and age) and the patient's Nova Scotia Health Card (MSI) number and/or insurance information.
  - b) The name of all physicians to whom copies of the reports should be sent.
  - c) A brief clinical history or presumptive diagnosis.
  - d) An indication of the urgency for the examination to assist in prioritization.

**C. To avoid delays in care, the consultant should:**

1. Provide a prompt response to the referring physician within 14 days acknowledging the referral and anticipated *wait time* or appointment date by fax or encrypted e-mail. Even when a firm appointment date cannot be provided, this acknowledgment should be supplied, along with an estimated appointment date. This should be followed later by confirmation of a firm date when it becomes available.
2. Schedule the appointment directly with the patient, except in exceptional circumstances. (Exceptions exist in the case of diagnostic specialties, such as Radiology. See "The Case of Diagnostic Specialties" below).
3. Advise the patient of any specific requirements prior to the appointment (e.g. bowel preparations, fasting, etc.).
4. Advise the patient to contact the consultant or referring physician if there is any change in his/her condition.
5. Communicate expectations about office procedures and policies to the patient (e.g. cancellations or confirming appointments in advance).

**D. Upon seeing the patient, the consultant should provide the referring physician with a timely written report (preferably within 14 days) that includes, but is not limited to:**

1. Relevant history and findings of examinations.
2. Conclusions regarding diagnosis (definitive/provisional, differential diagnosis where appropriate).

3. Diagnostic and therapeutic interventions that were implemented and/or recommended. (Including a statement of anticipated wait times, if the intervention(s) did not take place at the time of the consultation.) The consultant physician initiating any diagnostic or therapeutic intervention bears the responsibility for any patient follow-up, including notifying the patient of the results of investigations ordered.
4. Stated intentions for subsequent review or follow-up by the consultant, including a statement of the level and scope of any responsibility of care that the consultant is accepting.

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### **Further Recommendations**

1. The referring physician should inform the consultant (preferably by personal contact) if the estimated wait time is inappropriately long for the patient's condition, or if the patient's condition changes during the wait period. The referring physician should also consider referring the patient to another consultant if the clinical condition of the patient requires an earlier appointment than the consultant can accommodate.
2. The consultant should seek to minimize the possibility of adverse events while the patient is awaiting a consultation. This may include discussing alternative treatment options, if available, or offering possible referral elsewhere.
3. The duty of care arises out of the doctor-patient relationship, which is created whenever a physician agrees to treat a patient. It is therefore possible that the courts, in consideration of the specific facts of the case, may determine that the consultant owes a duty of care from the moment his/her office accepts a referral, regardless of whether the patient has been seen by the consultant. Given that a duty of care may be said to arise in these circumstances, consultants will want to ensure that they have a system in place to appropriately prioritize patients according to the level of urgency of their condition. Objective criteria should be used to assist in this screening process so that it is done in a consistent and non-arbitrary manner.
4. In cases where the patient has waited a significant period to see the consultant, the referring physician should inform the consultant about noteworthy interim changes in the patient's condition or treatment.
5. The consultant should ensure that the referring physician receives a timely report of subsequent interventions or interactions with the patient.

6. Within an inpatient setting, failure to designate the “most responsible physician” can affect the appropriate communication of diagnostic examination findings and consequent follow-up. Clarity regarding who is the most responsible physician is essential.
7. In cases where the consultant cares for the patient for an extended time, the consultant should provide an annual (or more frequent if appropriate) follow-up report to the referring physician.
8. The consultant and the referring physician should agree upon their respective post-consultation obligations to the patient and communicate these to the patient as necessary.
9. Upon discharging a patient from the hospital, the consultant should ensure the patient is scheduled for a follow-up appointment with the consultant, if necessary. If follow up with the patient’s family physician is deemed sufficient, the consultant should instruct the patient to follow up with their family physician, where appropriate. The consultant should also provide a document that clearly explains the patient’s follow-up care needs so that:
  - a) The *primary care physician* will reliably know the reasons for the admission, the circumstances of the hospitalization, any relevant recommendations for management, and any contemplated follow-up by the consultant; and
  - b) The *patient* will clearly understand the consultant’s expectations, and the mechanisms that will enable subsequent communication and follow-up, both with the consultant and with the primary care physician.
10. It is imperative that all physicians providing patient care respect their obligation to be accessible, personally or through a designated delegate to ensure safe continuity of care. They should inform the appropriate parties about how they can be contacted, or else provide contact information for their delegate(s) if they are not going to be available.
11. While medical office staff members often play an important role in facilitating communication, they are nevertheless extensions of medical practices for which physicians are ultimately responsible.

12. Physicians co-managing patients, particularly in a hospital setting, should make their respective roles and responsibilities clear to each other, to other care providers (e.g. hospital staff nurses, resident staff) and, where appropriate, to patients and/or their families. This should include a designation of “most responsible physician”.
  
13. Physicians have an ethical duty to respect their patients’ reasonable requests for second opinions.

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### **The Case of Diagnostic Specialties**

While appointments for diagnostic tests (consultations) are frequently made with the referring doctor’s office rather than the patient directly, physicians who work in diagnostic specialties for which appointments are given, such as diagnostic radiology or laboratory pathology, function in a consultative capacity with family practitioners and other specialists. As such, they may be responsible for the following:

1. Prompt acknowledgment of requests from referring physicians.
2. Prompt communication to referring physicians of anticipated wait times.
3. Confirmation of referral and appointment times to the consultant. (If the examination is to be performed within 48 hours, the contact should be made with the patient directly).
4. Provision of timely reports.

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## Questions and Answers

- 1. I have little or no managerial influence over my office staff because they are employees of the institution in which I work. How can I comply with this guideline given that the roles and activities of my office staff are so critical to the referral process?**

Physicians whose quality of care may be compromised by such institutional factors are encouraged to raise this matter with the appropriate staff and administrators. Taking action of this kind is supported by section 52 the Canadian Medical Association *Code of Ethics*, which states: "Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services."

- 2. My referral depends on the availability of diagnostic imaging, pathology services, or other third-party services over which I have no control. How can I comply with this guideline given that so much of the process is out of my hands?**

Limits on diagnostic resources are an unfortunate reality of today's medical environment. Despite these limitations, patients are entitled to know the approximate date of services ordered on their behalf.

- 3. As a family practitioner, I often book appointments with several specialists in the hope that my patient will be seen as soon as possible by one of them. I have been criticized by some colleagues for my "shotgun approach". Am I not justified in doing this to make sure that my patients get the best possible care?**

This practice is not justifiable because it may needlessly complicate other physicians' practices and/or lengthen the wait time of other patients. The Canadian Medical Association *Code of Ethics* expects physicians to recognize their broader responsibilities to society; specifically to use health care resources prudently (section 44) and to collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. (section 52).

- 4. As a specialist, am I correct to assume that my office should routinely contact referring physicians and patients with information such as preparation instructions, appointment dates, and anticipated appointment times?**

This is correct. However, the College recognizes that there are some situations where this may not be possible. These would include situations where the referring physician has supplied inaccurate or outdated patient contact information or where reasonable attempts to contact the patient have failed.

5. **As a specialist, I often see consultation requests containing little or no information. An example is “Chest pain – please assess”. What can I do about inadequate requests like this?**

Referring physicians are expected to provide complete, clear referral information. In the interest of both your patients and your peers, you may wish to raise your concerns in a collegial manner with the referring physician.

6. **I am a family physician. I recently referred a patient to a local specialist. The consultation letter I received from the specialist recommended that the patient be started on a particular medication. When I later saw the patient, I discovered that she had been taking the medication since seeing the specialist. How can such miscommunication be prevented?**

Notes sent from consultants should always distinguish between interventions that were *initiated* at the time of the consultation and those which were *recommended*. In the interest of both your patients and your peers, you may wish to raise your concerns in a collegial manner with the consultant.

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## Appendix

### Guiding Ethical Principles from the *CMA Code of Ethics*

#### *Responsibilities to the Patient*

- 15.** Recognize your limitations and, when indicated, recommend or seek additional opinions and services.
- 19.** Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.

#### *Communication, Decision Making and Consent*

- 23.** Recommend only those diagnostic and therapeutic services that you consider to be beneficial to our patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.
- 26.** Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.

#### *Responsibilities to Society*

- 44.** Use health care resources prudently.

#### *Responsibilities to the Profession*

- 52.** Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

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## Consultation Regarding this Document

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## Document History

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