

Whom, Why and How to Refer

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When a medical practitioner decides that the time has come to refer his patient to a specialist, certain psychological problems arise which may, at times, interfere with the smooth accomplishment of the referral. These problems can and do occur daily in medical practice, and it often makes little difference whether the specialist is a thoracic surgeon, a neurosurgeon or a psychiatrist. Referrals create certain anxieties and fears in the mind of the patient. Some of these anxieties are common to all referrals. The patient asks himself, "What's going on? What does the doctor think I really have? How serious is it? Will I come out of this alive, incapacitated, disfigured? Is this referral necessary? Why can't I go on as I am? Is the specialist he's sending me to really good?"

When good communications exist between the physician and his patient (and also between the physician and the specialist), the level of anxiety drops, and referral is much more easily accomplished. In some instances the intelligent and perceptive patient may sense the situation and may himself suggest the possibility of referral to a specialist. In most other instances, however, the preparation of the patient for a good referral takes time, patience and skill. In fact, the making of a good referral is one of the great unsung arts of medical practice. When all goes well, the patient is grateful to you for making the referral to a specialist, who, in this frame of refer-

ence, becomes only an extension of your therapeutic efforts. In other instances the fears and anxieties which are caused by the mere mention of a referral interfere seriously with the patient's future progress. It is in an effort to understand, allay and, possibly, prevent these fears and anxieties that this paper is being presented.

Whom to Refer

Since 50% to 75% of patients seen in general practice have symptoms which are completely or largely of emotional origin, the medical practitioner will have to be highly selective in deciding whom to refer to a psychiatrist. Even if we were to triple the number of psychiatrists in the country, it would never be possible (nor would it be advisable) to refer all patients with psychogenic symptoms for psychiatric treatment. Fortunately, the majority of patients with such problems can be effectively treated and, in fact, *are* being so treated by the family physician, with or without an occasional assist from a consulting psychiatrist.

Who are these patients? Which ones can be best treated by the medical practitioner, and which should be seen by a psychiatrist? Patients with psychiatric symptoms seen in doctors' offices can be divided into three main groups: 1) those with minor disorders; 2) those with major disorders; and 3) an intermediate group.

Due to the increased teaching of

psychiatric principles in our medical schools and the increased sophistication of our medical school graduates, most physicians now feel fairly comfortable in treating patients who fall in the *first group*. They will be suffering, for the most part, with minor anxieties, situational stresses and mild depressions. The time-honored techniques of ventilation, reeducation, reassurance, and persuasion are well known and skillfully used by most practitioners. Judicious use of the newer psychopharmaceuticals plus full employment of the doctor-patient relationship can help the majority of such patients in a relatively short time. Rarely do such patients require a referral to a psychiatrist.

In the *second group*, consisting of those with major mental disorders, psychotic reactions, suicidal depressions and persistent personality disorders, the indications for psychiatric referral are quite clear. Patients having psychotic reactions, whether schizophrenic, manic-depressive or organic, should be promptly referred to a psychiatrist. The exception is the patient suffering from transient delirium or confusional state, which is often associated with an infectious or toxic condition. In general, if any of the following symptoms are present, a psychiatrist is probably needed.

1. The persistence of incapacitating psychoneurotic symptoms, such as phobias, compulsive behavior, anxieties, obsessions or hysterical manifestations.
2. The persistence of psychogenic sexual problems.
3. The persistence of serious psychophysiological (psychosomatic) symptoms. These are often best treated *jointly* by the psychiatrist and the referring physician at the same time.
4. The presence of psychotic symptoms such as active hallucinations, delusions or thinking disorders.

5. Sudden changes of personality or judgment.

6. Exaggerated swings of mood and motor activity.

7. The development of retardation, depression and preoccupation with self-destructive thoughts. (Sometimes a suicidal gesture which brings the patient into the hospital emergency room may serve a useful purpose by bringing psychiatric help to a reluctant patient.)

The *third or intermediate* group of borderline patients will cause the greatest difficulty to the physician making a decision as to referral. In some cases, factors relating to the patient will be of greatest relevance. For example, we often see the patient with frankly psychiatric symptoms who stubbornly refuses to consult a psychiatrist no matter how skillfully the idea is presented. In such cases it is unwise to force the patient. Supportive and symptomatic treatment by the physician should be continued in the hope that he may eventually change his opinion. A patient who consults a psychiatrist under duress or against his will has little to gain from the experience. Another group of patients in this intermediate group may be intellectually, culturally or psychologically unsuited for prolonged psychotherapy, and the doctor's decision not to refer such patients is most often in the patient's best interest.

In other cases, factors relating to the physician himself are of paramount importance. For example, the background, education, aptitude, interests and time availability of the physician himself play an important role in whether he continues to treat the patient with psychiatric symptoms or refers him immediately to a psychiatrist. Some physicians, as is well known, have little background, interest or patience for people with psychiatric problems and give them short shrift. Other physicians with different backgrounds may be unusually interested in such cases and may de-

lay referral to a psychiatrist until it is dangerously late. Obviously no set rules can be laid down, and each case in this intermediate group must be judged on its own merits.

Why Refer

The obvious answer to why a patient is referred to a psychiatrist is to provide that patient with specialized help in order to restore his health as quickly as possible. If this thought can be communicated honestly and openly to the patient—often so much depends on this—then the patient will understand the reason for the referral and cooperate with his physician.

In this connection it is of crucial importance to avoid vagueness in making the referral. Vagueness on the part of the physician only leads to increased anxiety on the part of the patient. Unless you are specific, he is likely to think, "I wonder why the doctor is referring me to a psychiatrist. . . . Does he think I'm insane or something?" Select a specific symptom as a reason for your referral. For example, you may tell your anxious patient something like this: "Your fears of speaking in public have not responded to medication and our attempts at treatment. I think it would be quite helpful for you to see Dr. X, a psychiatrist, who is skilled in these matters." The physician, by focusing on a specific symptom, can help the anxious patient understand and accept the need for psychiatric consultation.

In most instances patients are referred to psychiatrists for consultation and treatment. The psychiatrist continues to see the patient in therapy and may report on his progress to the referring physician from time to time. (The reporting process is not always as complete as it should be, I regret to say. The psychiatrist owes the referring physician an initial report, and there should be continued communication whenever it is to the patient's benefit.) There is now a growing tendency to utilize the

psychiatrist as a consultant only. Very often a psychiatrist, by means of a single interview, may gain sufficient data to make significant suggestions regarding medication, management or type of treatment which may have beneficial effects on the patient's course. In such instances the patient continues to see his family physician on a regular basis until the situation is resolved.

Under no circumstances should the patient be sent to a psychiatrist in order to "get rid of him." If the patient senses that his physician is referring him for this purpose (and most patients are extraordinarily sensitive in this regard), the referral is off to a very poor start. If, however, the patient senses that the referral to a psychiatrist is made with his best interests at heart, the likelihood is that the physician's suggestions will be accepted in the spirit in which they are offered.

In general, a patient should be referred to a psychiatrist because, for a variety of reasons, the treatment he has been receiving has been of no avail in relieving his condition. This is not a negative reflection on the physician or on the patient but rather a realistic appraisal of a frequently encountered state of affairs in clinical practice. If this situation is promptly recognized by the treating physician and the why's of the referral carefully explained to the patient, the referral is accomplished without incident and to the benefit of all concerned.

How to Refer

In considering the question of how to refer, I should like to start by telling a story of how *not* to refer a patient to a psychiatrist. This is a true story of a case I had referred to me some years ago. I have told this tale to many medical audiences, but the lessons to be learned from it are so important that it bears repeating.

Several years ago a successful

young physician with a large general practice called my office. I was with a patient at the time and, therefore, unable to speak to the doctor; but I returned the call at the next break. He told me that he had sent a patient to my office and wanted to be sure to talk to me before I saw him. I told the doctor that I was solidly booked for the rest of the day and that it would be impossible for me to see him. However, if the matter was really urgent, I would make time for him as soon as possible or get someone else to see him. At that time I asked him the nature of the problem.

He replied as follows: "Here's the situation. This patient, Mr. Smith, is a taxi driver, 28 years of age, single, and has always been in good physical health. He came to my office a few days ago complaining about lice which were causing him to itch all over. He had used several ointments and lotions which had been suggested by friends and druggists but got no relief. The situation was driving him frantic. I had an office full of patients and was too busy to examine him personally, but I gave him a lotion to apply locally and told him to come back in three or four days. He was back the following day. He said the lotion helped for a while, but the itching returned worse than ever. This time I sent him to the examining room and had my nurse go over him with a bright light. She couldn't find anything at all, but I assumed that the lice had disappeared because of the lotion, even though the itching had remained. So I gave him another preparation with complete directions and told him to return in about three days.

"Well, he was back the following day, this time complaining that the itching was much worse. He was so bothered this time that I took him into the examining room and went over him myself with a fine-toothed comb. I was then convinced that he never did have lice. I told him that I thought the lice were

only in his mind, and I suggested he see a psychiatrist.

"At this point he really got upset and said, 'I was afraid you were going to say something like that. . . . I know what I've got, even though you can't find them!'"

The doctor continued, "At this point I was more convinced than ever that he needed a psychiatrist, so I told him, 'Okay, here's what I want you to do. I want you to see this doctor, Dr. Lebensohn. He is a specialist, a specialist in lice. He has a special microscope, and he may be able to see these lice where I can't.' So that's why I gave him your name, and that's why I wanted to give you the background story before you see him, so you would know what to do."

At this point in the telephone conversation there was a long and pregnant pause. I asked the doctor what he really expected me to do when Mr. Smith came to the office, and when he hesitated, I spent the next 20 minutes on the telephone explaining all the reasons why his referral, even though it was made with the best intentions, was doomed to misfire and could only end in catastrophe.

What actually happened? The taxi driver arrived about an hour later without an appointment, as instructed, and noticed that the waiting room and office did not seem to go along with a "lice specialist." After introducing himself, he asked my secretary what kind of a doctor I was. She, of course, told him I was a psychiatrist, whereupon his face took on an expression of disgust. He cried out, "So that's the game!" turned on his heel and walked out.

One can hardly blame this patient for behaving in this way after being tricked into seeing a psychiatrist, even though the doctor had the best of intentions. As a result of this well-meaning but unwise ruse, the patient was now more distrustful than ever of all physicians and became much more difficult to treat.

Lessons to be Learned

It may be helpful to go back over this story, study the various errors, and see what can be learned. The first question is: Should the referring doctor call the psychiatrist before the patient comes in? At times, such a call may be extremely helpful, but if the psychiatrist is called, it should be done with the knowledge and consent of the patient. Some patients, many of them paranoid, would prefer to see the psychiatrist without the benefit of a report which precedes them, a report which they fear may prejudice the psychiatrist. Often it is necessary for the referring physician to call the psychiatrist in order to obtain an appointment, but in such instances it is best, as always, to inform the patient.

Phone Calls

Except for emergencies, most psychiatrists do not accept phone calls during the treatment hour, for obvious reasons. Breaking into a therapeutic session may be like interrupting a surgeon in the middle of an operation. If a message is left, however, the psychiatrist will return the call at his first free moment. Sometimes it is a good idea to make the appointment with a secretary and to write a brief note to the psychiatrist, giving the central facts and the reason for the referral. It is often helpful to give the patient a copy of this note so that he knows exactly what has been said about him.

Getting an Appointment

A frequent and important complaint in recent years, voiced by many of my good friends in general practice, runs somewhat as follows: "Here I work on a patient to the point where he or she will accept psychiatric treatment. Then I call your office and find you're all booked up for the next one or

two months. What's a man to do?"

This is a serious problem, and the only way to solve it is to give the medical practitioner a greater familiarity with the nature of the psychiatrist's work. He then can pass this on to his patient as a part of the work-up or referral process. Due to the time-consuming nature of psychiatric practice, the number of patients any one psychiatrist can treat is necessarily limited. One psychiatrist can rarely see more than seven or eight patients in his office during the day, each interview lasting from 30 to 90 minutes. If he is conscientious, he knows that overloading his schedule results in fatigue and inferior work. Therefore, if you respect him as a psychiatrist, it is also important to respect his decisions regarding his ability to see a new patient.

If he is not able to see a patient immediately and you think the patient can wait, it is helpful to explain this to the patient and advise him to do so. After all, the patient has probably had his difficulty for many months, and sometimes for years. On the other hand, if it is something more urgent, send him to another psychiatrist who has free time or ask your psychiatric colleague for other names. Ordinarily, a psychiatrist's schedule is made up some weeks in advance, and he can usually tell you when he will have an opening. After all, many other specialists, particularly ophthalmologists, have waiting lists of two and three months. It is important to emphasize that, other than arranging for emergency hospitalization, it is almost impossible for the psychiatrist to do anything helpful for a new patient who is squeezed in between appointments. It takes a full hour, and sometimes three or four hours, in order to find out what the problem really is. Hence, it would have been of little or no help to see such a complicated case as the taxi driver for only a few minutes. This would only have antagonized him further. There is no substitute for time

in the handling of delicate psychiatric problems.

The Medical Work-Up

There is nothing more dangerous, in my estimation, than the premature psychiatric referral with an inadequate medical work-up. This holds not only for psychiatric, but for all other specialty referrals as well. Had the taxi driver in our story been given a careful examination on his first visit, perhaps our story would have had a happier ending. By prescribing treatment for a condition which did not actually exist, the doctor unwittingly reinforced the patient's delusions. When he finally examined the patient and found that he never had any lice, he was placed in the embarrassing position of having to reverse himself. It was perhaps because of this embarrassment that the doctor reversed himself once again and participated in the patient's delusions by suggesting treatment for a condition which did not exist.

In the course of a long and varied practice, I have found myself seeing patients who had been sent to me for psychiatric treatment, only to discover that the basic problem was medical. On one occasion the patient was referred to me for treatment of a depression. In the course of obtaining her history during the initial interview, I noticed that her skin was thick, her hair coarse and her whole appearance suggested hypothyroidism. I was placed in the embarrassing position of sending her back to her physician for further investigation. The PBI turned out to be 2.6, and she responded beautifully to thyroid medication.

On another occasion, a well-known internist referred me a patient who was experiencing peculiar sensations throughout his body. Numbness and paresthesias were present which he could not explain. The man held a responsible government position but was worried

because of a sick wife, many job difficulties, and a retarded child. The doctor gave the patient a Sodium Pentothal interview without any significant change taking place. The patient was referred to me because of a hysterical conversion reaction which persisted in spite of the doctor's efforts. On examining the patient during the initial interview, I was impressed by the organicity of the patient's complaints. He noted that when he shaved the left side of his face was numb. However, there seemed to be numbness on the right side of his body. Careful neurological examination revealed that this patient was suffering from a thrombosis of a branch of the posterior-inferior cerebellar artery. Naturally he was greatly relieved to learn that his symptoms had a physical base and that he did not require countless months of psychotherapy, which he could ill afford in either time or money.

Honesty

In psychiatric referrals the old adage "honesty is the best policy" still holds. There is no exception to this rule in referring a patient to a psychiatrist. Since honesty is important in all human relations, it is all the more important in dealing with the psychiatric patient, who has usually suffered from dishonest handling in the past and is particularly sensitive to dishonesty.

All deviations from the truth, no matter how innocent or well-meaning, invariably lead to disaster for the doctor, the psychiatrist, and—worst of all—the patient. In the story of the lice specialist, it would have been far better had the doctor stuck to his guns. After discovering his first error, he should have told the patient that he was recommending psychiatric treatment. Even if it meant the loss of a patient, it would have been worthwhile, for ultimately enough physicians would have arrived at the same conclusion to have made

some impression on the patient.

In spite of education in the field of psychiatry, certain doctors—particularly those of the old school—still regard the word psychiatrist with fear. For this reason they continue to use such euphemistic and, presumably, less shocking terms as neurologist, "nerve specialist," and "nerve doctor." If the problem is psychiatric and the patient is being referred to a psychiatrist, the doctor should say so. If the patient is deceitfully referred to any competent psychiatrist, he will learn his true identity in short order, and his confidence in the referring physician will be shaken. From my experience I find that much of the anxiety in this matter stems from the doctor rather than from the patient.

Another form of dishonesty in referral—and an example of what *not* to do—is illustrated by the following problem presented to a psychiatrist by a family physician. "Doctor, I have a patient who needs your help badly, but she hits the ceiling when I mention the word psychiatrist. Couldn't I simply tell her that you are just a diagnostician and let it go at that? Or better still, couldn't you just come to the house as a friend of the family? Or perhaps you could come to the house ostensibly to see her husband but really to see her? I would be glad to arrange it for you." Of course, yielding to any such deception is sanctioning the worst sort of medical practice. Under no circumstances should a psychiatrist ever be asked or permit himself to see a patient in any role other than his true one.

In addition to being unethical, ineffective and actually harmful, such a ruse may get physicians into serious legal difficulties. As an example of this, several years ago a high ranking Army officer consulted a psychiatrist about his extremely paranoid sister. He was anxious to have her safely hospitalized before he left on an overseas assignment, because he did

not wish to be called back for some psychiatric emergency, as he had in the past. The patient had been mentally ill for many years and had once seen a psychiatrist but had refused to return to his office. She apparently suspected that her brother was attempting to have her committed. Her brother finally prevailed on two psychiatrists to join him in the cocktail lounge of a large Washington hotel where, by prearrangement, he was to meet his sister. The sister arrived and was quite shocked to find her brother accompanied by two psychiatrists. They spoke to her briefly and filled out the necessary commitment papers, which enabled the police, waiting outside, to escort her to the hospital.

Needless to say, the courts took a very dim view of the whole matter, and although the patient was very much in need of treatment, she was released by order of the Court, and the doctors were severely reprimanded.

When to Refer

The interrogative adverb "when" is missing from the title of this paper that was assigned to me. However, timing of the referral is often of crucial importance. As indicated earlier, it is most important to do a careful medical work-up, even in cases which are obviously psychiatric. As in the case of the taxi driver, such a medical work-up not only is good medicine but also prevents the possibility of future embarrassment. On the other hand, it is unwise to subject the patient with psychosomatic complaints to an infinite barrage of laboratory and X-ray examinations. Continuing this for too long a period will only reinforce the concept of organic etiology in the mind of the patient. In recent years there has been a tendency to refer patients to psychiatrists a bit prematurely—sometimes, as in the case of the taxi driver, before the medical work-up is completed. Often the

physician underestimates his own ability to manage and treat the numerous emotional problems seen in the course of his practice. It rarely does any harm, and often helps greatly, for the physician to continue to give the patient support and reassurance while waiting to see how the process is going. Very frequently, the physician will be surprised to find that he is treating a transient situational disorder which did not require referral to a psychiatrist.

It is also wise to continue seeing the patient until he is accepted for treatment by a psychiatrist. Not every heart case needs to be seen by a cardiologist, nor does every person with an emotional disorder need to be seen by a psychiatrist. In each instance the knowledge of general cardiology and general psychiatry equips the general practitioner to treat many of the problems himself.

Obviously, the best time to refer the patient to a psychiatrist is at that moment when the physician has satisfied himself that he is no longer being helpful to the patient and that specialized techniques are needed.

To Whom to Refer

In order to make a good psychiatric referral, it is imperative for the medical practitioner to know the psychiatrists and psychiatric facilities in his area. The best information can be obtained from personal acquaintance with a psychiatrist. It is well to recognize that in psychiatry, just as in medicine or in surgery, there are many different schools of thought and many subspecialties within the specialty. For example, there are some psychiatrists who are specifically qualified and trained to give long-term psychotherapy or psychoanalysis; some who are equipped to administer the various forms of shock therapy; some who are primarily interested in psychopharmacology; others who limit their practice to office pa-

tients and do not have a hospital practice; and still others who limit their practice to those conditions which respond to intensive, brief psychotherapy. It is best to become acquainted with a psychiatrist who is well trained in *all* the accepted techniques of therapy and rely pretty much on his judgment.

In this connection it is unwise to tell your patient that he is being referred to a psychiatrist for the sole purpose of any one specific type of therapy, such as electroshock therapy or psychoanalysis. The selection of the most effective treatment modality is often a difficult and time consuming task, even for the psychiatrist. If the consulting psychiatrist should decide against recommending the specific treatment mentioned by the referring doctor, the patient is understandably bewildered. In the field of neurosurgery for example, the referring physician does not customarily tell the patient that he is being sent to the surgeon for a suboccipital craniotomy. The patient is simply told that he is being sent to another specialist for examination, diagnosis and recommendations for treatment. The same excellent principles should apply to a psychiatric referral.

Special Techniques

There are some special situations in which special techniques are indicated. In the case of the patient who is hospitalized because of a medical or surgical condition and who then develops psychiatric symptoms, one of the best techniques consists of the attending physician arranging to meet the psychiatrist at the bedside of the patient. The psychiatrist is introduced to the patient and remains while the attending physician relates the history of the problem and the nature of his concern. Very often such an initial interview is all that is needed to establish excellent rapport and eliminate the anxiety which would otherwise ac-

company a trip to the psychiatrist's office.

In certain situations (relatively infrequent, I must confess), the attending physician has accompanied a timorous patient to my office and has remained for the first few minutes of the interview, to make the introduction and give the background of the case. Such a maneuver, although costly in time, can be exceptionally reassuring to the frightened patient.

Preparing the Patient

A patient who has never consulted a psychiatrist before is often quite concerned about what to expect from his first interview. A few words of reassurance from the family physician can go a long way toward allaying this anxiety. The patient may be concerned about the expense of psychiatric therapy; therefore it is probably helpful to give the patient some idea of the prevailing fees in his community. If there is a serious economic problem, special arrangements may sometimes be made with the psychiatrist or the psychiatric clinic utilized.

A frequent source of misunderstanding on the part of both the referring physician and the patient is the length of time required for psychiatric treatment. Some physicians, in their efforts to allay the patient's anxieties, tend to minimize the difficulty and imply that, if he agrees to see a psychiatrist, he will be completely cured in a few sessions. This, as you know, is totally unrealistic, and there is no experiential basis for the physician making such a judgment. As you also know, it is very difficult to estimate the time required to treat any given condition. Other physicians err in the opposite direction and tell the patient that he will probably require two or three years of psychiatric treatment. This, understandably, tends to frighten the patient away. It is best to explain to the patient that psychotherapy

usually extends over a period of time which can only be determined by the treating psychiatrist. Rapid changes are the exception rather than the rule.

In general, the more a patient knows about what to expect from his first interview with a psychiatrist, the better it is for all concerned.

Summary

I have suggested ten points as aids to the physician in referring a patient to a psychiatrist.

1. Always do a careful work-up, even in the presence of obvious psychiatric illness.

2. Time the referral. Take enough time to establish a good working relationship with the patient before referring him to a psychiatrist. When you have done that, it becomes a meaningful measure and not a way of "getting rid of" a patient.

3. Never underestimate the abil-

ity of the sincere family physician to help the emotionally ill patient.

4. Be completely honest with your patient and with yourself. Tell him the specific reasons for which you are calling in a psychiatrist.

5. Avoid displaying needless anxiety or appearing to be in a rush. Remember that there is nothing more contagious than fear itself.

6. Know the psychiatrists and the psychiatric facilities in your area.

7. If you communicate with a psychiatrist before the referral, get the patient's permission and tell him what you have said.

8. Don't oversell psychiatry, any particular psychiatrist, or any particular form of psychiatric therapy. Let the treating psychiatrist orient the patient as he sees fit.

9. A single consultation with a psychiatrist is often very useful. He may enable you to continue more effective treatment with the patient.

10. Tell the patient as much as you can about what he may reasonably expect from psychiatry.