

List of New Patients With Referral Source and Information Received*

Diagnosis	No. of Patients	Referral Source			Information Received Before Visit	
		PC	Spec	Self	No	Yes
Movement disorders	30	12	15	3	20	10
Neuropathy, multiple sclerosis, or tumor	14	7	1	6	12	2
Seizures or dizziness, childhood disorders	11	5	5	1	9	2
Headache and pain	10	2	6	2	7	3
Alzheimer disease, CVA, psychiatric illness	9	8	0	1	7	2
Total	74	34	27	13	55	19

*PC indicates primary care physician; Spec, specialist; Self, self-referral; and CVA, cerebrovascular accident.

tain about what the referring physician thinks. Theoretically a consultant can call the referring physician before a patient is seen, but that is unusual. A few patients choose not to inform their physician of a planned visit to a consultant and occasionally patients request that the referring physician never be informed of the visit. For all these reasons, as well as the surprisingly rapid changes in just who is considered the primary care physician, communication in both directions is often less than ideal. Primary care physicians may also vary in whether they feel they should telephone or write the consultant; particularly if they feel that such a visit, as requested by the patient, is unnecessary. Some patients say they intend to return to their local physicians even while they are searching for an ideal, but hypothetical, alternative.

The actions of consultant physicians vary from an obsessive need to send a letter to someone, preferably to another physician, to a conscious or unconscious desire to "take over" what they might call the "principal care" role. With or without the intention to assume the role of a traditional primary care physician, specialists occasionally do serve in such a role. For all these reasons, specific data regarding patient and physician preferences about communications is suspect, as is the data that follows. Does the referring physician usually inform the consultant of questions or opinions before the patient is seen?

For 6 weeks the referral pattern to the private practice of 1 academic neurologist who specializes in movement disorders was prospectively studied. The 6 weeks included 2 brief out-of-town trips by the specialist, but was not a time of transiently smaller or transiently enlarged clinical duties, as happens in a university center when "on service." The percentage of patients with a referral letter, a brief note to the consultant, or a telephone call from the referring physician seemed typical of any similar 6-week period. There were only 2 telephone calls from referring physicians, both regarding patients who were considered to be important citizens. It is probable that some referring physicians did call the consultant's secretary; however, I lack that data.

As is seen in the **Table**, over 50% of the time no referral letter, telephone call, or "curbside consult" preceded the arrival of the patient. Many patients expected

such a letter to be present, and were always reassured that it was probably sent; occasionally it had been. In more than a few cases, it was significant that prior data were not available; for example, when seeing a patient with little medical knowledge and a complex chronic problem. In fact, so rarely is a good referral letter available when a consultation is performed that the consultant may assume the family physician doesn't care, is too busy to read a consultation report, or perhaps most likely of all, doesn't know of the visit of the patient. So why should consultants write the referring physician?

Six patients did specifically ask that no letter be sent to their physician. Two other patients said they were not planning to return to their referring physicians, 1 of whom had sent a very helpful summary of the case.

My conclusion is that, at least for this 1 consultant in a university setting, more often than not no referral information is sent by referring physicians. We can all do better in this day of fax machines and voice mail.

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Promoting the Use of Advance Directives: An Empirical Study

In the recent article "Promoting the Use of Advance Directives: An Empirical Study," Richter et al¹ found that structured discussion with patients and follow-up mailings substantially increased the use of advance directives. Based on our work, we stress the importance of the structured discussion in achieving desired results.

In our study, we tested whether education could increase completion of advance directives. Four groups of patients (n=20 in each group), aged 18 years and older, were randomly selected to receive either: (1) a distribution of advance directives at the office visit, (2) a distribution of advance directives plus patient-directed information emphasizing the importance of advance directives at the office visit, (3) a mailing of advance directives with patient-directed information, or (4) no intervention. Discussion with

patients regarding the documents was not part of the intervention in any group.

Three months after the intervention, charts were audited for presence of advance directives. No charts in any group contained advance directives. We interpreted this to mean that a simple distribution of information without discussion by a health care worker, even when accompanied by literature written in lay terms, has no effect on increasing the number of advance directives presented to the physician or office for the medical record. Like Richter et al, we are unsure if patient education elicited any positive effects such as prompting discussion among patients and significant others or other positive effects.

These studies, however, do underline the importance of personal discussion in the facilitation of behavioral changes, including the completion of advance directives.

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In reply

Following passage of the Patient Self-Determination Act,¹ hospitals and other health care entities created a plethora of forms and informational materials. Yet it is not at all clear that information alone increases completion and filing of advance directives among the general public. Coleman and Jerneckic's experience is likely the rule among those who have sought to increase the use of advance directives.

Pearlman² suggested that we "identify the optimal circumstances for advance care planning: where and when (inpatient, outpatient, health promotion screening visits), who should be involved, and how often advance directives should be discussed and reviewed." For some ethnic groups, information or discussions about end-of-life decision making may be anathema. Carrese and Rhodes³ found that discussing negative information conflicts with traditional Navajo values and may be viewed as potentially harmful by Navajo patients. Likewise, Blackhall and colleagues⁴ found that Korean American patients preferred that their families handle end-of-life treatment decisions.

Two studies have demonstrated that mailed forms and information increase use of advance directives by older adults.^{5,6} Older adults daily face the passing of family, friends, and even public figures that they have known and loved. Natural consequences, such as reduced anxiety for spouses or relatives, may reinforce decisions to adopt advance directives. It may be that for certain populations, who have already had multiple exposures to end-of-life decision making, mailed or hand-delivered materials are sufficient prompts for increasing use.

To summarize, there are likely a vast number of conditions that would increase the use of advance directives, or the use of other procedures to enhance patient autonomy in end-of-life decision making. These conditions will likely vary according to race, ethnicity, age, and health status of groups within the general population. The challenge lies in identifying those conditions and identifying types of advance directives that mesh with individual belief systems.

We could take one more step toward true patient autonomy by providing resources for grassroots development of advance directives. Perhaps community-based mini-grants to religious, health advocacy, and ethnic groups would facilitate the development of culturally appropriate procedures for increasing patient autonomy. Grantmakers could encourage collaboration with health and legal professionals and provide technical assistance in adapting procedures for advance directives to diverse groups. Particularly effective procedures might then be disseminated at the state or national level. Such strategies may enhance opportunities for all to engage in meaningful end-of-life decision making.

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4. Blackhall IJ, Murphy ST, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. *JAMA.* 1995;274:820-825.
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Addiction to Benzodiazepines— How Common?

In his article,¹ Dr Piper states "the literature provides no support for the notion that benzodiazepines are often used recklessly, in escalating dosage, or inappropriately" and "the belief that benzodiazepines are frequently consumed despite harmful medical effects and adverse social consequences, as required by the definition of addiction used . . . is not supported by the available literature." With regard to at least 1 large group of patients frequently seen by family physicians, these statements are untrue.