The Generalist's Patient and the Subspecialist

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Objective: To examine if required referring procedures from generalists to subspecialists for managed care patients affect communication between the physicians.

Background: Collaboration between generalists and subspecialists is essential for successful referrals and a satisfactory relationship between the physicians. However, breakdowns in information transfers in outpatient referrals continue to be described. Moreover, the referral process within managed care systems may be adding new elements that interfere with communication between physicians, promoting fragmentation of care.

Observations: Current referral forms or electronic approval mechanisms encourage responses for billing approval, but neglect methods to require questions from generalists and replies from the subspecialist. Other barriers to communication between physicians are discussed. Responsibilities for agencies, patients, and doctors are reviewed.

Conclusions: Insuring agencies need to provide uniform rules and educational mechanisms describing patients' timely responsibilities in the consultation process. In addition, methods need to be created to convey reasons and data for referral from generalists to subspecialists, and recommendations from subspecialists back to the generalists.

(Am J Manag Care 2002;8:79-82)

Communication between generalists and subspecialists is essential for successful referrals and a satisfactory relationship between the physicians. As medical knowledge advances and new information needs to be translated for the benefit of patients, finding new ways to promote collaboration is especially important. Any system that creates barriers for doctor-patient or doctor-doctor relationships must be avoided. In this regard, managed care plans may have requirements that can interfere with the referral process.

For example, as a primary care physician (PCP) participating in several managed care plans, I must refer a patient to a subspecialist when needed. However, recently I received telephone calls from 3 patients requesting that I send referrals to subspecialists they had already visited or were seeing at the time of the call.

The first patient requested 2 referrals, one for her ophthalmologist and the other for a retinologist treating her for both glaucoma and macular degeneration. The second patient reported that he had sustained a knee injury, went to an emergency room out of town, and was told to see an orthopedist. He had already seen the orthopedist on returning home and was calling me to request a referral for that subspecialist in order to receive payment for the visit. The third patient was sitting in the office of a dermatologist who refused to see the patient unless I arranged a referral immediately.

In all cases, the patients' understanding of their responsibilities was at least muddled, or they refused to respect the requirements of the third-party insurers that they contact their PCP in advance of their actions. They were asking me to provide clerical assistance to help them avoid medical charges.

These patients selected consultants from their plan that I did not know or rarely used. Of greater concern, however, is that I am still awaiting a report from each consultant detailing diagnosis, management, and whether return visits are indicated.

··· POTENTIAL NEW BARRIERS TO COLLABORATION CREATED BY REFERRAL POLICIES OF MANAGED CARE ORGANIZATIONS ···

The ingredients for a successful collaborative consultation include a trusting doctor-patient relationship and specific questions from the PCP to the consultant. In addition, when doctors want to refer to an expert, reputation and previous experience

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play a role in the selection of the consultant. Unknown consultants in a member's managed care organization (MCO) may be knowledgeable, but who they are and what they can do may be difficult to fathom from most lists of specialty providers.

Although doctor time constraints, poor referral data, absent replies, or instances in which the subspecialist did not address the original question have long been understood as communications problems in the referral system, breakdown of information transfer in outpatient referrals has again been noted in academic centers.[1] Poor communication in group practices and clinics has also been reported to lead to inadequate attention being paid to patient follow-up.[2] In addition to these known problems, concern must be raised if MCOs add requirements that can interfere with physician communication.

For example, contractual issues may affect patient behavior (**Table**). Because patients must select their PCP from panels provided by their plan, the development of trust may be delayed until after one or more visits to a previously unknown doctor. Trust is especially important if an extra visit to the PCP is required before a specialty consultation. Problems like the examples provided above occur when patients believe they are able to act on their own without specific authorization. Although patient understanding of their responsibilities within managed care plans is improving, patients still tend to seek their own specialists for self- or out-of-network consultations.

Similarly, if the subspecialist does not know the PCP, the subspecialist's responsibilities to the referring doctor are more easily overlooked. Some current referral forms or electronic authorizations do not provide data entry for the PCP or mechanisms for the specialist's reply. Other factors listed in the Table have more indirect effects, possibly infringing on physician time, availability, and doctor-patient relationships.

Table. Barriers to Collaboration Between Physicians, Patients, and Subspecialists

Effects of Contractual Issues on Patients
- Select PCP
  - Known vs unknown MDs
  - Develop trust
- Understand MCO's subspecialist lists
- Need to contact PCP prior to referral
  - Possible extra visit to PCP prior to referral
  - Additional PCP contact after referral if subspecialist requires special tests or procedures

Effects of Regulations on PCPs and Subspecialists
- Know policy requirements of various open/closed plans
- Select unknown subspecialists
  - Availability of curriculum vitae
  - Lack of knowledge of subspecialists' experience (quality)
- Need to switch subspecialists to comply with coverage
- Communication failures between PCPs and subspecialists

PCP = primary care physician; MCO = managed care organization.

··· RESPONSIBILITIES OF MANAGED CARE ORGANIZATIONS, PRIMARY CARE PHYSICIANS, AND PATIENTS ···

Managed Care Organizations and Patients

The principle of a referral mechanism has merit. A referral system requires a review of the appropriateness of the visit to the subspecialist and provides a beginning communication with the consultant. The MCO must educate the insured members about the requirements of the referral system, especially in the case of a desired self-referral or out-of-network consultation. Many times, a description of what members are required to do to appropriately access the referral system is buried in the paperwork an insured member receives, and the procedures are not clarified. Moreover, referral requirements vary among MCOs. Perhaps a simple educational form describing the insuring company's particular referral system should be given to and signed by the insured member at the time the policy is issued or at the first visit to the PCP, when a review of the patients' understanding of their responsibilities can take place. Having as uniform a referral system as possible should be a goal among MCOs.

The Referring Physician

The referring physician also has responsibilities. Foremost is indicating a reason for the referral. Yet the paperwork from most MCOs provides very little space or only a check box to indicate the reason for referral. In electronic forms, there is space only for a coded diagnosis. It is next to impossible, then, to use most of these forms or automated methods of referral for that purpose. Moreover, the referral form has no space for a consultant's reply. Such forms are a deterrent to communication: the PCP completes a form that cannot

provide sufficient medical data to the consultant, and the consultant merely files the form assuming the PCP's obligation to the consultant has been completed.

Consultants

Lack of a consultant's report to the PCP is common in my experience, especially when the patient self-refers, but also when I refer and the subspecialist and I do not know each other.

In the eye case mentioned above, the subspecialist should send me a simple report on the status of the glaucoma and the retina, the nature of the treatment, and details of required follow-up. The responsibility for conveying this information should not devolve to the patient. Similarly in the knee injury case, I should not receive a call from the patient for a further series of referrals to permit magnetic resonance imaging or physiotherapy. In the case of the patient who visited a dermatologist, what do I do if the patient calls for another referral a year later to "check my skin for cancer"?

Can Managed Care Organizations Aid in Communication?

Should the third party require a report from the subspecialist before payment? This provision might increase communication, but requiring a report to the MCO could interfere with a patient's privacy. Moreover, the insuring plan cannot legislate consultants' actions. However, it would not be difficult to redesign a referral that could be made standard for all insurers. Referrals could include evidence on the subspecialist's billing request that a written opinion has been rendered and forwarded to the PCP. To preserve confidentiality, the referring form could be in 2 parts. The first part could be the simple secretarial information for the insurer; the second, consisting of questions by the referrer and the reply by the consultant, could be removed by the consultant when completed and forwarded to the referring physician. Such consultant forms are common for hospital records.

If e-mail is used for referrals, a separate page for reasons for referral could be initiated by the PCP. This page would appear only at the subspecialist's office where, in order to complete the bill, a reply to the referrer would be required. For confidentiality purposes, this request and reply would never be forwarded to the insuring agent.

The burdens of clerical and administrative requirements have increased. Yet paperwork should not be used to suit only the needs of third-party payers. Clerical and administrative reports should also aid communication and transmittal of data that are essential for doctors caring for patients.

In the referral process, the insuring organization, the patient, the PCP, and the subspecialist are all responsible not only for their own actions, but also to each other. For this reason, standards for collaboration become essential. To encourage maximum collaboration, especially in cases with multiple subspecialists, rules and duties have been described for generalists and subspecialists,[3,4] but few have been outlined for MCOs or patients. The desires of the public and the national movement for patients' rights exemplify expanding patient expectations[5] rather than contractual duties or an understanding of individual responsibilities. A patient's responsibilities become especially muddled in the self-referral process, in which transfer of data between subspecialist and generalist is not defined, and may be less than when the PCP initiates the consultation request.

In this computerized age, the possibility of e-mail alerts needs to be considered as a new method of interphysician communication.[6,7] Other examples include direct cell phone contact and consultation conferences among PCPs for review of consultation questions.[8]

Improving interphysician communication or paperwork may not affect self-referrals, however. One possibility that might encourage subspecialists to provide opinions and recommendations to PCPs for self-referred patients is a differential fee. If the subspecialist indicates that a formal consultation has been forwarded to the PCP, then the consultant's fee allowance would apply. Otherwise, the visit would be reimbursed at the generalist level. For out-of-network consultations, the patient would need to request that this information be included with the bill sent for reimbursement.

The current desire for open and instant access creates a challenge to provide new strategies for communication, not simply to satisfy expectations of patients, but to coordinate data and prevent fragmentation of medical care. The cost-benefits and patient satisfaction that can emerge make the effort worthwhile.

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