Primary and Subspecialty Care: Building a Collaborative Relationship

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous. Please send scenarios to Caroline Wellbery, MD, at afpjournal@aafp.org. Materials are edited to retain confidentiality.

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Case Scenario

I recently diagnosed cancer in one of my patients and referred him to an oncologist. The cancer turned out to be a rare, aggressive type that had already spread. The oncologist indicated that the management of this tumor required further input from another subspecialist, and agreed to arrange the secondary referral. However, he did not make the referral in a timely fashion, although our office has prompted him with phone calls and emails. Meanwhile, the patient has been anxiously contacting us and asking for updates. Should we bypass the first oncologist and find a subspecialist on our own? Our office has worked well with this oncologist in the past, and we do not want to damage our relationship with him.

Commentary: Family Physician's Perspective

This scenario points to the issue of referral etiquette among colleagues. Namely, what are the expected roles, responsibilities, and behaviors when caring for a mutual patient?

For the referring physician, proper etiquette includes identifying the clinical reason for the referral, confirming the appropriateness with respect to the subspecialty, providing the subspecialist with accurate and timely information, and maintaining an open and effective line of communication. For the subspecialist, etiquette involves accepting the referral, further evaluating the clinical concern, formulating and executing a treatment plan (including recommendations for a secondary referral, if needed), and maintaining a similar commitment to open and effective communication. In this scenario, the oncologist overlooked the latter two components. Unlike a consultation, which primarily involves evaluation without treatment, a referral requests the subspecialist to assume and direct care for a clinical problem.[1] The oncologist's inattention to this responsibility, along with his lack of communication, suggests that he is not following good referral etiquette. To his credit, he discussed the need for secondary referral with the primary care physician. Secondary referrals often add another layer of confusion and complexity if not communicated to the original referring physician.[1]

As family physicians, we pride ourselves on being able to coordinate care among multiple physicians, and our patients often (and appropriately) rely on us to decipher complexity and reconcile inconsistency. However, this is not possible when there is an information void. If the initial oncologist was having difficulty making the secondary referral, then this should be communicated to the referring physician. It would provide reassurance to the referring physician and patient, and continue a respectful professional relationship.

In this case, it is necessary to bypass the first oncologist and independently find a subspecialist. There is a risk that the initial oncologist may feel slighted; however, in a time-sensitive situation in which several attempts to advance referral were unsuccessful, it is the right thing to do. Clearly, the issue of future referrals to this oncologist has to be considered. If the situation appears to be an isolated incident, then there is no reason to stop referring to him; however, if the pattern repeats itself, it is time to seek another oncologist.

To streamline referrals, consider developing a referral agreement to be used between a

primary care physician and a subspecialist that includes these elements of referral etiquette.[2] A consultation/referral request form also can be used as a communication vehicle between physicians.[1] It is unclear if such tools would have made a difference in this situation. Nevertheless, referral agreements and more explicit forms are two solutions to enhance referral efficiency. Any tool should include a procedure for what to do when there is inertia in the care process, and an agreement to have a timely physician-to-physician conversation if there are breakdowns in the system.

This scenario is more about communication than anything else, and in the end, the value of good communication cannot be underestimated. In one study, the second most important factor in a family physician's selection of a subspecialist was the quality of previous feedback.[3] Having a personal knowledge of the subspecialist was the most important factor. This scenario illustrates that both of these factors are dependent on one another, and further highlights that communication is not static and can always be improved.

Commentary: Subspecialist's Perspective

I am an oncologist and work in a hospital-based community practice. As a subspecialist, the success of my practice depends almost entirely on referrals from primary care physicians. I agree that there are responsibilities the referring physician and the subspecialist should accept to properly coordinate patient care.

There is the responsibility of the referring physician to provide the appropriate clinical information to the subspecialist and request that a specific clinical question be addressed. The manner in which this transfer of information occurs can vary. In busy practices, information transfer is often accomplished by fax sent by a referral coordinator. Many practices use a referral form, which will outline the clinical question in addition to appending appropriate medical records. In certain situations, direct physician-to-physician communication may be necessary. Urgent concerns or complex medical problems should prompt a phone call or email, although it requires more of the physicians' time.

The success of the information transfer varies from practice to practice. Studies suggest that effective transfer of medical records and clear definition of the clinical problem occur in only a minority of referrals.[4] In my experience, patients often present to my office with limited information and a vaguely outlined clinical question. This underscores how good communication can facilitate optimal transfer of care.

This scenario also raises the question of timeliness. The ability of the subspecialist to see a patient promptly is necessary to establish a strong working relationship with the primary care physician. With a diagnosis of cancer, there may not always be a medical reason to see the patient immediately, but from an emotional perspective, it may be important to the patient and, therefore, to the referring physician. If a patient does need to be seen urgently for medical reasons, direct communication is required to expedite a timely referral.

All too often there is no communication from the subspecialist outlining treatment recommendations or even providing confirmation that the patient was seen. At a minimum, a letter outlining the therapeutic recommendations should be sent to the referring physician. If there are urgent medical matters or decisions to be made, my practice speaks with the referring physician by phone to allow his or her participation in the decision-making process. If I anticipate a delay in transcription or mailing, I also call the primary care physician to transmit my recommendations. I believe this is helpful in the care of the patient and in fostering relationships with referring physicians.

It is the responsibility of each physician to make certain that the patient has appropriate continuity of care, which includes data transfer and communication to the next person who will assume that care.[5] In this scenario, if the oncologist recommended a secondary referral to a subspecialist, it was his responsibility to facilitate the transfer of care. He did not fulfill his obligation to the patient or the referring physician. I certainly understand the primary care physician's frustration, and can see how this interaction might affect future referrals to the oncologist.

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