

## VIEWPOINT

# Selecting a Specialist

## Adding Evidence to the Clinical Practice of Making Referrals

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**Referring patients to other physicians** is one of the most fundamental and frequently performed tasks in clinical practice. In 2009, referrals to other physicians were made during almost 1 in 10 ambulatory visits in the United States for a total of more than 100 million referrals.<sup>1</sup> Despite the routine nature of referrals, there is significant variation in how and when physicians choose to ask for specialist involvement. Rates of referral appear to vary up to 5-fold, with both overreferral and underreferral being common.<sup>2</sup> Decisions about whether to refer appear to be influenced by both patient factors, such as illness severity and expectations, as well as physician training and expertise.<sup>2</sup> As a consequence, standardizing and optimizing the referral process may affect the cost and quality of care.<sup>3</sup>

Even when appropriate referral decisions are made, there is little consistency in how physicians select consultants. Some physicians have little or no control over the choice, especially in the inpatient setting where options are limited to on-call specialists who change frequently and, sometimes, unpredictably. In other environments, the culture is simply to refer to a particular clinic or department. In these circumstances, clinicians spend little time considering which particular specialist their patients will see. However, in many cases, physicians have substantial influence over the referral process and could consider a broad range of factors in their decision making (**Box**).<sup>4</sup>

### Factors Influencing the Selection of Consultants

Perceived consultant reputation and expertise are key considerations. Ease of communication with colleagues and feedback from previously referred patients are also important. Access is often central, with many physicians referring patients to consultants with the first available appointment, who work at their institution, or in geographic locations that are convenient for the patient. Higher out-of-pocket costs for specialists who are not within a patient's insurance network may also influence the choice.

Other factors, which some may be reluctant to acknowledge, are frequently considered to help establish the "fit" between the patient and consultant.<sup>5</sup> In cases for which communication is crucial, a referring physician may be inclined to refer patients to language-, sex-, or race-concordant consultants. Similarly, patients who strongly value thoroughness may be intentionally referred to consultants who are more liberal with diagnostic testing. As an integrated measure of performance, physicians are sometimes asked to identify the specialists from whom they would choose to receive their own care.

Most physicians, even those who have little control over the referral process, would undoubtedly value assurances that their patients will be receiving care of exceptional quality with regard to diagnostic acumen, therapeutic choice, or strategic execution. In reality, physicians must often base their referral recommendations on little or no objective information. For example, although consultants may use presumed markers of clinical excellence, such as academic pedigree, publication record, or professional rank, there are limited empirical data to substantiate whether, and to what extent, those attributes correlate with measures of quality. Equally important, physicians have few mechanisms for personal performance feedback and little or no training in how to evaluate the quality of care that their peers provide.

### Potential Sources of Actionable Data

One potential solution is to provide more data to help inform the process of selecting a consultant. For example, quality metrics that are collected about a physician's practice—like those currently used in pay-for-performance and other initiatives—could inform referral recommendations. Similarly, methods created by health insurers, such as the proposed Medicare reimbursement scheme that assesses physician value based on aspects of quality and cost, could help physicians select consultants.

Although acquiring more granular and detailed data about physician performance may be helpful, it alone will be insufficient for improving crucial aspects of the referral and recommendation process. For example, quality metrics are generally surrogate measures for single diseases and may not validly capture outcomes for patients with multiple or complex medical conditions. Knowing that a consultant's patients generally achieve good glycemic control also does not indicate how easy it is for patients to have their blood drawn, how effectively results are communicated to patients, or how collegial or collaborative consultants and their staff are in comanagement along with referring physicians.

Physician-specific data on outcomes that are important to patients, such as functional status and symptom-free days, could also improve referral recommendations although these data are not currently available and will be difficult to collect. A body of literature has found that in some cases, the degree of specialization, higher patient volume, and even fewer years since finishing training may be associated with quality and patient outcomes.<sup>6</sup> Although current measures are far from comprehensive and current characteristics may be limited, they are routinely collected and could be made

### Box. Questions Frequently Considered by Physicians When Making Referral Recommendations

#### Consultant's Clinical Expertise

Does this physician have enough expertise with the problem for which the patient requires consultation (eg, specialized training, focus of his/her clinical practice, length of time since certification)?

Do other physicians also refer their patients to this specialist?

Does the physician have other experiences (eg, published research) that represent expertise in this particular clinical area?

Is the physician affiliated with a good institution (and other specialists or services) where the patient will receive outstanding care?

#### Interactions Between Patient and Consultant

Can the patient schedule an appointment with the physician in the appropriate or desired time frame?

Is the physician's practice location easy to get to?

Does the physician accept the patient's insurance? What are the out-of-pocket costs for consultation likely to be?

Does the physician communicate well with patients and their families?

What is the quality and promptness of the physician's support staff and the quality of the facilities?

Does the physician have genuine concern for the well-being of his/her patients?

Does the physician's practice style match with the expectations of the patient?

Does the physician have personal attributes (eg, sex, age) that are important to the patient?

#### Interactions Between Referring Physician and Consultant

How well will the specialist communicate with the referring physician?

Does the physician use the same electronic health records as the referring physician?

Will this physician provide good continuity of care and follow-up communication?

Does the physician have infrastructure for communication during an emergency or after hours (eg, is the physician part of practice group, does that plan have a coverage pool)?

Will the physician return the patient to the referring physician for ongoing care?

Will the physician refer other patients to the referring physician in return for having referred patients to him/her?

available to clinicians, but they would still need to be summarized in order to be usable in routine practice.

With the increased attention to transparency and patient empowerment, measures of patient satisfaction and experience

may overcome some of the limitations of other measures and therefore represent important sources for guiding referrals. Health care organizations have begun engaging this domain through instruments such as the Hospital Consumer Assessment of Healthcare Providers and Systems. Groups such as Press Ganey, along with a number of websites, such as Healthgrades and Angie's List, are working to measure and publicize information about patient satisfaction more systematically. Appointment wait times, ease of access to ancillary services, and efficiency in follow-up could all be measured and made publicly accessible, as they already are in some health care systems. Such information can also elucidate site characteristics that may benefit particular patient populations.

However, much of the currently available data on patient satisfaction are limited by difficulties normalizing patient experience across clinical conditions and accounting for case mix. Higher levels of patient satisfaction—at least as currently measured—may in some cases correlate with worse clinical outcomes rather than better ones, making use of those data for choosing consultants even more problematic. There is also much room for improvement in integrating clinical and patient-reported outcomes in order to understand likely patient trajectories and counsel individuals in a way that maximizes their experience.

#### Subjective Integration to Optimize Choice

In the end, even if and when extensive data about consultants become available to referring physicians and patients, the expertise of astute clinicians will almost certainly be required to overcome the shortcomings of these data and the myriad objective and qualitative variables important for achieving good outcomes for individual patients. This is especially true because patients differ in what they need from the consultants who will be seeing them. Some may be diagnostic dilemmas requiring superb diagnostic skills. Others may only need exceptional technical skills for difficult procedures. Some patients with incurable illness primarily need physicians who can provide outstanding emotional support.

As a result, efforts to improve the selection of specialists to whom patients should be referred will require both data-driven and more qualitative components to evolve beyond its current status. Accessible data will almost certainly help and, over time, referring physicians will better understand which measures are helpful in guiding their recommendations. Efforts to improve the selection of practitioners, combined with initiatives to reduce variation in the rates of specialist referrals and to provide alternative approaches to traditional face-to-face visits, will all be important for the promise of care redesign to maximize health care value.

#### ARTICLE INFORMATION

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