Interspecialty Communication

Overcoming Philosophies and Disincentives

INTERSPECIALTY COMMUNICATION can probably thwart unneeded visits, improve the selection of testing, provide a better estimate of the urgency of the visit from the perspective of the consultant, and improve communication on sensitive issues. The family physician may also learn more from an interaction such as a phone call than from a one-way referral letter at a later date, because of both the immediacy and the opportunity to ask questions. If this communication can do so much, why is there not more?

In the current system, family physicians are busy and tend to telephone only for urgent matters. Phone calls are disruptive to both family physician and consultant schedules. Although consultants are potentially rewarded financially for taking phone calls through future referrals, this reward is indirect and may not exist for specialists paid by capitation. Thus, consultants often do not encourage these phone calls and may act like they are an imposition or immediately say "make an appointment" (which was the response I got from a consultant I called recently after being unsuccessful three times in getting a reasonable appointment through his office staff for my patient with an urgent problem). Writing good referral notes takes time, sometimes as much as or more than the visit.

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In addition, consultants and family physicians appear to have a different philosophy of care. To family physicians, consultants appear to take a limited system view and to be more process, diagnosis, and technique oriented than outcome oriented. For example, a dermatologist gave oral steroids for minor skin lesions caused by sarcoidosis, resulting in loss of diabetic control. Also, a surgeon consultant ordered a chest computed tomographic scan every 6 months to verify the extension of metastatic colon cancer in a patient of mine. As this did not change therapy, I thought it was a waste of money. After calling and asking about it, he quit doing it; actually, I do not even see a reason for continuing the surgeon's visits in this case. An emergency department physician ordered a head and abdominal computed tomographic scan in a patient with vomiting and fever of 1 day's duration that had stopped within 6 hours of the emergency department visit. Sometimes, consultants' motives appear to be financial (the neurologist who always gets a computed tomographic scan and electroencephalogram on his or her own equipment, the gastroenterologist who performs endoscopy on every patient, and the radiologist who always recommends yet another radiologic study).

On the other hand, both consultants and family physicians make incorrect presumptions about the others' motives. An oncologist ordered many tests to verify the extent of disease in a patient of mine with known metastatic breast cancer; after a phone call, I learned that the tests were necessary to determine response to chemotherapy and, thus, the potential for success of a bone marrow transplantation. I could easily have thought this was diagnostic overkill.

Maybe some innovative ideas would improve interspecialty communication. As suggested by Epstein,[1] newer means of communication can be used, such as telephone messaging systems (which are less disruptive and time consuming than phone calls and letters), electronic mail, and fax machines. Our practice is gradually increasing the use of these systems, but consultants are variably available on these systems. Also, there is a fear of lack of confidentiality of the system.

Family physicians and consultants should be rewarded for communication with each other. For example, in addition to the usual measures of workload or productivity, determination of the pay of consultants could include consideration of the following: (1) the number of phone calls or E-mail consultations accepted from referring physicians; (2) nonpayment until a postconsultation note is sent back to the referring physician (one of our local health maintenance organizations follows this plan); and (3) the satisfaction of the referring physicians with the consultant.

These three options could be accomplished in managed care, and at least the first two could be accomplished in fee-for-service medical care. Measurement of the satisfaction of the referring physicians may be necessary in systems that limit the ability of the family physicians to chose the consultant and can take into account many intangibles rather than merely counting the episodes of communication.

In addition, medical schools, large physician groups, and managed care plans should consider interspecialty communication training to improve understanding of the philosophies of care and techniques for interaction, another avenue suggested by Epstein.[1] Although it may sound demeaning to individuals as well trained as physicians are, many interspecialty differences in orientation can be overcome by sufficient communication and understanding. This training may be targeted to specific common diagnoses, such as coronary artery disease.

Overall, interspecialty communication is good for patients, and the new world should bring more and better means of communication. Any readers with working incentive plans or ideas to encourage interspecialty communication, please write to the ARCHIVES so we can share with other readers.

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1. Epstein RM. Communication between primary care physicians and consultants. *Arch Fam Med.* 1995;4:403-409.

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