

Effective Physician-to-Physician Communication: An Essential Ingredient for Care Coordination

By Diane Shannon, MD, MPH

In this article...

Consider some of the causes of miscommunication between physicians and some suggestions on how to remedy the situation.

Health care experts, policy makers, and patient advocacy groups have identified fragmentation of care as a major flaw in the current health care system—a flaw that has a negative effect on quality, patient outcomes, and health care costs.¹⁻⁴

A primary objective of the recently enacted Accountable Care Act (ACA) is improving care coordination.⁵ Two models encouraged by the ACA—patient-centered medical home and accountable care organizations (ACOs)—are espoused as approaches for achieving better coordination of care.⁵⁻⁷

Indeed, the proposed rules for accountable care organizations published by the Centers for Medicare and Medicaid include metrics that will be used to determine participants' eligibility for receiving shared savings; a number of these metrics directly relate to care coordination.⁸

Effective communication among health care providers is essential to providing coordinated care.⁹ However, communication in health care has been shown to be less than optimal, with frequent gaps and errors. According to The Joint Commission, communication problems were the most commonly cited root cause of sentinel events in 2010.¹⁰

Communication between physicians—essential for the transfer of nuanced clinical information—is not immune from these frequent deficiencies. In a study of communication between referring pediatricians and consultants, specialists reported receiving communication regarding only half of initial referrals; general pediatricians reported receiving communication from consultants about initial referrals in only 84 percent of cases.¹¹ A meta-analysis of information transfer at

hospital discharge found that direct communication between hospital-based and primary care physicians was uncommon, occurring at only 3 percent to 20 percent of discharges.¹²

Effective communication between physicians is especially vital in certain clinical settings: between referring physicians and consultants; between emergency department or hospital-based physicians and primary care providers; between house staff at end-of-shift; and between primary care providers caring for patients who transfer locations. Although all these settings provide important opportunities to improve communication and care coordination, we'll focus on communication between referring and consulting physicians.

The consequences

Without effective, timely communication between physicians, both the quality of care and the patient experience can suffer. In a recent study of 4,720 physicians, physicians who reported a lack of timely communication regarding referrals had less confidence in their ability to provide high-quality care than colleagues who received timely communication.¹³

Co-author of the study, Ann S. O'Malley, MD, MPH, senior researcher at the Center for Studying Health System Change, believes the results confirm that physicians see a connection between communication and quality.

“Primary care physicians know that if they don't get information about referrals back from specialists, particularly for patients with complex conditions, it has an impact on quality. Not only are there quantitative data to show that, but our findings reinforce that physicians realize this.”

Gaps in communication may lead to patient harm, delays in care, continuation of incorrect treatment, increased length of stay, and increased costs.^{14, 15} According to Lon McPherson, MD, senior vice president of medical affairs and chief quality officer at Munroe Regional Medical Center in Ocala, Florida, lack of direct communication between physicians leads to delays in patients receiving the assessment and treatment they need.



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The growth in asynchronous communication has reduced the chance for direct communication between physicians.

“If the referring physicians don’t call consultants, they can’t convey a sense of urgency when a consult is needed within 12 hours, or within four hours, or immediately, and there may be a delay in treatment. Also, key historical or physical findings may not be transmitted to the consultants, so they may omit important parts of the evaluation.”

McPherson recalls a patient case in which a gap in physician-to-physician communication strongly affected the quality of care. During an admission for pneumonia, an elderly man was found to have trace heme-positive stools and an iron deficiency anemia. He was dehydrated, had low serum potassium, moderately impaired renal function, and an elevated digoxin level. An order was placed for a gastroenterology consult.

Without first communicating with the referring physician, the specialist evaluated the patient and scheduled a colonoscopy. As part of the oral preparation, the patient’s oral potassium was stopped. During the procedure, the patient sustained a cardiac arrest, likely due to the combination of elevated digoxin and hypokalemia. He survived the immediate event, but sustained severe brain damage.

“If the referring physician had called the gastroenterologist and said, ‘Hey, Bob, I have a patient who’s admitted for other reasons but I’d like you to evaluate him for a work-up once he’s been discharged and is medically stable,’ this adverse event could have been avoided.”

Timothy B. Bullard, MD, MBA, chief medical officer at Orlando Health in Florida has found that root cause analyses conducted at his organization after an adverse event often uncover a gap in communication about a critical

piece of information. He believes that in many instances a direct conversation between physicians could have prevented that gap and potentially averted the adverse event.

How did we get here?

Health system design

According to communication experts and physician leaders, the dearth of direct communication between physicians is caused by several overlapping factors. Primary among these are disincentives for communication that exist in the current health care system.

According to O’Malley, one of the leading barriers to physician-to-physician communication is lack of reimbursement for the time spent contacting and speaking with colleagues about a patient’s care. “Coordination of care and communication are not reimbursed in our current system. Physicians are not paid to take time out of the hectic volume-based reimbursement model to communicate.”

Her recent study found that physicians who worked in settings in which incentives were not dependent on the volume of visits were more likely to communicate with other physicians about referrals.¹³

Barry R. Silbaugh, MD, MS, former chief executive officer of ACPE, also believes that time pressure under the current volume-based reimbursement system hinders direct communication between physicians.

“Physicians are paid for doing more procedures and seeing more patients. They tend to speed up and just don’t feel that they have the time to spend communicating about patient care. It’s hard to see a direct correla-

tion between talking with another physician and meeting your productivity expectations. First and foremost, physicians have too much activity in their daily professional lives.”

Peer relationships

Ronald M. Epstein, MD, director of the Center for Communication and Disparities Research and professor of family medicine, psychiatry, oncology, and nursing at the University of Rochester Medical Center, believes that increased physical distance between physicians has weakened physician relationships and exacerbated communication gaps.

“Fewer and fewer primary care physicians admit to hospitals, and there are no venues for them to meet the cardiologist, the nephrologist, the radiologist. It used to be that when I saw an X-ray reading, I personally knew that radiologist. I knew what his or her skills were. I knew what they really meant when they said ‘clinical correlation needed’ or ‘might consider an MRI scan.’ Now I don’t really understand the intent of some of the messages that I read in the chart.”

The trend toward larger physician groups and medical staffs may adversely affect relationships between physicians and have a negative impact on physician-to-physician communication. According to McPherson, “When you have several hundred physicians on staff, it’s hard to know each individual practitioner. In addition, when physicians get together in groups, your relationship may be primarily with one or two of the consultants in a group, but not the other three or four. That collegiality, that sense of being a peer, has gone away.”

O'Malley's research substantiates this premise. The national survey of physicians found that the greater the number of managed care contracts a primary care physician maintained, the less favorably he or she rated communication with specialists about referrals.¹³

Asynchronous communication

The increased use of asynchronous communication, such as e-mail, text messages, and electronic medical records, may be affecting the number of direct conversations that take place between physicians.

According to Silbaugh, "In the old days, you would have a physician-to-physician conversation about a patient with a complex problem, either face-to-face or on the telephone, with physicians discussing the case in real time. Now, such conversations are unusual. The question is, what are we missing by communicating this way and not having face-to-face communication?"

Epstein also believes the growth in asynchronous communication has reduced the chance for direct communication between physicians. "Electronic communication is incredibly powerful, but it doesn't supersede the need for personal knowledge between physicians who work together. If you've met a person, even just once, and can associate a face to an e-mail, it carries more weight than if he or she is simply an electronic presence."

Physician training

The content and breadth of physician training also affect the effectiveness of communication among physicians. According to Timothy Keogh, PhD, assistant professor of managerial communication at the Citadel School of Business Administration in Charleston, South Carolina, and adjunct appointment at Tulane University Medical School, physicians are trained to focus in on their area of expertise.

"Physicians tend to be very action-oriented and data-oriented. They may not take in the whole picture. Instead, they're working on their part of the patient's issue. Physicians tend to assume everyone is doing their job. They think, 'They'll catch their part and I'll catch mine.' So, they'll flip through the patient record to the sentences they need and then move on."

Such focus may promote detail-oriented thinking, but may impede communication with other care providers.

Grace Emerson Terrell, MD, MMM, president and chief executive officer of Cornerstone Health Care in High Point, North Carolina, believes a lack of training in communication is to blame for ineffective physician-to-physician communication. "Not all physicians have been trained in effective ways of communicating."

O'Malley concurs. "We're not trained in medical school or residency to communicate well with people outside our specialty. We're trained within our own content area and our own armamentarium of tools and knowledge. There isn't sufficient emphasis in our training on taking the time to write a really good referral letter."

The solutions

Physician leaders can improve physician-to-physician communication by fostering organizational culture change, building a supportive infrastructure, and supporting initiatives to standardize communication across their organizations.

Fostering organizational culture change

Physician leaders can take several steps to ensure that the culture of their organization supports rather than impedes physician-to-physician communication. According to Silbaugh, a strongly hierarchical culture is less conducive to provider

communication. He asserts that generalists in such an environment may be less likely to develop open, collegial relationships with specialists and may be more hesitant to call directly about referrals than those in a setting with less hierarchy.

"Experts say that to have a high-reliability organization, the hierarchy must break down in safety-critical activities. The physician executive is in a good position to model non-hierarchical behaviors."

Terrell believes that providers in a strongly patient-centric culture may be more likely to contact each other regarding patient care issues compared with those in one that is less patient-focused.

"I think that once an organization takes on a patient-centric approach, conversations between physicians about patients will occur naturally and the clinical pieces will fall into place." Terrell uses patient stories as part of her presentations and monthly staff newsletters to foster and support a patient-centric approach to care.

Physician leaders can foster culture change by supporting relationships between physicians—especially physicians likely to request or receive referrals from each other—with structured professional events or other opportunities for physicians to meet colleagues. Physician leaders who maintain a clinical practice can model the desired communication behaviors for the medical staff, by directly contacting other physicians regarding referrals, for example.

Physician leaders also can set expectations for physician-to-physician communication through policy development and peer review feedback. Brigham and Women's Hospital in Boston has published on its website a list of expectations regarding physician communication. These standards enumerate specific requirements regarding communication between referring and consulting physicians, such as direct

verbal communication between ED physicians and primary care physicians regarding patients under consideration for admission.¹⁶

Some organizations use peer review feedback to support improved physician-to-physician communication. According to McPherson, during the peer review process at Munroe Regional Medical Center, physicians are commonly sent letters with feedback that the situation would have been improved by direct communication between the consultant and referring physician.

Building a supportive infrastructure

Physician executives can build an infrastructure supportive of physician-to-physician communication by fostering the development of processes to better coordinate care and ensuring the availability of technology that streamlines communication. According to O'Malley, ensuring the implementation of these effective care processes is a key role of organizational leaders.

"Health care executives have a lot of power to organize physicians and encourage them, along with nurses, to create care processes that coordinate care for patients who are transferred from their system to another setting or to the outpatient sector. It's certainly within their power to create committees of specialists, hospitalists, and outpatient physicians to work together so that things don't fall through the cracks when patients go from one setting to another."

The structure inherent in the processes to coordinate care can foster better communication among care providers.

Physician leaders also can support physician-to-physician communication by ensuring that health care providers have easy access to effective, streamlined channels for communication. According to McPherson, it is important for health care leaders

to provide tools that break down communication barriers. He fostered the implementation of a communication system at Munroe Regional Medical Center that facilitates direct conversations among physicians via their preferred mode of contact—cell phone, pager, text message, e-mail, or office landline— by triaging all incoming calls and applying a personalized algorithm for call placement.

Physicians can dial a single number, request a colleague by name, and, if his or her algorithm is set to receive calls from physicians directly, be immediately connected to that physician. "The system has made physician-to-physician calls much easier," he says.

Epstein has found that electronic information systems can support improved physician-to-physician communication. He recalls a patient with an unusual set of rheumatologic symptoms. Using e-mail and the tasking function of the electronic health record system, he was able to communicate directly with a dermatologist and a rheumatologist and confirm a diagnosis within 20 minutes.

However, he points out that these specialists were willing to push aside other work and respond immediately because of his pre-existing relationships with them. "Electronic communication is incredibly powerful, but doesn't supersede the need for personal knowledge between physicians who work together."

Standardizing communication

Physician leaders can develop and support initiatives to standardize communication between referring and consulting physicians. Distribution of guidelines with structured referral sheets (e.g., checklists to be completed at the time of referral and standard forms for specialists' replies) has been shown to improve communication between primary care providers and specialists.¹⁷

Physician-researchers within a medical home environment tested the use of one-page templates containing content elements found to be of value during referral communication.¹⁸ They found that clinicians rated these elements as providing value, with the most valuable components for communication from the primary care physician being specific questions for the specialists and exam features of note, and the most valuable components for communication from the specialist being brief education about the condition. Of note, the researchers found via chart review that these components were lacking from most referral communication.

Terrell believes that communication tools like SBAR (Situation-Background-Assessment-Recommendation), which has primarily been applied to nurse-physician communication, could be used to standardize and improve physician-to-physician communication.

"SBAR is often used in communications between doctors and nurses. The nursing culture has fully embraced it, but it needs to be more integrated into the physician culture. As we're starting to put checklists and other process improvement tools in place to aid in communication, it would be helpful for the physician community to be more engaged in SBAR from training onward, as a way to have effective discussions about clinical information with everyone on the care team."

As Epstein stated in a 1995 article on the problem communication, "Personal knowledge and personal contact between the primary care physician and the consultant can transform an otherwise anonymous professional relationship into a working partnership."¹⁹

Such working partnerships form the foundation for care coordination and the provision of timely, safe, high-quality care, and are especially

important in integrated care delivery models such as the patient-centered medical home. In their role as key decision-makers and influencers of organizational culture, physician executives can play a critical role in fostering greater care coordination by improving physician-to-physician communication.




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