The Referral Paradox

As a primary care nurse practitioner, a referral to a specialist is sometimes necessary. When a patient presents with a complaint outside of our scope of care or when a procedure we do not perform is required, a referral to a specialist is necessary. However, the referral process is fraught with problems. These include over-referring, low patient completion rate and the lack of effective communication between the specialist and primary care provider (PCP). The referral may be unnecessary, thus wasting the patient’s time and health care dollars. Worse, referrals may lead to patient harm, such as unnecessary tests, procedures, and surgeries.

Communication difficulties between the specialist and the PCP is a long-standing problem. In 1964, Kunkle described the process as “often incomplete and needlessly inefficient.”1(p.663) Patel et al2 evaluated over one hundred thousand referrals from a large academic medical center, where the specialist and PCP shared the same electronic medical record (EMR). Completed appointments were documented for only 34.8% of the referrals. This low number does not include the final closing of the referral loop, which is the information sharing from the specialist to the referring provider. Community health centers (CHC) often face the added burden of specialists being outside of the CHC EMR system. Patrick et al3 evaluated 406 referrals from PCPs at a community health center in Chicago. Communication from specialists to referring provider was present in only 31% of the charts reviewed. Without the communication from the specialist, PCPs may have to rely on the patient’s interpretation of the specialist’s recommendation. The PCP may be unaware of medications or imaging ordered by the specialist. Obtaining the consult report may require the time-consuming task of calling the specialist’s office and waiting for a fax of the consult letter.

Primary care nurse practitioners are educated to manage common acute and chronic health conditions. When a diagnosis is unclear, when a procedure not offered by the PCP is required, or when complex care management is necessary, specialty referral is may be the best course of action. However, specialty referral may not change the treatment plan and may lead to unnecessary tests and procedures. Partly due to the reimbursement process, but also for other reasons, such as requirements for institutional credentialing, unnecessary surgery continues to regularly occur.4 By not referring a patient to a specialist, NPs may be protecting them from unnecessary tests and procedures. I once referred a patient to a urologist for evaluation of Peyronie’s disease. The specialist recommended a surgical procedure for benign prostatic hypertrophy (BPH). The patient had no symptoms of BPH. Another example is a patient referred to an orthopedic specialist for unexplained calf pain. The specialist scheduled the patient for total knee replacement surgery, despite a lack of knee pain. It can be difficult for a patient to comprehend that the procedure the specialist recommended is not necessary, especially when the referral to the specialist was provided by the PCP. This erodes trust in the entire system.

As our career unfolds, we may become more adept at treating conditions that we would not have treated soon after graduation. Based on our education and experience, we will have different referral thresholds. Recent graduate NPs may have a lower threshold for referring compared to experienced NPs. Several studies5,6 have demonstrated that ‘non-physician’ (nurse practitioners and physician assistants (PAs)) referrals are ‘less appropriate’ than those of physicians, implying that the patient’s condition could have been properly managed by the PCP. Neither of these studies differentiate NPs from PAs, nor do they differentiate the number of years of experience of the NP or PA. A primary care NP previously employed in a cardiology practice will have more confidence in treating a patient with atypical chest pain, rather than referring to cardiology compared to a new graduate who has never worked in cardiology.

As nurse practitioners, we need to protect our patients from unnecessary tests, procedures, and surgery. Prior to offering a referral, we should consider what the specialist will do that cannot be done in primary care. Expanding our repertoire of procedural offerings, by gaining expertise in skin biopsies and joint injections, for example, can limit our referrals to specialists. Those working in group practices might consider consulting with an in-office colleague prior to offering a specialty referral. E-consults might also decrease the need for traditional referrals7. Working closely with specialists to outline pre-referral testing or communication requirements may increase referral quality. Evaluating the referral process from a system’s standpoint may enhance the entire process.

As more public aid health plans are transitioned to managed care, referrals will remain a fact of life. We need to be sure they necessary and beneficial to the patient. Protecting our patients from unnecessary referrals is one of the many ways that NPs advocate for their patients.

1Kunkle EC. Communication Breakdown in Referral of the Patient. *JAMA*. 1964;187(9):663. doi:10.1001/jama.1964.03060220037011.

2Patel MP, Schettini P, O’Leary CP, Bosworth HB, Anderson JB, Shah KP. Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System. *Journal of General Internal Medicine*. 2018;33(5):715-721. doi:10.1007/s11606-018-4392-z.

3Patrick G, Bisgaier J, Hasham I, Navarra T, Hickner J. Specialty Care Referral Patterns for the Underserved: A Study of Community Health Centers on the South Side of Chicago. *Journal of Health Care for the Poor and Underserved*. 2011;22(4):1302-1314. doi:10.1353/hpu.2011.0147.

4Stahel PF, VanderHeiden TF, Kim FJ. Why do surgeons continue to perform unnecessary surgery? *Patient Safety in Surgery*. 2017;11(1). doi:10.1186/s13037-016-0117-6.

5Lohr RH, West CP, Beliveau M, et al. Comparison of the Quality of Patient Referrals From Physicians, Physician Assistants, and Nurse Practitioners. *Mayo Clinic Proceedings*. 2013;88(11):1266-1271. doi:10.1016/j.mayocp.2013.08.013.

6Balazs GC, Doria RB, Yow BG, Anderson AB, Ahmed SI, Jex JW. High rate of inappropriate referrals to pediatric orthopedics in an egalitarian healthcare system. *Journal of Pediatric Orthopaedics B*. 2019;28(5):509-513. doi:10.1097/bpb.0000000000000554.

7Vimalananda VG, Gupte G, Seraj SM, et al. Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis. *Journal of Telemedicine and Telecare*. 2015;21(6):323-330. doi:10.1177/1357633x15582108.