The Unique Nature of the Process of Primary Care

Specialist Management and Coordination of “Out-of-domain Care”

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Background and Objectives: Fifteen percent of Medicare patients receive care only from specialists. This has led to the supposition that there might be a “hidden system of primary care,” where specialists provide comprehensive care to their patients, including care traditionally outside their specialty domain. This study explores the perspectives of specialists at an academic medical center on their decisions to provide “out-of-domain” care and how it is coordinated. Methods: We used grounded theory methodology and a constant comparative process with 13 specialist interviews. Results: Patient requests drive the provision of out-of-domain care. Specialist comfort with this care and desire to perform it are involved with their decision to provide out-of-domain care. Coordination of out-of-domain care performed by specialists can be difficult and time consuming but is important and is facilitated by electronic medical records. Conclusions: The results suggest that there is no hidden system of primary care. Coordination among all providers of medical care for a patient is needed to prevent medical errors, especially when specialists provide out-of-domain care.

According to the Institute of Medicine, primary care is defined as “accessible, comprehensive, coordinated, and continuous.”¹² The health care system of the United States is largely organized around specialty care.³ Over a period of 2 years, 14.7% of the state of Washington Medicare beneficiaries saw only specialists, provoking speculation about a “hidden system of primary care.”⁴⁻⁵

It has been suggested that some specialists provide one of the elements of primary care, comprehensiveness of care, including care that is traditionally outside the domain of their specialty. This reportedly occurred with greatest frequency among specialists in neurology, oncology, pulmonology, rheumatology, general surgery, and gynecology.⁴ But, are these specialists truly providing comprehensive care, including the coordination of care that might be expected of primary care?⁶ That is, are they arranging for patients to receive all necessary care, including off-site referrals, comprehensive preventive care services, and care in the functional, organic, and social dimensions?⁷

Unfortunately, multiple providers with different settings, goals, and philosophies may lead to fragmentation of care. Without proper coordination of care, including managing and interpreting information among the patient’s multiple providers, errors are likely to occur. This was illustrated by the case “Ms. Martinez” in Crossing the Quality Chasm, where an abnormal mammogram result was not shared with the patient or her primary care physician, leading to more than a year’s delay in her diagnosis of breast cancer.⁸ Physicians may work so independently that they provide care without complete information about patients’ conditions, medical histories, or the treatment and diagnostics received in other settings. For example, family physicians and chiropractors receive information from each other only 25% of the time.⁹ This lack of continuity has been suggested to play a role in medical errors and patient safety.⁸

Overall, there has been little investigation into the phenomenon of specialists providing care outside the traditional domain of their specialty or specialists assuming a generalist role.⁹ This study’s purpose, therefore, was to investigate, from the specialist’s perspective, the circumstances under which a specialist
provides care that is traditionally felt to be out of the domain of that specialty and how this care is coordinated with the other physicians caring for the patient. We assessed the strategy of a varied group of medical and surgical specialists with respect to their approach to their specialist and generalist roles in everyday outpatient care, as well as perceived problems with fragmentation of care. We used grounded theory qualitative methods to allow us to “go beyond the numbers” to investigate the provision and coordination of out-of-domain specialty patient care.

Methods
This study used grounded theory methodology with data collection through semi-structured face-to-face interviews of approximately one half hour in length. We interviewed 13 specialists at an academic medical institution from August 2002 through February 2003. This institution has more than 700 physicians on staff and has an electronic medical record (EMR) for most departments. The physicians’ specialties were pulmonology/critical care medicine (three), neurology (one), pediatric neurology (one), hematology/oncology (one), general surgery (one), orthopedics (three), and obstetrics-gynecology (three), including one subspecialist in matenal-fetal medicine. We chose physicians whose specialties corresponded with those that have been previously identified as providing some of the highest and lowest proportions of traditionally out-of-domain care and majority care. The specialists had been in practice from 10 to 32 years; four were women.

Table 1 provides a synopsis of interview topics. Interviews were audiotaped and transcribed. Interview transcripts were then independently analyzed as they were collected by each of the authors, allowing for a continuous iterative process where interview questions could be modified for clarification. Over the course of the interviews, the investigators met three times to discuss emerging themes and to use this information to shape our further sampling and questions. Subsequent sampling included a decision to include, for example, a pediatric subspecialist and more obstetrician-gynecologists and pulmonologists. We judged the interview process to be complete when new interviews did not yield additional information. The Institutional Review Board of the Medical University of South Carolina approved this research.

Results
The following themes emerged from the analysis of the data:

Provision of out-of-domain care is patient driven and of low complexity.

Among obstetrician-gynecologists, female gender and pregnancy define the domain of care. Therefore, female, and especially pregnant, patients frequently came to their obstetrician-gynecologist with concerns other than reproductive and prenatal health. But, many specialists indicated that their patients largely determined whether they provided care that was traditionally outside the domain of their specialty. That is, the patient plays a large part in choosing the agenda of a visit with the specialist. Some specialists expressed that patients will try to “take the path of least resistance,” i.e., they use the doctor who is most convenient and bundle their concerns together to make efficient use of doctor visits.

If somebody has a cold, we will be asked whether or not we can prescribe a sleeping medicine, we will be asked is it okay if I take a cruise, what do I need, can I have a flu shot, what do I do for this and that. Do we do sophisticated hypertension management? No. Do we switch somebody from oral agents to insulin? No. But do we try to be pretty service oriented toward our patients? Yes. (an oncologist)

Specialists mainly chose to do out-of-domain care that was of low complexity or closely related to their specialty. Most specialists, except orthopedic surgeons, would do one-time refills of anti-hypertensive medications but avoided things like comprehensive diabetes management.

It [provision of out-of-domain care] depends on what it is and how much follow-up is required by what I’m doing. For treating diabetes, I’d rather a primary care physician does that so that they can be following up
with the eye exams and 24-hour urine and education and things like that. If it’s to prescribe someone their anti-ulcer medication, you know, I don’t have a problem doing that. (a pulmonologist)

Comprehensive care for low-complexity conditions was not completely consistent with what might be seen as primary care. Virtually all of the specialists we interviewed, except the orthopedic surgeons, would not treat a sprained ankle because they would not feel comfortable doing this; orthopedic specialists didn’t treat anything but musculoskeletal conditions.

Respiratory tract infections commonly, viral gastroenteritis-type disorders commonly. Orthopedic injury is rare. (an obstetrician-gynecologist)

Specialist comfort with out-of-domain care.

The internal medicine specialists felt that they were “first an internist” and so described feeling comfortable with a wide range of medical care, with nothing outside their domain. One pulmonologist asserted that as a critical care specialist, she is “the ultimate internist.” Most of the surgical specialists and obstetrician-gynecologists felt that patients sometimes pushed them beyond their comfort level with requests for out-of-domain care. In such situations, these specialists said they either explained their specialist role to these patients and referred them (back) to a primary care physician or proceeded to make simple interventions but not without some discomfort.

I saw somebody for migraines, for which I can certainly give them the basic medicines, but this person had already taken that, and they still were not getting better. She didn’t want to go to her primary care or neurologist so she came to me, and I gave her something. I didn’t feel comfortable because I wasn’t sure if I was treating it correctly. She had kind of gone beyond my limited scope of migraines. (an obstetrician-gynecologist)

I don’t remember the last time I treated anybody outside of my specialty. I generally refer out. I would feel very uncomfortable. The only circumstances would be a real necessity or urgency where nobody else would be available, and it would be a one-time occurrence. People want you to be their regular doctor but not too often. It’s pretty rare for me since most people are here for knee replacements. I don’t have any examples, and I’ve never done it. (an orthopedic surgeon)

Specialist desire to do out-of-domain care.

Some specialists in internal medicine subspecialties wanted to provide aspects of primary care; others wanted to avoid it, preferring to compartmentalize their specialty role. None of the orthopedic surgeons acted in a primary care role or expressed any interest in doing so. One non-surgical specialist said his department actively discouraged any out-of-domain care, largely due to a departmental shortage of specialty physicians relative to patient demand.

I don’t know about my partners, whether they may [provide out-of-domain care] once in a while, but typically I don’t think that they do, and [they] are also being encouraged to do less and less just because there are so few of us and such an increasingly high demand. (a pediatric neurologist)

Communication with the primary care physician is important.

All specialists thought communication with the primary care physician was important, although this happened in varying degrees. Many specialists reported that this was something they did routinely with every patient. However, some specialists expressed that this was time consuming and might not happen as much as they would like.

In the majority of cases, the patient does have a primary care physician. So you sort of run the risk of providing fragmented, confusing care if you decide to take on the role of a primary care physician even in a limited sense. And, if you happen not to communicate with the primary care doctor, then he is suddenly out of the loop. (a neurologist)

Quite frankly, I see huge numbers of patients, I just don’t have the time to dictate four or five letters a day to primary care docs. I don’t have time and can’t do that. I’ll often tell patients to go back and see your regular doctor about your hypertension or whatever. The answer to your question should be yes, I always send the primary care doctor a letter or records or whatever, but I don’t, and I hang my head in shame. (an orthopedic surgeon)

Fragmented care can lead to medical errors.

Many specialists volunteered that fragmentation of care could be dangerous for patients. One specialist worried about providing primary care, since that could interfere with the care plan of the patient’s primary care physician, especially if communication is not good, citing “too many cooks . . .” More than one specialist worried about the risk of polypharmacy, especially in elderly patients.
The informants did indicate that information flow is aided by the use of an EMR, a strategy encouraged by the Institute of Medicine to decrease the fragmentation of care and concomitant disruption of information that are key causes of medical errors.6,8 Having the patient record available electronically may provide the necessary information regarding treatment by multiple providers without explicit communication avenues about the patient. Unfortunately, this may decrease expectations about communication between providers, with particularly deleterious consequences for patients who use physicians who are not all in the same health system linked by the same EMR. Thus the present findings with regard to EMR, although encouraging, may represent particular problems with coordination for patients whose primary care and specialist physicians are not in the same health care system. Communication with other physicians should be emphasized and modeled in both specialty and primary care training programs.

Limitations
We acknowledge that this study is limited in its setting, with all the specialists being at a single academic medical center with substantial linking available via EMRs. While such a collection of specialists is often found in the setting of academic medicine, there is likely less coordination among a community of specialists who work without a central EMR system. Alternatively, they may use different, perhaps more direct, communication strategies for specialists, such as telephone calls.

Conclusions
We have explored out-of-domain care by specialists and proposed a model whereby this care is driven by the patient’s choice. Coordination of this out-of-domain care with the primary care physician is difficult and, therefore, inconsistent.

Specialists should take care to communicate with the patient’s other physicians when providing out-of-domain care. Both specialty and primary care trainees should learn by example to communicate freely with other physicians about their shared patients. EMRs may facilitate this coordination and may also lead to a reduction in medical errors.

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