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Changing the nature of physician referral relationships in the US: the impact of managed care

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Abstract

Prior to the era of managed care in the US, health care delivery was managed by the professional activities of physicians. Managed care replaces management by profession with bureaucratic management structures and oversight, such as utilization review and gatekeeping (required referrals to specialty care). Practically, this means that physicians cannot use the professional relationships that typified practice under fee-for-service medicine, potentially changing not only what physicians do (e.g., order test or not, refer or not), but also *how* they do what they do.

In this paper I look at just one of the changes brought about by managed care: contractual arrangements that require primary care providers to refer patients to a closed panel of specialist physicians. Through an in-depth case study of 45 primary care providers' in the USA who face restricted specialist panels for their managed care patients, but not for their fee-for-service patients, I investigate how the practice of referring is changed by this requirement. First, I use interview data to describe primary care providers' general preferences for referral consultants, as well as their views of the referral process and potential barriers in it. Next I present data from all referrals over a four-week period to analyze the extent of referral relationships in actual referrals. Finally, I conclude by discussing some ways that managed care entities can facilitate rather than diminish referral relationships among physicians.

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Introduction

The introduction of managed care (MC) in the US has transformed the delivery of health care from an activity controlled by physicians' professional practice and authority to one controlled by bureaucratic mechanisms (Hafferty & Light, 1995). Altering the delivery of care, of course, is one of the *desired* effects of MC, i.e., to effectively coordinate and oversee the delivery of care such that excessive, and possibly unnecessary care is eliminated, thereby improving quality while reducing costs. Altering delivery mechanisms, however, may have the *undesired* effect that patients feel they can no longer trust their relationships with providers (Mechanic, 1996; Davies & Rundall, 2000), and providers believe they

cannot practice in professionally appropriate ways (Halm, Causino, & Blumenthal, 1997; Hoff, 2000; Luft, 1999). One important mechanism MC organizations use to manage health care delivery is the primary care provider (PCP) as gatekeeper to specialty care (Gold et al., 1995; Halm et al., 1997).

Researchers estimate that between 15 and 16 million referrals are made annually in the US health care system (Forrest & Reid, 1997). Referrals are made from one provider to another both because individual providers have different expertise, and because the increasing specialization of medicine has led to highly segregated knowledge and procedures practiced by different types of providers. Physician referral is targeted by MC because of the high costs associated with specialty care (Greenfield et al., 1992). Gatekeeping alters the cost of referral for both the PCP and the patient, and is associated with reduced specialist use (Shea, Stuart,

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Vasey, & Nag, 1999; see also Franks, Mooney, & Sorbero, 2000). While this is one of the goals of MC, there is concern that factors other than patient medical needs will influence referral patterns under MC (Donelan et al., 1997; Halm et al., 1997).¹

Researchers have focused a great deal of attention on the issue of physician referrals, comparing differences in referral rates under fee-for-service (FFS) and MC (e.g., Bachman & Freeborn, 1999; Forrest & Reid, 1997). My concern with physician referral takes a more sociological approach in recognizing that MC arrangements change not only the incentives to refer, but also the *mechanism* through which the referral process works.

An important aspect of the referral process prior to MC was the physician's referral network, making referral relationships *among* physicians a crucial element of the referral process. Little attention, however, has been paid to how MC affects relationships among physicians (other than financial relationships). Gatekeeping with restricted physician panels changes referring from a professional decision delivered via professional networks into a more bureaucratic process. For providers trained to practice under a primarily FFS payment system that exerted few controls over delivery, the transition to MC referral rules may pose a dramatic and unwanted change in the referral process. In contrast, the predominance of MC in certain parts of the US, at least since the mid-1990s (Marquis & Long, 1999), may mean that new physicians beginning practice during this time take MC rules as given. Halm et al. (1997), for example, find that physicians with fewer years in practice have more positive attitudes toward gatekeeping than their more experienced peers.

Referrals from PCPs are the main conduit for bringing specialty care attention to patients in MC systems, so understanding how MC affects the overall referral process has implications for patient care outcomes, as well as for physicians' acceptance of and satisfaction with these arrangements. I begin by describing the "ideal type" referral process in both FFS and MC, noting differences in the importance of physician relationships in each. Next I describe my case study of the referral process among 45 PCPs who face

¹Even prior to the introduction of MC, wide variations in referral patterns were identified, resulting from differences in patient characteristics (e.g., Penchansky & Fox, 1970; Salam-Schaatz, Moore, Rucker, & Pearson, 1994) and physician factors, including specialty training (Bachman & Freeborn, 1999; Kravitz et al., 1992), and comfort with diagnostic uncertainty and risk-taking (Bachman & Freeborn, 1999; Calman, Hyman, & Licht, 1992). In addition to patient and physician characteristics, other research suggests that factors in the practice environment also contribute to referral variation, including aspects of the local market (Gonzalez & Rizzo, 1991), as well as practice workload and perceived control over the work environment (Bachman & Freeborn, 1999).

restricted specialist panels for their MC patients, but not for their FFS patients. In the research methods section, I present interviews with PCPs regarding their preferences when making referrals to specialists, and their perceptions of the impact of MC on the referral process. I then describe the type of relationships and communication between PCPs and specialists during actual referrals made over a 4-week period. Finally, I conclude by switching gears to discuss the potential contribution MC could make in "managing" the referral process. I give recommendations for improving the referral process in MC systems.

The referral process

Fee-for-service

Physicians have described the process of making referrals as a two-part decision (e.g., Schaffer & Holloman, 1985): (1) whether to refer, and (2) to whom to refer. Under FFS arrangements, physicians pay close attention to the second decision because they must establish and rely on their own individual referral networks (see column 1 in Table 1). This discussion of the referral process under FFS focuses exclusively on a FFS system, and therefore draws on research that predates (i.e., pre-1990) the MC transformation of health care in the US. In Shortell's (1973) classic study of physician referral under FFS, one of the most important factors affecting a physician's decision of who to refer to was having a personal relationship with the consultant. Providers also rely on the professional reputation of physicians when making referral decisions (Ludke, 1982).

In addition to personal and professional relationships, FFS referrals often rely on direct communication during the referral process (see row 2, column 1 in Table 1). Ludke (1982) found that referring physicians evaluate consultants' past communication when making referral decisions. Not surprisingly, physicians and consultants exchange more productive and pertinent information when they communicate directly (McPhee, Lo, Saika, & Meltzer, 1984; Lee, Pappius, & Goldman, 1983), which is more likely when they have a personal relationship. Communicating directly, however, may require a significant investment of time by providers.

In FFS, providers also have incentives to monitor one another in the referral process (see row 3, column 1 in Table 1). Generalists can stop referring their patients to specialists who do not provide quality care, or who fail to competently communicate with the referring physician or her patients. Referring physicians who observe negligence and do nothing to stop it share legal responsibility for that negligence. In addition, PCPs will reward high quality consultants with continued referrals,

Table 1
The referral process under fee-for-service and managed care

Aspects of the referral process	FEE-FOR-SERVICE	MANAGED CARE
Type of relationship between providers	Personal–Professional Reliance on referral relationships and networks Both PCP and consultant attentive to relationship	Bureaucratically Managed Reliance on “approved list” of providers No incentives to invest in relationships, especially if list changes frequently
Type of communication	Direct Contact Contextual information exchange High time demand	Referral Form Basic information exchange Low time demand
Type of control	Social/Professional Providers have incentives for monitoring quality and behavior Providers have ability to reward high quality (or sanction low quality) Inertia, friendship, etc., may inhibit monitoring and sanctioning of low quality care	Bureaucratic Screening/monitoring of quality and behavior by MC plan MC plan can encourage quality care (e.g., EBM), and sanction low quality care Providers have few incentives to screen or monitor referral relationship Providers have limited ability to reward/sanction quality

Note: EBM—evidence-based medicine, MC—Managed Care, PCP—Primary Care Provider.

while providers receiving referrals pay attention to (and reward, when possible) their origin (Schaffer & Holloman, 1985).

A referral process based in professional referral networks, as in the FFS process just described, can work well because the social relationships underlying the network provide a flexible mechanism that facilitates the flow of both information and control (see also Grembowski, Cook, Patrick, & Roussel, 1998). As network analysts have found in other contexts, social relationships capture and facilitate the flow of both concrete and contextual information (Burt, 1992; Granovetter, 1973; Uzzi, 1996). Actors embedded in a network of social relationships (Granovetter, 1985), for example, gain information about others' reliability, either through direct past experience, or through third party connections (e.g., reputation). Social relationships are also important because they provide a ready mechanism for exerting social control. Social ties increase the efficacy of social influence, and increase conformity to rules and norms (Horne, 2001).

A referral process based in personal and professional relationships does not, however, guarantee high quality care. Referral relationships based in social ties may be stuck in old-boy networks, or based on friendship or inertia, resulting in referrals to known, but not necessarily high-quality providers. Indeed physicians typically select consultants from a circle of colleagues with whom they share similar background, interests or training (Schaffer & Holloman, 1985). In FFS referrals,

while social relationships can give providers access to important contextual information, as well as control over the process, these relationships are, at best, uneven, indicating that their constituent benefits are also uneven.

Managed care

The referral process operates via physician's professional networks in FFS medicine. What changes in the referral process under MC? Recall the two decisions providers make before generating a referral: whether to refer, and to whom to refer. Under MC, the most important decision is whether to refer, given the incentives to reduce specialty care. In addition, MC arrangements that restrict referrals to a limited panel of “approved providers” limit PCPs' ability to decide to whom to refer. It is unclear how extensive or restrictive MC networks are in the US. On the one hand, there is much concern about networks being too restrictive, such that patients' have limited ability to access specialists. Eighteen US states, for example, have regulations that guarantee patients access to out-of-network providers (Dudley & Luft, 2001). Among some health policy experts, on the other hand, there is the perception that the networks are so inclusive as to be meaningless (e.g., Luft, 1999, p. 959).

Regardless of how complete panel restrictions really are, MC arrangements reduce incentives for providers to actively build referral relationships and networks, in contrast to FFS, where both PCPs and specialists are

attentive to the referral relationship. MC organizations bureaucratically establish and manage the referral network, removing the activity from the professional practice of physicians (see column 2 in Table 1).

MC referrals typically require communication via a bureaucratic mechanism, such as a referral form, rather than direct interpersonal contact between providers. Communication by way of a standardized form means that only very basic information can be exchanged (see row 2, in Table 1). Moreover, the quality of the information exchanged is likely to be lower when referring to an unknown physician in a standardized format because less contextual information will be exchanged and there may be more ambiguity in the interpretation of information. Indeed there is evidence that PCPs in the US refer more often to *unknown* specialists, and communicate with specialists *less* when referring MC patients than non-MC patients (Roulidis & Schulman, 1994).

While communication via a MC referral form may be deficient compared to the best case of referrals under FFS (i.e., direct communication between providers with an established referral relationship), it may have two advantages, especially for referrals for routine care. First, a standardized referral form can ensure that essential information is transmitted for every referral. While this basic information may be less than the contextual information shared during direct contact, it is possible it is *more* information than that shared in referrals between providers who are unknown to one another. Second, filling out a basic form may decrease the amount of time required by PCPs at the time of referral.

Finally, control mechanisms in the referral process are also changed under MC. PCPs who cannot choose who to refer to have limited ability to stop referring to specialists they view as problematic. This inhibits one of the main control mechanisms PCPs typically have in the referral process. Moreover, if specialists no longer need to recognize who is making referrals to them, for example, because they are guaranteed patients or salary by the MC organization, they have fewer incentives to be attentive to the referral relationship with PCPs. In contrast, a potential benefit of MC is the capacity to better coordinate relationships and facilitate communication among providers, as well as to exert more systematic control over quality. That is, the MC organization, itself, becomes responsible for screening providers.

MC changes the mechanism for referring from one based in professional relationships to one based in bureaucratic management. The advantages (and disadvantages) brought about by this change are the same that occur with the bureaucratization of any process, such as, increased predictability (rigidity), uniformity (control) and efficiency (social costs). Recognizing the

change in process caused by MC raises a number of questions that must be answered in order to understand the full impact of MC. Does communication and reliance on referral relationships really differ between FFS and MC referrals? Are providers concerned about differences in communication and control in the referral process between FFS and MC? If so, what are the implications for care and practice?

Research methods

To investigate the referral process and the nature of referral relationships, I conducted an in-depth case study of 45 PCPs, who provide continuing primary care in one of 11 multi-specialty group-practice ambulatory clinics of a large University medical system. The first part of the case study consisted of semi-structured interviews that lasted approximately 45 min each and asked PCPs about the factors they use to choose consultants for specialty care, as well as their perceptions of barriers in referring for specialty care.

All primary physicians (excluding residents) practicing in the seven Family Medicine clinics ($N = 45$), and all clinical faculty from the Department of Medicine who practice in one of four Internal Medicine clinics ($N = 20$) were contacted (letter and e-mail message) to participate in this study, from which a total of 45 consented to participate (69% response rate). The resulting sample consists of 33 Family Practice physicians and 12 Internists.

As shown in Table 2, the PCPs interviewed included 23 men and 22 women. The mean age of respondents is 40 years, and the mean years in clinical practice (post-residency) is about 8 years overall, with Family Medicine practitioners averaging slightly fewer years in practice than Internal Medicine. About one quarter of respondents are 45 years or older, and have been in practice for 10 or more years.² While these respondents are not meant to be representative, they are younger and less experienced than the national average for PCPs (Pasko, Seidman, & Birkhead, 2000, pp. 302, 307).

Finally, respondents reported a wide range of coverage of MC patients. On average, respondents' practices are comprised mostly of MC patients (approximately 67%), but about one quarter of respondents had fewer than 50% MC patients in their practices.

The second part of the case study consisted of a prospective study of all referrals made over a 4-week period between February and March 1999 by the 33 Family Practice physicians. This study of 515 total referrals attached a short questionnaire to each referral form (required for every referral) and asked about

²Non-respondents did not differ significantly from respondents by sex, age or years in practice.

Table 2
Demographics of primary care providers by specialty

	Family medicine	Internal medicine
Sex		
Number male	18	5
Number female	15	7
Age		
Mean	40 years	40 years
Range	30–60 years	34–48 years
Years in practice		
Mean	7 years	10 years
Range	1–35 years	4–18 years
% MC patients		
Mean	67%	67%
Range	5–100%	13–100%

Table 3
Referrals by insurance type

	Referrals % (N)
Referrals without insurance information	27% (139)
Referrals including insurance information	73% (376)
Insurance type	
Managed care	82% (309/376)
Other	18% (67/376)

reasons for selecting the consultant, previous contact with the consultant, type of referral and insurance type of the patient. In addition, it asked referral clerks in each clinic to report logistical information about the referral, such as who scheduled the appointment, and how much time it took to schedule.

Referrals made for simple procedures only, in which no consultant is ever specified, e.g., X-rays, were excluded from the study. As shown in Table 3, of the 515 referrals that met the study criteria, 139 questionnaires (27%) included no information regarding the patient's insurance, and so were excluded from the analysis. Of the remaining 376 referrals, the vast majority were for MC patients (82%), with 12% for FFS patients (indemnity insurance), 5% for Medicaid/Medicare patients (non-managed care plans), and about 1% for patients who were self-paying.

The practice setting

The University medical system and its primary care and specialist providers comprise a large Independent Practice Association (IPA). An IPA is a group of providers who form a "practice association", i.e., a network of solo and/or group practices, that negotiates

with MC plans to cover enrollees. A number of different MC organizations contract with the IPA. Most providers in this system see both MC and FFS patients in their practices, though some see only MC patients. All MC patients are capitated and must see only physicians within the IPA to be covered, meaning that all MC patients, regardless of MC plan, are restricted to the same IPA providers. While the IPA studied here is relatively large (at the time of this study, approximately 875 providers, of whom about 200 are PCPs), it does not include all providers in the region in which it is located. For providers, this means that being "restricted" to the IPA for referrals is a real restriction. Only under special circumstances can capitated patients see physicians outside of the IPA. Such out-of-IPA visits require additional paperwork for the referring provider, as well as special approval from the MC plan. The IPA pays all providers, including PCPs and specialists, by salary. Providers face no individual financial risks (or incentives) regarding referrals. All the PCPs interviewed, however, are aware that the IPA as a whole suffers a loss when they refer a capitated patient out-of-IPA.

Findings

Relying on personal networks

All but one of the 45 PCPs interviewed said they preferred to refer to consultants with whom they already had an established relationship, either a previous referral relationship or a personal tie. For example, an Internist explained,

I think we [PCPs] each have a different core group of who we refer to based on who we know. So sometimes it is who shares a play group with your kids, who lives next door to you, or who you went to school with.

Similarly, a Family Practitioner explained who he prefers to refer to and consult with for specialty care.

The only thing I found is to develop relationships with specific individuals.... Some of them have persisted since I was a resident. There are people whom I consult with and who provide supportive consultations and arrangements, but it is because I have known them for 13 or 15 years.

When not able to rely on a pre-existing relationship with a consultant, PCPs continue to make use of their social networks for referring to specialists. Two-thirds of the PCPs said that when they do not know any specialists in a particular area, they ask for recommendations from colleagues and other sources, including patients.

If I have something that I need to refer, but have no idea of who to refer to, the first thing that I usually do is to ask one of my colleagues and see if they have any suggestions.

Family Practitioner

It is easier to just ask a colleague. If I don't know somebody in a particular subspecialty and I want information, I will ask a couple of colleagues first. I will even call somebody. For instance, I needed to find somebody in a specific niche in psychiatry, so I just call[ed] up a psychiatrist that I know.

Internist

Recommendations from social ties are important because they often include more information than merely the specialist's name being sought. Consider this comment by a Family Practitioner,

It is not uncommon [to ask]—'who would you send this to' or 'have you had any experience with so and so', 'is there anybody that is particularly good in X?' And those discussions often lead into 'well you know so and so is really crummy' or 'didn't hear back from them' or something else. So you learn a little bit more about the dynamics.

This comment indicates that relying on social networks and interpersonal communication provides important information to PCPs.

In contrast, one-third of the PCPs ($n = 14$) said they would merely take the first specialist available when they needed to make a referral to a subspecialty in which they did not know any consultants. We might expect that the PCPs willing to take the first available consultant are providers who have had the least time to establish a referral network. PCPs who said they would take the first available, however, had a higher mean age, 43 years, than respondents overall, and about the same years experience (9). Given the description above of the referral process under MC, we might expect, alternatively, that providers who see only MC patients, for whom they cannot rely on a referral network, are more likely to simply take the first available consultant. PCPs willing to take the first available consultant did have a slightly higher percentage of MC patients (73%) compared to PCPs who ask colleagues for a recommendation (67%).

Information benefits of referral relationships

Most providers prefer to refer to specialists they have relationships with because they identify real benefits from those consultations. One of the most important benefits described by PCPs is that personal relationships facilitate information exchange. One Family Practitioner explained simply, "When I know the people

[specialists].... I get [consultation] letters back in a timely fashion." Similarly, an Internist gave a specific example of the kind of information exchanged through referral relationships,

I am on a committee with Dr. [Smith], so now I don't feel bad about paging him and asking him questions like—'this lady is here and she wants Viagra. Are you guys doing that? Who should I refer her to? I have never done that; it's off label'. He was very nice. Called me back and gave me the information.

Internist

Other PCPs point to the clinical knowledge gained through informal consultation with specialists they know, knowledge that potentially reduces the need for similar referrals in the future.

I have relationships that lead to [collaboration]. I can call someone and say 'can I run something by you and if need be I would be happy to send them to you, but tell me if I am on the right track here'. That kind of thing. That's the level of communication that could be most critical, but it just doesn't happen as often as it should. Which is expensive and I think leads to unnecessary referrals. There's not enough trust.

Family Practitioner

There have been occasions when I want opinions about something. I mean the people I call here are people that I know. For example, I will call Dr. X in Cardiology....and we talk about things back and forth. There have been times when he says, "just keep doing what you have been doing" and also times when he says, "well lets see him, lets do this other test." So on those occasions collaboration worked well.

Family Practitioner

In addition to direct information exchange, PCPs explain that personal relationships often entail short-hand expectations about the clinical division of labor, ensuring, for example, non-duplication of tests, and smoothing continuity of patient care.

If you don't know who the person is, they don't know who you are, they may have preconceived notions about your ability to care for the patient and you may have preconceived notions over what you expect or don't expect.... And that recently just happened. I sent a patient to a vascular surgery clinic [rather than an individual specialist]; [the patient] wound up seeing a cardiologist. The cardiologist did 8 million different tests that weren't needed because they [*sic*] didn't know the patient. And we had a little

exchange back and forth and we cleared it up but it could have been avoided, with better communication.

Internist

The best referrals are to a person that you know because you have to know what each other is thinking. So if I have a referral in the hospital for example, and it is a physical medicine patient and I send the referral to Dr. Y, he knows he is going to write for PT, going to write for OT, going to follow-up with the patient. When he sends me a referral he knows I am going to write for blood pressure medications, I am going to write for other different medicines, etc. and this is just an understanding that we have had over the years, versus if a new PM&R person came aboard you wouldn't have that. And so what happens is that the patient is in the hospital a day or two longer because the communication is not there, life is busy and they don't get to me and I don't get to them and it's less succinct care either financially or health care wise too. I think it is better care when you know who you are working with and what their expectations are.

Internist

Others explain that knowing the consultant improves communication with patients. Consider the following statements.

Well I always feel more comfortable when I know the doctor that [patients] are going to see because you can fill patients in a little bit before they go.

Family Practitioner

There are patients who really do want to know if there is some string connecting you to the consultant. To know that there will be communication both ways and also that I personally bless this visit so that Mrs. Smith does get to see a doctor who I know. I never try to sell patients that I know Dr. Jones if I don't. But it does make it harder for them sometimes to follow through the referral if they know that I am sending them to somebody that neither of us knows.

Family Practitioner

Similarly, an Internist explained the impact on patients when he has to make a referral to a clinic group in the IPA, rather than to a specific consultant,

It's not the same thing as telling a patient that you are going to see doctor A, B or C. Patients don't like it; I don't like it either. I don't know who they are going to see. They may not have the records, etc and I think this whole clinic philosophy is bad patient care frankly.

Internist

When PCPs have a relationship with consultants, they say they are more likely to phone or email the consultant

at the time of the referral, potentially reducing costs and improving care overall by reducing unnecessary referrals and test duplication, and by increasing the amount and quality of communication between PCPs and consultants.

Social control in referral relationships

Many of the PCPs explained that having personal relationships with specialists allows more control in the referral process by facilitating having their patients seen in a timely manner. For example, one Family Practitioner explained,

Usually I want the patient to be seen sooner than the [specialist] appointment is to be made. If it is with those specialists who I have a personal relationship with, then I can call them or their staff and then [patients] are usually in like that. (snaps fingers)

Another explained,

When I know the [specialists].... they are timely getting people in and patients are more satisfied.

Family Practitioner

Similarly, an Internist explained,

The [physicians] that I know socially I tend to refer patients to them because I can call them up and say—'Hey, can you see so and so who has this.' 'Sure no problem.' Whereas if I call you up and you don't know who I am or you just think I am a doctor down at Clinic X, you would be less likely to say—'Yeah I will see them.' And that is a two way street. They call me up and they have a patient they want to be seen and I get them in my clinic fairly quickly.

PCPs explain that their ability to use personal relationships to influence the referral process is important even within the IPA because the size and high demand for specialty care within the IPA often limits patients' timely access to specialists.

[The IPA] is kind of a double-edged thing. Because although the care they get is, I think, usually very good, the access is difficult. When somebody has to sit for 2 hours in a waiting room before they are seen or have to wait 2 months before they are seen, then it doesn't matter if they see the best doctor in the world, it's just they [patients] are not going to like it. I'm not going to like it. Patients can get very good care and still not be at all happy.

Internist

Some PCPs thought the fact that all physicians in the IPA are salaried contributed to the problem of timely access to specialty care, as well as impeded communication between PCPs and specialists.

Here, they are so busy that the need to develop the relationship isn't there as much. It's changing a little bit, but it's really not there. Whether they get that referral from you or not, they are still going to be just as busy.

Family Practitioner

There is not a strong enough impetus I think or there is certainly not a financial impetus for our specialists to see more patients and as a result of that when I send a patient to an outside physician I get a much more timely referral and I get more feedback and that kind of stuff.

Internist

Some PCPs recognize that their access to specialty care for MC patients is based more on bureaucratic rather than personal relationships.

You have to depend on the system to some degree. There are some systems that make it very difficult to make a referral to an individual provider. The IPA makes it pretty tough and so sometimes I will just say refer to neurology, I don't care who this patient sees. I am looking for a technical solution; I'm looking for a procedure where we are assuming that everyone is technically skilled.

Family Practitioner

The concept at a major medical center like this is that you're sending patients to the institution not to any person. It's sort of a quality control of the institution as a referral source, but individual relationships are variable.

Family Practitioner

Referral process with MC restricted panels

All PCPs claimed they stop referring to consultants who give low-quality care, although very few thought quality was a problem in the IPA. For example, one Family Practitioner explained,

Before I came here, we had one HMO that only had one ENT doctor in it, so if [a patient] came in with that HMO, we would really delay referring to the guy. [Instead] we would ask someone in Family Medicine who had a special interest in ENT, or curbside an ENT doctor. But we were forced to refer because he was the only ENT in the [HMO], but if he wasn't the only one, I would not have referred to him.

Family Practitioner

About half of the PCPs believe that MC panel restrictions limit their ability to *stop* referring to consultants they identify as problematic for reasons other than quality. Most PCPs identified poor commu-

nication from consultants, to either the patient or themselves, as a major reason to stop referring to a specialist, but some felt that MC panel restrictions limited their ability to do so. Consider the following exchange with an Internist.

Internist: There are some people that I don't like to refer to, because I get patient complaints. But say for example, orthopedics...if this is the only person who is doing hips and knees then what can you do? So the [patient] has [managed care insurance] so they have to see someone [in the IPA], and that means they have to see this person.

Interviewer: So what do you do in that situation?

Internist: You just tell [the patient], 'well you know this is the way that it is. Orthopedics is difficult to get into; we don't have that many orthopedic doctors. If you go elsewhere you are going to have to pay out of pocket, and the out of plan thing in [managed care] has come back a number of times saying—'personality conflict is not a reason for us to approve out of plan physicians.' So it is one of those grin and bear it [situations].

In contrast, one Family Practitioner thought the large size of the IPA meant *more* ability to differentiate among sub-specialists, not less.

I can specify not to refer them to Dr. X, so Dr. X won't get any more patients from me. And that usually works because of the umpteen providers in any of the subspecialty departments. There is enough clinical overlap so there's not just one person only who can handle this particular problem.

Family Practitioner

When PCPs are unhappy about limited access to specialists or feel their patients require care outside of the IPA, they sometimes seek an out-of-IPA referral. A majority of PCPs, however, identified the process of making an out-of-IPA referral as a serious barrier.

There are times where I have [made out-of-IPA referrals] because of access issues. But you know, when you have to do an out-of-IPA thing with any of the insurances, the road blocks are so harsh that it's not usually worth it.

Internist

[Making an out-of-IPA referral] is a big hassle, because usually that means filling out a form just to get it on the agenda of the desk of the person at the other end who has to approve it. Then, universally, it comes back saying they need more information. So you then have to figure out which progress note from your patient's record, which other parts of the record you have to send to confirm that, yes, they actually

need to go [out-of-IPA]. Along with that, writing a statement as to why this has to be out-of- plan. So it takes possibly $\frac{1}{2}$ hour to an hour over two or three sessions to get approval. That's a big hassle. It's not reimbursable time. It's just time that you sink into taking care of a patient.

Family Practitioner

The system needs to be made a little more receptive to people out in the community because it takes me 25 minutes of umpteen phone calls to try and get a patient admitted and being treated rudely at a couple points along the way. In the meantime there are very few community physicians who are going to put up with that kind of baloney, but I was stuck because it was a patient that had to go to the IPA. And I said to them, at any point if I had the option I would have switched. But because of the insurance I didn't have that option [to go out-of-IPA].

Family Practitioner

Illustrating the shift under MC away from concern about who to refer to, a Family Practitioner with 85% MC patients, said,

The choice for me isn't so much where to refer because I usually don't have a choice. Insurance tells me to go to the [IPA]. I can sometimes choose consultants from within that from the short list that I have.

Family Practitioner

Characteristics of actual referrals

The 33 Family Practitioners who were interviewed above participated in a 4-week study of all referrals made in that period to assess the type of relationships and level of contact between providers during actual referrals. All providers in the IPA must complete a brief form at the time of a referral, so a brief questionnaire was attached for the study period asking providers about the extent to which they knew or had previous experience with consultants to whom they were referring.

As shown in Table 4, column one, only about half of all MC referrals were to a consultant whom the PCP knew or had prior experience with, compared to two-

thirds of non-managed care referrals. Given that these data are not statistically representative, the chi-square statistics reported in the bottom row of Table 4 are merely illustrative. Column two shows that fewer MC referrals were accompanied by communication between providers at the time of the referral. MC referrals were also less likely to be accompanied by direct contact between the PCP and consultant.

As noted above in section two, the referral form required by the IPA may be an efficient way of ensuring minimal communication between providers, while reducing the amount of time providers must spend on a referral. PCPs may find this efficiency desirable for referrals of routine medical conditions or procedures, but not so for more complicated referrals in which information exchange is important. Examining the level of communication involved in referrals for routine versus urgent or emergent patients suggests this may be the case (see columns 4 and 5 in Table 4). There was significantly less communication between providers for MC referrals for routine patients, but no difference in the level of communication for more serious referrals.

In addition to changes in the referral process for PCPs, MC often imposes logistical barriers. For example, referral clerks reported in interviews that they spend less time scheduling referral visits for non-MC patients. According to the data gathered at the time of the referral, approximately half of all non-MC referrals took less than 5 minutes to schedule compared to only about one-third of MC referrals (see column one in Table 5). At the other end of the continuum, however, MC referrals were *less* likely to be the most time consuming to schedule. Column two in Table 5 shows that significantly fewer MC referrals required more than 15 minutes to schedule. As in Table 4, the chi-square statistics in Table 5 are merely illustrative.

Discussion and conclusion

Most of the PCPs interviewed in this case study say they prefer to rely on established referral relationships because they feel that those relationships facilitate

Table 4
Type of relationship and contact between PCP and specialist at time of referral, by insurance type

Insurance type	Prior relationship w/ consultant	Any contact at referral	Direct contact at referral	Any contact for routine referrals	Any contact for non-routine referrals
Managed care (%)	50	39	24	36	51
Non-managed care (%)	66	48	34	48	53
	$X^2 = 5.8$ $N = 376$	$X^2 = 1.8$ $N = 376$	$X^2 = 2.2$ $N = 356$	$X^2 = 2.6$ $N = 282$	$X^2 = 0.03$ $N = 88$

Table 5
Amount of time to schedule referrals by insurance type

Insurance type	Time spent scheduling referral	
	<5 min	> 15 min
Managed care (%)	34	12
Non-managed care (%)	49	25
	$\chi^2 = 4.7$	$\chi^2 = 7.2$
	$N = 343$	$N = 343$

communication and information exchange, as well as give them more control over the referral process. Similar to findings in larger representative samples of providers' referral behavior (e.g., Halm et al., 1997), many expressed concern and dissatisfaction with the referral process under MC, particularly with having to rely only on MC lists of consultants. Some claimed that MC limits their ability to actively choose among consultants. Many were unhappy about not being able to act on their own professional judgement when making referrals.

Typically we think of the professional judgment of physicians as encompassing only clinical decisions regarding patient care, and much attention has focused on the erosion of the doctor–patient relationship under MC (e.g., Castellani & Wear, 2000; Scheid, 2000; Warren, Weitz, & Kulis, 1999). It is important, however, to recognize that professional practice also entails relationships *among* providers. To the extent that MC mechanisms alter professional relationships (Hafferty & Light, 1995), we should not be surprised that physicians often are displeased with it.

Some PCPs in this case study did not believe that established referral relationships were particularly valuable in the referral process. Providers with this view were neither the youngest nor the least experienced, though they did have a somewhat higher percentage of MC patients. Because it is not necessary to actively build referral relationships under MC, in contrast to FFS, providers with a majority of MC patients, or those who practice in predominantly MC regions of the US, may have little reason or opportunity to compare referral mechanisms in different systems of care. These providers may be less likely to view relying on referral networks as part of the professional practice of medicine, and therefore unlikely to be dissatisfied with the referral process under MC.

The PCPs' actual referral behavior in this case study indicates that the referral process does differ for MC versus non-MC patients, such that MC referrals were less likely to be made to consultants with whom the PCP had an established relationship, and were characterized by somewhat less communication and somewhat more logistical difficulties. The case study evidence, however,

also suggests that the reduction in communication in MC referrals may occur for exactly the appropriate type of referrals, i.e., the most routine. Other studies suggest, similarly, that while formal referrals for MC patients may decrease, *informal* consultation among providers regarding MC patients may actually increase (Keating, Zaslavsky, & Ayanian, 1998).

In line with many general concerns about MC, some findings from this case study suggest that MC negatively affects the referral process by reducing communication and reliance on established relationships; this, however, is not inevitably the case. MC attempts to impose bureaucratic structure on health care relationships. As Max Weber (1946) explained long ago, bureaucracy produces significant control and information capabilities. Viewed this way, it is possible to think about how MC could effectively “manage” the referral process by *enhancing* rather than diminishing information and control in the referral process.

MC plans could establish mechanisms that lower the costs of direct communication between PCPs and specialists, for example, by facilitating contact prior to the referral process. The practice by many MC plans of merely distributing a list of “approved” care-givers does not facilitate the kind of valuable communication PCPs say is important in the referral process. Similarly, membership in an IPA, or any provider network, in no way guarantees that providers will establish, or utilize professionally-based referral networks. MC organizations, however, could create incentives and mechanisms for PCPs and specialists to communicate directly during the referral process, especially for non-routine referrals. Further, MC plans could sanction consultants who do not communicate results back to the PCP in a timely manner. Incentives for direct, informative and timely communication would go far beyond the common practice of relying on the standardized referral form. Though it also appears that accurate and appropriate use of referral forms for routine referrals may be both efficient and effective.

An important component of the referral process not addressed by this case study, or indeed in many studies of referral rates and outcomes, is the consultant's side of the referral relationship. Future work on the referral process should address consultants' views of the referral process and changes brought about by MC, such as, whether specialists prefer referrals from known PCPs, and if they identify similar benefits of established referral relationships.

An in-depth case study such as the one discussed here, is not able or intended to identify causal explanations of referral patterns or outcomes. Rather, this study of the referral process is meant to highlight how MC alters delivery mechanisms, in order to begin to understand more completely how MC impacts providers. Recognizing the importance of delivery illustrates that MC

changes not only the doctor–patient relationship, but providers' professional relationships as well. Only by studying the impact of MC on delivery mechanisms as well as outcomes, can we understand the overall impact of managed care, both positive and negative, on health care.

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