Loss of doctor-to-doctor communication: lessons from the reconfiguration of mental health services in England

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Objective: To explore the tensions across the primary–secondary interface when referral from primary care is to a team and to inform service developments in other specialties.

Methods: A nested qualitative study within a randomized controlled trial of primary care and Community Mental Health Teams (CMHTs) in Croydon and Manchester, UK. For the qualitative study, interviews were carried out with general practitioners (GPs), psychiatrists and managers or clinical leads of the CMHTs.

Results: GPs described the need for access to specialist knowledge, which they perceived to lie with the psychiatrist, and referral to a team was not perceived to allow this access. A personal threshold was identified by GPs after which they referred the patient to secondary care. CMHTs and psychiatrists recognized that this personal threshold differed between GPs, but their criteria for accepting referrals did not seem to allow for a flexible response to referral requests, leading to the referral being labelled as 'inappropriate'. The lack of direct doctor-to-doctor communication was perceived by respondents to contribute to a fragmentation of patient care. Strategies were described whereby the system was bypassed to achieve doctor-to-doctor communication, which undermined the team.

Conclusions: Development of intermediate or 'Tier 2' services beyond the mental health services, where the GP refers to a team rather than to a specialist (hospital consultant) could benefit from reflecting on experiences with mental health services. There is a danger that new community services for the physically ill will engender the same level of confusion and discontent described by GPs and other health professionals in this study who are concerned with mental health care. Flexibility is needed within care pathways, including the provision of direct doctor-to-doctor communication together with approaches to minimize the marginalization of non-medical professionals.

Introduction

Recent developments in health policy in the UK, and internationally, seek to 'move care closer to home'.[1] The aim is to develop integrated services, built around new community-based teams that will provide more 'appropriate' care for different levels of need by reconfiguring care pathways across the interface between primary and specialist care.[2] The current policy across all specialties is better to manage the interface between primary care and the secondary or specialist sector, and potentially reduce referrals from primary to secondary care. One way of trying to achieve this is the development of an intermediate tier (so-called 'Tier 2'), where the appropriateness of the referral requested is assessed by a multidisciplinary community-based team with the expectation that assessment of the patient will not always involve the hospital specialist.[3]

It is relevant to current policy that mental health services have been using this approach over the last 20 years, with a gradual change from direct referral from the general practitioner (GP) to psychiatrist towards referral from the GP to a multidisciplinary team. Experiences with this established service reconfiguration can inform new models of working at the interface in other specialties.

GP-initiated referral from primary to secondary care appears to be a deceptively simple process yet it has generated a long-standing debate.[4] Policy-makers and managers tend to view GPs who are high referrers to

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secondary care as performing less satisfactorily than those who make fewer referrals, while some academics have said that the converse is true.[5] The issue is thus complex. There is no direct relationship between patient or practice factors (such as practice size and demographics) and rate of referral, although it is suggested that some GP factors (such as training and experience in a particular specialty) may increase referral rates,[6] while certain aspects of the GP relationship with the patient and response to patient pressure might also influence referral.[7,8] It has been suggested that individual GPs might have a unique 'referral threshold'[9] combining all those characteristics that might have a bearing on the decision to refer such as confidence in their clinical judgement, awareness of the chances of life-threatening events occurring, their current medical knowledge and a need to sustain the esteem of consultant colleagues. This concept was supported in one study of referrals to psychologists, in which it was found that GPs referred when they felt that they had reached the limits of their own capability for treating a particular problem, taking into account the patient's suitability for psychological therapy and access to psychology services.[10] Indeed, in a study of referral to generic mental health services, the authors concluded that, given the emotive responses of GPs to 'minor' mental illness, the contribution of guidelines, which assume consistently rational and predictable responses to illness in determining decision-making about referral, may be limited.[11]

Generic Community Mental Health Teams (CMHTs) are now the main vehicle for coordinating and delivering specialist community mental health care in England.[12–14] The Department of Health has consistently recommended that CMHTs should refine their role and focus care on those patients with greatest need.[15–17] It has, however, proved difficult to establish consistent priorities due to the difficulty in agreeing what constitutes 'greatest need', and a lack of alternative provision for patients with common mental health problems. A key issue for CMHTs, therefore, is how they gate-keep access to their service.[18] Previous studies have suggested that gate-keeping decisions have been largely determined by individual clinicians and teams, rather than through formal strategic control.[19] Some authors have suggested that 'consultation-liaison',[20] a new model of working that necessitates setting up more effective channels of communication between primary and secondary care clinicians, might limit referral, however there is no evidence to support this in the literature,[21] and some to the contrary.[22] It has been reported[23] that referring to a team can impede the establishment of professional relationships and transfer of knowledge.

The use of qualitative methods allows the exploration of the perspectives and attitudes of professionals in the context of their organizations and health care teams,[24] detecting obstacles to changing performance and explaining why improvement does or does not occur. The aim of this paper is to identify the lessons the National Health Service (NHS) and other similar systems might learn relevant to the re-organization of changes in referral management and policy-encouraging innovation and new models of care with blurring of professional boundaries,[1] from the reconfiguration in mental health services over the past 20 years.

Methods

This qualitative study was nested in a multisite cluster randomized controlled trial (RCT) to investigate the Threshold Assessment Grid (TAG),[25,26] a brief assessment of mental health problem severity and risk designed for use when referring patients to adult mental health services. The CMHTs studied had explicit referral criteria which advised referrers that the team would provide advice and care for patients with severe mental health problems. The study was carried out between January and September 2005 in Croydon, South London and Manchester. GPs (from both intervention and control arms of the main study) and mental health team leaders and consultant psychiatrists in 11 CMHTs (8 in Croydon and 3 in Manchester) were invited to participate in semi-structured interviews. Purposive sampling of GPs was used to ensure variation in practice size, GP gender, ethnicity and experience. A total of 35 interviews with GPs were carried out by CM and MSt. Team leaders (12) and psychiatrists (14) in the TAG study were invited to participate in interviews and a total of 17 (12 team leaders and 5 psychiatrists) consented and were interviewed by CM, MSt, CCG and LG.

The semi-structured interviews lasted between 30 and 90 min and explored the referral process from the perspective of the respondent and their professional background, as well as the barriers and facilitators to the use of TAG in the referral (by GPs) or decision-making about a referral (psychiatrists and CMHT leads), which are not addressed in this paper. GPs were asked to describe characteristics of patients whom they wished to refer to the CMHT, expectations of a referral to the CMHT, working with the CMHT and relationships with colleagues across the interface. Interviews with psychiatrists and CMHT leads explored views on what sorts of patients the team would assess and manage, the appropriateness of referrals made by GPs, and relationships with GPs and within the team. The interviewer used a combination of open questions to elicit free responses, and more focused questions for probing and prompting. All interviews were audiotaped with consent and transcribed verbatim. The interview schedule was modified in light of emerging data and interviews were continued until category saturation was achieved.[26]

Analysis of the 52 interviews was completed independently by four of the authors from the research team with differing professional backgrounds (GP, psychiatrist, nurse researcher and psychology researcher) and perspectives. Analysis proceeded in parallel with the interviews and was inductive. Transcripts were read

and discussed by researchers and coding was informed by the accumulating data and continuing thematic analysis. Thematic categories were identified in initial interviews which were then tested or explored in subsequent interviews where disconfirmatory evidence was sought.[27] We used 'framework' analysis techniques to facilitate pattern matching and building explanations between the sets of data.[28]

The study was approved by Metropolitan Multicentre Ethics Committee (04/MRE11/8) with Local Research Ethics Committee approval in London and Manchester, and research governance support from the Manchester and Croydon Primary Care Trusts and South London and Croydon Maudsley NHS Trust and Manchester Mental Health and Social Care Trust.

Results

To ensure that reported data remained completely anonymous, all participants were coded via GP practice/CMHT name (allocated a number) and individual professionals. Data presented in this paper are identified by respondent's profession (GPs – general practitioners, CMHTs – community mental health team leaders and Psych – consultant psychiatrist). The team leaders were mental health nurses, community psychiatric nurses, occupational therapists or social workers. Data are presented to illustrate the themes that are particularly related to the process of referral across the primary–secondary interface.

Access to specialist knowledge

GPs reported making referral to CMHTs for two reasons. First to obtain access to 'specialist knowledge' which they perceive to lie with the psychiatrist (the 'specialist') and which enables them to manage the individual patient, and also to manage future patients, but not with the goal of transferring care and clinical responsibility:

'...I wanted a consultant's opinion rather than it being an urgent situation were somebody was suicidal, it was just a consultant's opinion where, where, a patient was really extremely challenging to treat...' (GP 610/190)

The second reason is to request team input to the care of the individual patient:

'Well in those cases, it isn't about getting a diagnosis, it is about having someone to share the burden of caring for the patient.' (GP 620/172)

GPs were emphatic that where specific advice about diagnosis of management was requested, it was the psychiatrist whom they wanted the patient to see:

'...And it was a situation where it needed a consultant to see the couple... saw them once, gave that consultant opinion, didn't need any other input... that was a really good example of using the consultant for a consultant's opinion...' (GP 630/168)

Psychiatrists promoted the view that the expertise for the holistic assessment of a patient and decisions about management lay with themselves:

Interviewer (prompting the respondent about the roles of the CMHT members): 'So, within the team?'
Respondent: 'I do believe that doctors do probably have a more holistic view of the patient, in that we have a different perspective in terms of the longitudinal history of the patient, rather than having a cross-sectional view. And while, so we have got sort of, a multidisciplinary view, but also I think a more longitudinal assessment of the patient... I think CPNs tend to have a more cross-sectional view, as well as social workers.' (Psych 23/1)

Perhaps surprisingly, the CMHT team leaders also described how they viewed the psychiatrist as the expert within the team:

'...it is the consultant who provides, I suppose, expertise and advice specifically around medication and diagnosis...' (CMHT 13/1)

The lack of direct communication between GP and psychiatrists was seen by both primary and secondary care doctors as a key difficulty in the referral process, creating a barrier to access for patients:

'So not knowing the GP makes the referral difficult to assess for the team. In the days when I knew all my GPs on the patch, I knew when to take a referral seriously.' (Psych 24/2)

CMHT leaders noted the impact that the lack of direct communication between doctors had on the relationships with primary care:

'...there's a big gap between our consultant and the GPs, you know, he doesn't have any direct contact with them, he doesn't know them, so that changes the relationship.' (CMHT 23/1)

Thus, all respondents recognized that the reduction in direct doctor-to-doctor communication had affected the referral process. GPs described a need to have access to specialist knowledge, which they perceived to lie with the psychiatrist, as did the psychiatrists interviewed. Perhaps interestingly, CMHT leads also suggested that certain specialist knowledge lay with the psychiatrists and that the reduction in doctor-to-doctor communication had reduced GPs' access to this knowledge.

Personal threshold

GPs described a personal threshold for referral which relates to their feelings of confidence and competence with an individual patient:

'...once I've decided I can't hold that risk myself, I'm afraid I do want the, the more expert team to see them...' (GP 649/176)

'...and sometimes you feel, you know, you're treating the patient and you still need the support. Just to, sort of, for the consultant or specialist to say, 'yes, what you're doing is right, just carry on.' (GP 399)

The variation in confidence and competence between GPs was well recognized by CMHT leads and psychiatrists who accepted that the threshold for different GPs would vary:

'...I think for a lot of GPs it's, for them, there are issues around how comfortable or competent they feel in dealing with people with mental health issues...' (CMHT 17/8)

'I suppose to a degree, I'm somewhat reluctant to say that there is a problem because, you know, at the end of the day, a GP is a GP. And if someone's causing them a problem and they want a second opinion then to some degree I think, you know, as a mental health, no not as a mental health, as a medical practitioner with expertise, they should be allowed to ask for help and support with clients.' (Psych 23/3)

In addition, GPs described how the role of secondary care should be to provide help, support and expertise to the GP, but CMHT leads did not feel that this broader role was possible within their tight referral criteria which did not allow for any variability in the confidence of the referring GP:

'...there are some GPs out there who've got special interest in mental health issues who will actually keep patients on because it's for their own sort of professional interest and development... and then you'll get others who are just so swamped and so overloaded that the merest hints that a person might be depressed... is their sort of reasoning for... referring...' (CMHT 17/8)

Thus, the personal threshold between GPs was seen to be understandable by psychiatrists who felt that the system should be flexible enough to accommodate this, whereas the statements made by CMHT leads suggested that they resented this variation in confidence between GPs.

Having to justify referral

Much of the data in GP interviews contained discussion of patients and situations where GPs had encountered difficulties in getting the CMHT to accept referrals. The CMHT was perceived by all GPs as looking for reasons not to accept referrals:

'...it seems to me that everybody... their first thought when they get a referral is how can I push this away? How can I get it off to somebody else and become somebody else's problem? Not how can I help this patient? You know, and that I think goes from the lowest office clerk to consultants yeah... their first thought is how will I ditch this? Not how do I help this patient?' (GP 16/171)

'...the way to do it is not to make the hoops ever more difficult to jump through because GPs are world class, if there was a hoop jumping Olympics we'd flippin' win hands down, yeah.

Making it more difficult to get a referral through, it will not stop inappropriate referrals...'(GP 16/191)

'...we are effectively having all of our referrals... vetted and somebody says 'yes, this is reasonable, no, it isn't'. How patronising is that? And it's really, galling, a nuisance...' (GP 262)

The last quote illustrates the attitudes of a number of GPs to the system of their referral being judged by a multidisciplinary team, and this may link with their wish for direct doctor-to-doctor communication. This attitude may well be perceived to undermine the non-medical professionals within the CMHTs.

Gaming

Psychiatrists were aware of the gaming that went on so that GPs could have a patient assessed by the CMHT:

'I suspect that people tend to tick the more extreme forms of suicidal risk to get the patients seen and into secondary services... Anybody who knows anything about games theory would tell you and they'd be quite right to do it, I'd do it.' (Psych 23/2)

But to access specialist knowledge and avoid the need to justify referral to the team, GPs described strategies to bypass the team:

'So, if I really want the patient seen, if I want that certainty, I will simply ring [names Psychiatrist] and speak directly to her. She always sees them for me.' (GP 284)

About half of the psychiatrists admitted seeing patients who were directly referred to them:

'You do still have a number of GPs probably who will want to write, who'll write straight to me and I would look at the letter and, the ones which they write straight to me probably will be, "Dear ..., I'd like you to see this patient, can you see him yourself because of the following reason?"' (Psych 25/1)

One psychiatrist disclosed that he bypassed the CMHT referral meeting and saw patients himself when the GP requested this, even when the team had agreed that the referral was not 'appropriate' for them:

Q: And do you see people... are those people seen or does the majority view...?
A: Yes. Well I just say I will see the patient. (Psych 23/1)

This apparent collusion between GPs and psychiatrists could serve to undermine both the referral system, the function of the team and the expertise of CMHT members. The CMHT leads recognized that the psychiatrists in the team would bypass their system and this had a uniformly negative effect on their perception of team function and relationships:

'They think that if we, if we assess somebody as not suitable for the service and they feel that's not right or that there isn't the services for that person, they sometimes go over our heads and

contact the consultants directly... 'cos it's a doctor to doctor thing, "these pesky nurses are getting above themselves".' (CMHT 24/1)

One team, however, described how their team was less dominated by the psychiatrist and they perceived that their team offered a flexible approach to referrals and to have a lower threshold for accepting referrals:

'CMHTs, I think, nationally, have some very common features, but our role, I think the way that we work, I suppose we have our own characteristic, which is, I think, we're a very flexible team, we probably have a lower threshold for accepting some assessments than others, certainly people that sort of walk in and request a service, for example. We are less medically led than other teams.' (CMHT NE 15/4)

Fragmentation of care

The consequences of tight referral criteria and the lack of direct communication between GP and psychiatrist were identified as causing fragmentation of care leading to some patients 'falling through the net' resulting in no service being available to them:

'...And there is a patient there who just needs to see somebody. And this bouncing of referrals, I don't think is very good for the patient. And that has happened a few times. And all of that just adds on to the time that somebody's waiting, or worse, they fall through the net' altogether. And I find that quite difficult.' (GP 357/128)

'...At the moment there is still an uneasy and unhelpful situation where you find that we are expecting secondary care to do it, sometimes secondary care are expecting us to do it and I think there needs to be clear demarcation with adequate communication between us so that we know who is doing what...' (GP 406)

The lack of alternative services was identified by GPs and CMHT leads as an alternative reason for this fragmentation of care:

'...maybe these patients don't need to go through secondary care because they might need other resources. The other thing is, those resources aren't there, then, you do get a degree of patient pressure to do something...' (GP 406)

'...we've become too specialized...the service has not grown to look after those we used to see like people with depression, anxiety and neuroses...' (CMHT 23/2)

'...theoretically, we have an operational policy which suggests we work with people with severe mental health problems, but we get' all kinds of people referred... and there is nowhere else for them to go' (CMHT 15/2)

The psychiatrists identified this fragmentation and described how the system was operating at risk because of communication issues both within the team as well as across the primary–secondary interface, in addition to interpretation of the referral criteria:

Sometime is there gonna be some disaster with a patient because a GP refuses to go out and refuses to see the patient, says it's community mental health, and the community mental health team will say, "It's nothing to do with us, it's out of hours," and the consultant isn't informed, or the consultant says, "It's not my responsibility, I'll do a domiciliary with the GP," and something happens and that's gonna get to enquiry level if it happens. These are things that have been brought up in the local negotiating committee [names Trust] again and again and again.' (Psych 24/3)

It was recognized by psychiatrists and CMHT leads that the functioning of the team and line management responsibilities are not clarified within CMHTs, and both groups disclosed feelings of unease in working in such a situation:

'I think the criteria's always changing... depending on the knowledge, depending on the skills, depending on the input of your consultant... I think an awful lot of it sometimes depends on the personalities and the sort of people in the team...' (CMHT 17/7)

'It's not a very fair situation, I don't think, to put clinicians in 'cos it's giving you responsibility without power or authority, which is, I think you have to be able to live with the strategy and not let it bother you.' (Psych 24/3)

All respondents identified managing risks within their everyday work that arose particularly from their way of working, and reported concerns about the implications for patient care and safety.

Discussion

Main findings

There is a need to take account of the impact of any system change on all the health professionals working within a system, such as the impact on GPs of an imposed restriction of access to 'specialist knowledge', which they perceive lies with the hospital specialist (in this study the psychiatrist). The personal threshold that other studies report[6] is well described by GP respondents in this study, with a feeling that once that threshold is reached, referral for expert opinion is the only option. Referral threshold varies between GPs, so that a referral is made partly on perceived clinical need, but also on the personal capacity and/or competence to continue to manage the patient in primary care. The referral criteria within the individual CMHT, however, only take into consideration clinical need and risk, even though CMHT respondents individually recognize that their personal knowledge of the GP and a judgement about his or her competence may subtly influence whether or not a referral is accepted.

This is recognized as a legitimate part of the referral process by psychiatrists who describe how they bypass the imposed system to see patients, and by CMHTs who describe knowing and responding to perceived varying levels of competence in their GP colleagues.

GPs describe a perceived threat to their professional autonomy in decision-making about referrals by having to negotiate a referral through the CMHT. This leads to a situation in which psychiatrists and CMHT respondents particularly describe 'game-playing', with a manipulation of referral details to fit imposed criteria. This could also lead to an undermining of non-medical team members and a marginalizing of their expertise. As a result of bypassing the system, lines of responsibility for the patient seem unclear and there is a danger of patients 'falling through the net', a situation about which all health professionals involved express concern.

Our data contrast with previous work in the USA,[29] where high levels of satisfaction with communication across the primary–secondary interface were articulated by psychiatrists, but supports other work[23] on the single point of access, which suggested that this impeded the establishment of professional relationships and was particularly negatively viewed by GPs (but not by mental health professionals).

Poor communication and arguments or judgements about the referral criteria and appropriateness of referrals have a negative impact on patient care. Policies for management of referrals across the interface must take into account the need for flexibility around referral criteria.

Implications for the development of other services across the primary–secondary interface

The UK NHS is currently seen to perform well internationally in terms of efficiency because of the gate-keeping role of GPs.[30] The proposed policy changes, with the development of 'Tier 2' and management referral centres will reduce this gate-keeping role and limit GPs' access to a hospital specialist and with this comes the loss of the direct relationship between GP and specialist.

There is a need to minimize barriers to referral by allowing generalists to work to the limits of their knowledge and skill, and to refer easily and promptly to their specialist colleagues (who may or may not be medical doctors) when those limits are reached. In addition, specialists need to be allowed to use their skills maximally by being enabled to work with a selected population for whom their particular skills are needed. This is said to be a more appropriate way of providing good quality patient care, minimizing risk and utilizing the complementary nature of the generalist and specialist.[31] In addition, expectations of GPs will

need to be explored and modified if referral behaviour is to change so that referrals are made to a team and the expertise of non-medical professionals is not undermined and marginalized.

Current NHS policies seek to reconfigure care pathways and enhance multiprofessional working through a focus on new community-based, or 'Tier 2', teams. As such changes have already occurred in mental health care, there are lessons for those seeking to develop new models of working at the interface in other specialties and we make specific recommendations to policy-makers based on the results of this study (Box 1). Without such clarity of vision, there must be concern that 'Tier 2' services for the physically ill will simply engender the confusion and discontent described in this study, and experienced daily by GPs and professionals who work with patients with mental health problems.

Initiatives which seek to move specialists out of hospitals must learn from the last two decades of reform in community mental health services. Thus far, initiatives to change service configuration beyond mental health care have largely been limited to simply moving outpatient clinics into the community, which have been demonstrated to provide poor value for money[32] and the development of a new cadre of GPs with a special interest,[33] which is as yet somewhat patchy and lacking formal evaluation.[34]

Current evidence would suggest that if interventions are to be effective in improving outcomes of care and reducing referrals and admissions, they need to be incorporated into more complex, multifaceted interventions involving closer collaboration with primary care[31] along the lines that have been described in the multifaceted approach to service re-design known as the Chronic Care Model.[35] This should move beyond the development of looser linkages such as 'consultation-liaison', which only seeks to increase contact and communication between specialists and generalists, to the development of clear and transparent care pathways in which the role and responsibilities of the hospital specialist (as well of other professionals) are clearly defined, and the generalist still has appropriate and negotiated access to specialist advice.[36]

Strengths and limitations of the study

The strength of this nested qualitative study in an RCT of a new referral method, lies in its geographical

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Box 1 Recommendations for the development of 'Tier 2' services

Strategic discussions are needed between primary care, Tier 2 services and secondary care to identify the best demand management strategy, rather than the imposition of strict referral criteria and thresholds by the Tier 2 service.

Policy needs to reflect the clinical reality that primary care clinicians sometimes need advice or respite, and that clinical need is not the only factor under-pinning referral behaviour. It needs to legitimize short-term involvement by Tier 2 services to support patients in primary care.

Referral criteria need to be flexible so that GPs can request access to specialist knowledge and expertise (which may or may not lie with a doctor) by direct communication between clinicians.

Expectations of GPs will need to be explored and modified if referral behaviour is to change so that referrals are made to a team, and non-medical professionals are not undermined and marginalized.

coverage – 35 practices and 11 CMHTs in London and Manchester. The study is limited by the apparent reluctance of psychiatrists to be interviewed (for reasons which we were not able to explore, as direct communication between psychiatrists and the research team was limited), so caution must be applied in interpreting this data-set. In addition, we did not interview other CMHT members, such as psychologists, who may have different perspectives and views.

Finally, we assume in our recommendations for developing 'Tier 2' services in other specialties (Box 1) that the same issues apply to referrals for physical problems as for referral of patients with mental health problems. This may not be necessarily true, though it is plausible.

Acknowledgements

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