EDITORIAL

Let Them Down Easy

By Philip A. Baer, MDCM, FRCPC, FACR

My patient of 26 years calls to let me know he needs a referral to a rheumatologist closer to home. Not an uncommon request these days, with virtual visits receding, and in-person visits requiring long commutes in post-pandemic traffic becoming the norm again. No problem: I keep a list of area rheumatologists just for this purpose. I choose a colleague, send the key information, and wait.

Two days later, I receive a fax back headlined "Not Accepting New Referrals." At first glance, this doesn't sound good: I had talked up the virtues of this rheumatologist, and now I must start over. However, closer inspection of the document makes me happier. While my selected colleague is not accepting consults, they have passed my request over to a new associate in their office. I'm totally fine with that.

There is an art to rejecting referrals. First, you must be comfortable with the fact that this is allowed, as long as it is done in a non-discriminatory fashion. You are perfectly free to limit the types of diseases you offer care for in an outpatient practice. That isn't the case if you are on-call to an emergency department or providing in-patient consultations. A few years ago, I was representing rheumatology in a provincial medical association health care sustainability working group, looking at improving the appropriateness of medical care. The idea of rejecting referrals was novel to many of the other specialists. I proposed a small fee for triaging referrals and providing alternatives for rejected referrals, but unfortunately, this idea has not yet been implemented.

You also must be cognizant of the supply-demand equation in your specialty. During the early pandemic, when referrals dried up, one couldn't be as choosy. In normal times, we all know there is a shortage of rheumatologists to service the demand for care, even in many urban areas. Read the "Stand Up and Be Counted" articles from the CRA if you want to review the evidence.[1]

I rarely have someone sitting in to observe my office, but I still remember having an American physician who worked in industry and was new to rheumatology come to visit, en route to a meeting we were both attending. Between patients, I was handling documents, one of which was a new referral. I declined the consultation, sending a note back with my reasons and alternative suggestions. My colleague was aghast, as he told me that I would never get another referral from that physician. I told him I doubted he was right, but I could live with the consequences. Sure enough, two hours later I received another referral from the same physician, which I accepted.

Offering options beyond a simple rejection is vital when triaging referrals. As a referring physician myself, I don't want referral rejections that simply inform me that the consultant I had selected does not perform a particular orthopedic procedure, or only deals with cosmetic dermatology. My patients and I are looking for solutions, not roadblocks. Similarly, when I cannot accept a referral, I don't want to leave the requesting physician in limbo or feeling lost. My plan is to reject quickly rather than leave someone hanging, and to provide concrete alternatives to advance the patient's care.

My rejected referral letter is my opus: clear, comprehensive, and tailored to the situation. I don't start with a negative headline, but with an acknowledgment of the referral, followed by specific reasons outlining why I cannot accept it. Then, I provide suggestions for alternative pathways for the patient, including links to relevant clinics, and the names, phone and fax numbers of other specialists who might be able to assist. The template is dynamic, with frequent additions keeping it relevant. For example, when I heard a colleague had developed an interest in fibromyalgia, I added their contact information to be included for relevant referrals in that domain.

I am also sensitive to the fact that long-established referral patterns may mean that the family doctor and I practice in proximity, but the patient may live far away from both of us. Directories of rheumatologists do exist, such as on the ORA website, but family physicians may not yet be in the habit of consulting them. I try to assist by suggesting rheumatologists who may be more convenient for the patient. After all, does it make sense for a patient to drive 90 minutes each way to my office, bypassing the offices of dozens of my colleagues, to see me? Environmentally, clinically, and in every other way, my answer is no.

Most recently, a patient was referred with a host of non-specific symptoms post-COVID infection. Comprehensive imaging, lab and serologic studies were all normal. I felt there was a low likelihood that the patient had

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a defined rheumatic disease. I could accept the referral, have the patient wait months to see me, and confirm my immediate appraisal. Instead, I consulted Dr. Google and found an excellent directory of post-COVID resources and clinics on the website of the Ontario College of Family Physicians (OCFP)[2], including the following:

"On June 7, 2021, Unity Health Toronto launched a new Outpatient Post-COVID Condition Rehabilitation Program at Providence Healthcare. This program will support medically stable patients who are experiencing non-urgent post-COVID-19 symptoms through an inter-professional team that includes a physiatrist, an occupational therapist, physiotherapist, speech language pathologist, and social worker. Additional consultation services from other health disciplines such as a pharmacist or dietitian are available as needed, as well as access to medical specialty consultations."

That is far more than I could ever hope to provide in my solo office practice!

I always end my rejection letter with the phrase "Feel free to call me if you wish to discuss this matter further." Such calls are rare, but if someone takes the time and makes the effort, I am usually willing to reconsider my position.

It really helps to remember why triage is so important: it improves access for patients who can truly benefit from rheumatology care, while providing alternatives to languishing on a long wait list for those who can be redirected to more appropriate alternative resources.

Issues with referrals are highlighted in several recent articles I came across:

Dr. Alykhan Abdullah, an Ontario family physician (FP), writes about "A Day in a Life of a Family Physician", which sounds far worse than any day in my working life, and one of his many issues is "failed referrals to specialists without any guidance." As he doesn't refer patients to me, I can't help him directly, but maybe this editorial will help indirectly.[3]

Dr. Jabir Jassam, also an Ontario FP, points out in a Medical Post article "Do FPs cause delays in other specialists' wait time?" that "unnecessary referrals prolong the wait times of other doctors, but also the wait times of family doctors themselves because—besides the time consumed writing, attaching files and faxing the referrals—they may need to read all the incoming reports. In my opinion: The wait time for some specialists is very long for many reasons and family doctors are one of these reasons."[4]

Finally, an editorial in the July 2022 issue of *Arthritis Care & Research* highlights the value of clinical academic rheumatology practitioners in the American context. The authors recommend: "Screening of all outpatient rheumatology consults and scheduling of only patients with an inflammatory rheumatic disease in the university outpatient rheumatology clinic, assuring that patients most in need of rheumatologic care are seen in a timely manner and that more complicated cases are available for training fellows and residents. The university hospital administration recognizes the advantage of scheduling these patients who generate higher evaluation and management codes (in other words higher fees) and significantly more downstream revenue for the hospital compared to patients with noninflammatory musculoskeletal problems." Well, I am not triaging for financial reasons, but the theme resonates.[5]

Key learning: You can reject referrals but do it kindly and provide alternatives to the referring health care provider.

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