Building and Maintaining a Referral Base

Whether you are just starting practice or you've been practicing oncology for 30 years, a key to getting patient referrals from other physicians is to gain the referring physician's trust. And, of no surprise, the way you do that is by providing good care, communicating well, and being available to them. But specifically how do you make a good impression on potential referring physicians, and if you're new to practice, how do you even meet them?

Find Ways to Let Them Know Who You Are

When you are just starting out, the practice you are joining is your biggest ally in helping you meet physicians in the community. Jivesh Sharma, MD, who heads up Texas Cancer Associates in Dallas, Texas, says of the group's role, "We're stakeholders in helping [our new oncologists] establish as successful a practice as possible." Sharma has been successful in both building his own referral base and helping new oncologists. When he started practice 14 years ago, he joined two other physicians, one of whom was a colleague during training. The group now has seven oncologists and three midlevel providers.

Sharma offers several ways the senior partners can assist new group members. "We introduce them to physicians that we have long relationships with, and sometimes even include those physicians in the interview process so they know who's coming." He adds, "Senior members of the group can take them on rounds or stop by physicians' offices and introduce them. Sometimes we hold a reception for the new physician in our lobby or at the hospital. The hospital also has meet-and-greets that new physicians can attend."

The call rotation is also an opportunity to meet referring physicians. "Taking call together is part of the handoff in adding the new person to the family of physicians within the practice," says Sharma. "Then, by taking care of each other's patients, we get to know each others' referring physicians, and the comfort level builds."

As an oncologist fairly new to practice, Jason Beckrow, DO, agrees that mentoring and introductions from a senior oncologist are invaluable. Beckrow has been in practice nearly 2 years in Lansing, Michigan, at the Michigan State University Department of Osteopathic Medicine where he trained. He joined a local solo practitioner who had an established referral base she had built over 25 years. "When one of the [referring] doctors had a new patient, she would say, 'I have a new partner,' and would steer referrals to me. So I was able to take advantage of her referral base as well as build relationships independently with physicians where I had trained."

A written announcement is another way that senior partners can introduce referring physicians to a new associate, as Beckrow reports. "Just before I joined her practice, she sent out a letter with my picture and credentials, welcoming me to the practice. It was also a thank-you from her for all of the referrals over the years."

Do Good Work, Be Nice, Build Trust

Both Sharma and Beckrow emphasize that the cornerstone of building a referral base is providing excellent patient care. Effective communication with both patients and their families is a critical part of that care. "Cancer is a life-threatening illness, so the level of confidence that both patients and their families need to have is higher," Sharma points out. "I think the referring physicians are aware of how well you help patients navigate through their fears, because otherwise [the referring physicians] have to do that."

An internist with 30 years' experience, Patrick Logan, MD (Northwestern University Feinberg School of Medicine) of Winnetka, Illinois, agrees. "Oncologists' credentials are a baseline for me to refer to them, but once I know they are smart and have good training, then the personal interaction in the case is really important. How do they interact with me and with the patients? And not only the patient, but the spouse and the children."

Other physicians may be aware of your interpersonal skills even before they have met you, and your communication with patients and families is not the only interpersonal competency that is important. "I'm at the hospital every day," Logan says. "I see the oncologists on rounds—how they interact with house staff, how they treat the medical students and the first- and second-year residents."

Commenting that the key elements of being respected are "kind of simple stuff," Beckrow shares what he calls the best advice he ever received: "No matter where you are, you need to work hard every day, do good work, be respectful of people, and build a reputation. It takes years." He adds that while a reputation is not made overnight, it could possibly be destroyed overnight.

"Referring physicians have to feel you are competent and feel comfortable with you—they are trusting you with their patients," Sharma stresses.

Have Good Office Staff

Your office procedures and the interpersonal behavior of your staff are also a critical part of your total service. Systems should be in place so that referring physicians' calls are put

through to you promptly, and your appointment secretary should know your priorities in working with new patients. Be sure written reports to physicians are processed promptly and accurately.

Interpersonal skills of clerical and clinical staff make strong impressions on patients, who in fact interact more frequently with your staff than they do with you. And patients do report back to their primary care doctor about the care they received.

“It’s the whole package, not just the oncologist,” Logan comments. “The new oncologist needs to know that he can be the smartest guy in the world, but if he doesn’t have a compassionate secretary, and biller, and chemo nurse, he has nothing.”

Conversely, positive staff interactions with patients are big pluses for your practice, and patients also tell their physicians about the kindnesses they received. “Everybody really needs to know that the little things they do are so important,” Logan says. “I go and thank them. ‘Mrs. Jones told me you were as nice to her as you could have been, and you were nice to her family.’”

Clear Any Barriers

Make sure there are no obstacles that could keep you from getting referrals, such as the credentialing process, misunderstandings, or previous problems.

For oncologists joining a new practice, it’s critical to begin the credentialing process for insurance plans and hospitals well in advance of starting practice. “The process of getting on the plan needs to begin 6 months ahead of time,” cautions Sharma. He notes that a new physician needs to have a state license, a provider number, and to be part of all of the insurance panels used locally. “A lot of that work begins a few months before someone starts,” he says, adding that completing the relevant applications is another area in which the group can help a new associate.

A misunderstanding—about your area of specialty, your credentials, or your availability, for example—could also deter a referral. Beckrow says that the location of his office had led to a misunderstanding. Because his office is across the street from Lansing’s Sparrow Hospital, some physicians at Ingham Regional, where he trained, assumed he was a Sparrow employee. Beckrow addressed that by making rounds at Ingham as much as possible. “I’d run into someone on the elevator who would say, ‘I thought you worked at Sparrow,’ and I would say, ‘No, I’m in private practice.’ My referrals from Ingham are going up because that message has been disseminated.”

It’s important to be aware of your individual reputation among the medical community, as well as that of the practice as a whole. A physician joining a practice in a new city may

not be aware of the existence of unresolved personality conflicts, the perception of a lack of availability, or other complaints about the practice. Indeed, group members themselves may be unaware of problems perceived by referring physicians.

If a physician has referred to you in the past but no longer sends patients, try to find out why. Make it clear that you want him or her to be candid, and listen carefully, without being defensive. You may learn about staff problems, reports that were deemed inadequate, a misunderstanding that you can clear up, or behavior that you need to change.

Teach

Helping the patient is, of course, both the referring physician’s and the oncologist’s goal in a referral. As oncologists, you have an important role in educating referring physicians as well as the public about advances in cancer care and the efficacy of chemotherapy and other treatments for improving patient care.

Some recent studies have shown that some patients who might benefit from chemotherapy are not being referred at all. An abstract presented at the 2006 ASCO Annual Meeting showed that primary care physicians were less likely to refer patients with stage IB non–small-cell lung cancer (NCSLC) than patients with stage IIB breast cancer.¹ In addition, physicians were more likely to know that chemotherapy improved survival rates in patients with advanced breast cancer than that chemotherapy improved advanced NCSLC survival rates. The authors concluded that primary care physicians have a significant lack of knowledge about the role and benefit of adjuvant therapy in treating patients with advanced-stage NSCLC, and that this lack of understanding could lead to a less-aggressive referral pattern.

Another study looked at the role of the surgeon in determining referrals of patients with colon cancer to medical oncologists.² After adjusting for tumor and patient characteristics, the study found that surgeons accounted for approximately 20% of the variation in whether a patient with stage III colon cancer was referred to a medical oncologist. Surgeons who practiced in a teaching hospital and who had graduated from medical school less than 10 years earlier were significantly more likely to refer these patients to a medical oncologist.

These two studies highlight the important role of the oncologist in educating colleagues about the state of the science in oncology. Offer to participate in medical conferences and grand rounds attended by other physicians.

Logan, the internist, underscores the importance of the oncologist’s role in teaching primary care physicians. Logan goes to the cancer grand rounds and every oncology conference where a patient of his is being discussed. “Cancer

Tips for Building and Maintaining a Referral Base

- Go out of your way to interact with referring physicians—join them in the hospital dining room, participate in medical society meetings.
- Take a physician to lunch to explain your background and philosophy.
- Volunteer to speak to cancer support groups or at consumer education events.
- Present educational sessions at medical conferences.
- Participate in managed care plans used by referring physicians.
- Be available to see a referred patient quickly—within a day, if possible.
- Be sure your staff members relate well with patients.
- Work at knowing each referring doctor's practice style and communication preferences.
- Be constructive in informing referring physicians about the work-up you expect.
- Keep the referring doctor informed—in the way he or she prefers—about the patient's progress and complications.
- Consider yourself part of a team in caring for the patient.

is a challenge, and it's a big part of what I do. My patients die of cancer, heart disease, and stroke, so I'm there."

Educating patients is also an important avenue for getting the word out about advances in cancer care. Serving as a speaker at cancer support groups is an opportunity for community involvement and teaching the public. Sharma notes that he has given talks for Gilda's Club (New York, New York), serves on the board of the Dallas, Texas, chapter of the Komen Foundation, and has provided education about basic oncology for volunteers with the American Cancer Society (Washington, DC).

Don't Avoid an Awkward Conversation

What should you do if the patient's care by the referring physician was inappropriate? Excellent advice for this very situation was offered by Christopher E. Desch, MD, and Douglas W. Blayney, MD, in a previous *Journal of Oncology Practice* article³:

"[It] can be uncomfortable when the oncologist is referred a patient who has had an incomplete or bungled work-up, inadequate treatment, or is requesting chemotherapy when it is not indicated or when it's too late. While uncommon, the conflicting interests between maintaining good relations with a reliable source of patients (for instance, a referring surgeon who is convinced that the surgery was complete and the

obligation to tell a patient that they still need more surgery) is awkward. The best physicians in private practice create systems of communication and informal education that promote excellence among the doctors with whom they work. Honest and direct communication is the best way to manage these situations."

Because addressing such a situation is challenging and something no one does easily, it's important to remind yourself that medicine is about the patients, not about the doctors. Beckrow advises, "First and foremost, do what you need to do that is right for the patient. Then, find a way to provide constructive criticism, perhaps asking how we as a team can avoid this down the road."

He acknowledges that addressing concerns is especially difficult for a junior physician, but notes that he is "slowly gaining his voice." At first, he rarely spoke up at tumor boards, but finds that he is now more comfortable in his knowledge and skills.

Logan considers feedback from an oncologist important and helpful. "The oncologist has to be able to say to me, 'You know, Logan, you could have done XYZ earlier before you sent her to me.' They are teaching me. I won't be offended. It makes me a better doctor." He adds with a laugh, "They need to be willing to do that gently."

Involve the Referring Physician

Referring physicians want different levels of involvement. "Some want to know everything you are doing with a patient, and some want just the basics—kind of a less is more situation," says Beckrow.

The oncologist should send a written report after each visit to the referring physicians, including a thank-you for the referral. Beckrow says that when the referral has come from a surgeon, he sends the initial report to both the surgeon and the primary care physician. Subsequent letters are sent to the primary care doctor, with a copy to other providers who may be involved. "I err on the side of including more people," he says, "so that if someone develops a complication later, the involved parties will have a record."

Logan says, "What I want oncologists to do is keep me in the loop, not only in terms of what they are doing but also how things are going psychosocially and if there are complications." He also really appreciates a phone call in addition to the written report.

A valuable role that a primary care physician can play is in helping to determine the appropriate place for the patient on the continuum of conservative to aggressive therapy. "It's very helpful when you have a primary care doctor to call—they're going to have their finger on the pulse of where that person is," Beckrow says. "The oncologist needs to build that

relationship with the patient, but until you've established that rapport, the primary care doc is going to know if palliative care would be better than chemotherapy."

Logan couldn't agree more. "That's why I go to the tumor board," he says. "Because the radiation oncologist and the surgeon have no idea who this person is. I've made house calls and know the daughter who will take her to therapy and buy her wig. When they are considering not giving chemo to a 90-year-old patient of mine, I'm going to be able to tell them that she drives a Harley and has a 60-year-old boyfriend."

Logan says that as the primary care doctor, he also wants to be included in the end-of-life decisions—not second-guessing, but being involved. "I'll fight till the end of the day to keep the patient alive if there is hope on the other side of the ventilator, but I won't refer to oncologists who don't know when to give up, or who cave in to what I call the brother-in-law from Peoria." He describes the "brother-in-law from Peoria" as the relative who was never there when a patient needed support, but comes in and wants to disagree with the decision to send the patient to hospice, or knows of some great oncologist in another part of the country.

Communication between you and the primary care physician should go both ways. Ask him or her to let you know how the patient does in the future. "Usually, it's the one-way street of

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bad news," Logan says. "But when there is good news, it's our responsibility to reinforce the oncologists and their staff. They need to know, and their nurses and secretaries need to know, that Mrs Jones made it. All those people that took care of her in the midst of the battle need to know they did a great job, and that 10 years later she is really doing well and has great grandchildren now. And it was because of their good work."

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