

Health Behavior News Service

February 24, 2009

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When Specialists Collide: Too Many Medical Opinions

Where do you turn when the health care team reaches an impasse even as an urgent medical problem calls for decisions and choices that you simply don't feel qualified to make? Help is available if you know who to ask.

When her grandmother experienced a sudden onset of dizziness, slurred speech and facial drooping, Kafi Grigsby found herself in an emergency department waiting room, surrounded by five doctors with four different opinions on what had occurred and how to treat it.

She recalls: "The ER doctor said it could be a stroke. My grandmother has a blood condition and the neurologist said that a blood clot could have caused a TIA. The hematologist said, no, her blood looked good. The vascular surgeon suggested that her veins were thin, allowing blood to 'leak' through. The primary care physician deferred to the neurologist."

A recent study from the Archives of Internal Medicine finds that less than half of adult inpatients could even recite the name of at least one the doctors taking care of them. Yet these same patients and their families must deal with complex situations where specialists' scopes of practice overlap.

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You might be surprised to learn that sorting out a patient's complex case is a specific function of several groups of health professionals. Don't wait for them to find you first — most likely you'll have to 'flag them down' and explicitly ask for their help.

"All these doctors with all these scenarios," Grigsby says. Yet, "we didn't have any understanding of what happened. None of these reasons they gave, at that time or later, addressed her slurred speech."

Grigsby, who is director of communications and public relations for the Center for the Advancement of Health (of which the Health Behavior News Service is a part), has been involved with health and insurance groups throughout her career. Yet the situation left her and her family feeling frustrated and overwhelmed.

Choosing a Leader

You may need to look no further for than the primary care physician — if you have one — for help in navigating a perplexing health care system.

“That’s exactly what a general internist does,” says Sandra Fryhofer, M.D. “We help coordinate the care. It’s like the captain of the ship. When there are conflicting recommendations from specialists, we speak up.”

Putting all the pieces of a case together is a serious matter, not a conversation to shoehorn in during a physical examination. “For something complex like that, an appointment is good,” says Fryhofer, who is past president of the American College of Physicians.

“In acute situations, if someone is having a heart attack, the cardiologist would be in charge and at different times, other physicians take the lead,” Fryhofer says. “But in the whole scheme of things the PCP is the underlying thread holding it all together.”

In the grandmother’s case, the family felt they needed to go in a different direction.

“My grandmother has private insurance and of course, Medicare,” Grigsby says. “In theory, you would think the case manager assigned to her after the blood disease would help her navigate this situation. [But] we never got a call from her health plan at any point, even after all the costly tests and specialists. You think, ‘Why wasn’t the health plan alerted? Why don’t they call?’”

Case managers who are affiliated with an insurance company can help coordinate a patient’s care. However, they are under pressure to make sure that care is cost-effective and to act in the best interests of the health plan. Another route is for patients to seek out an unaffiliated case manager who does not have insurance company ties. The hospital might be able to provide a referral or you could look for local agencies that offer case management services.

It could be that a new breed of medical provider has the edge when it comes to dealing with difficult care challenges. Although “any competent internist should be able to function in that role, as a bit of a choreographer of care,” says Bernard Kaminetsky, M.D., “physicians are very busy to the point of being overwhelmed.”

Kaminetsky is the medical director of MDVIP, a company of medical practices that provide what most people think of as ‘concierge medicine.’ But “we don’t like the term ‘concierge,’ he says. “It conjures up images of heated towel racks. We call it personalized medicine.”

To be sure, the \$1,500 yearly fees that MDVIP charges pales in comparison with the up to \$50,000 fees commanded by high-end concierge or boutique practices.

With lighter caseloads than the average internist, Kaminetsky says that concierge practices allow doctors more opportunity to read the latest journals, research new

protocols and reconcile treatment recommendations — and time is a luxury beyond the reach of internists working 16-hour days.

“In this type of scenario, a family has to have confidence that there is someone who is coordinating care, looking at specialists’ notes, making tough choices,” he says.

Yet another option: families might consider a specialist in the care of the elderly to act as the bridge between patient and specialists.

Ann Mayo, DNSc, is a gerontology clinical nurse specialist. Mostly employed by acute care hospitals, the gerontology CNS “works within the patient sphere, the nurse sphere — and the system sphere,” Mayo says.

“Ideally the hospital employs CNSs who can intervene early on, but if not, by the time a family calls me and says, ‘we want you to advocate for us,’ they are usually discouraged and they’re getting mad,” says Mayo, who is also a professor at the University of San Diego.

She says that even among the most well-meaning specialists, communication can become a problem when there’s more than one disease process at play. “Especially with older adults: they’re frail, and they may have several other conditions, like diabetes.”

In cases where medical wires are hopelessly crossed, “I would pick up the phone and call every one of the providers and say, ‘we have conflicting information; I’m trying to get everybody on the same page here,’” Mayo says. “I would get everybody — including family and patient — together and have a multidisciplinary meeting: ‘Let’s talk about what we know and what we don’t know.’”

Your Voice in the Discussion

If no agreement can be reached regarding the next step, “the CNS would refocus the light beam away from those providers and back onto the patient and family and mediate on what they want, finding out what their priorities are and what they would like to do,” Mayo says.

It’s only natural for doctors to look at cases through the lens of their own specialty, Fryhofer says. “Sometimes you have to weigh risks and benefits. It’s not all black and white, or decisions would be easy.”

Kaminetsky concurs: “There are very hard decisions, and usually no ‘right’ answer. Some considerations are: Does the health care surrogate know the patient’s wishes? Is there a living will? Specialists may all have their biases, one way or another. No intervention? Aggressive treatment? You need someone to sit down with the family and sort through all these issues. In rare instances, I’ve gotten hospital ethicists involved in the discussion.”

Sometimes patients turn to the practitioner they trust the most and elect to follow his or her advice.

“Collectively, as a family, we decided on the vascular surgeon,” Grigsby says. “He was the most thorough, and as a hospitalist [a hospital-based doctor], he could see medical records electronically and firsthand. In the end, we followed the protocol he recommended.”

Ideally, those adrift in a sea of specialists could find an anchor in a “medical home,” in which patients have access to more treatment coordination and support from a care team. But while the medical home concept is gaining support, it’s a long way from being widely available.

As it is, patients and families must get involved when doctors disagree, Fryhofer says. “You have to have these kinds of discussions or the patients will be pushed around like little checkers.”

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Health Care “Choreographers”

These professionals can guide you through a maze of specialists and help unravel complex cases.

Clinical Nurse Specialist: The CNS is a master’s-prepared advanced practice RN, educated to work closely with patients and families and see beyond the acute care unit and hospital into the bigger system. To get a CNS on your case, speak to the nurse manager or nursing director for the unit or facility.

“Concierge” Doctor: An ‘extended-care’ warranty of sorts: by signing up for a concierge or personalized medicine practice, you secure navigation services for the day when your condition becomes highly complicated.

Geriatric Specialist: A geriatrician is a physician with an additional focus on meeting the medical needs of the elderly. The U.S. Administration on Aging offers an Eldercare Locator site for finding local resources:
<http://www.eldercare.gov/Eldercare.NET/Public/Home.aspx>

Insurer-Based Case Manager: Insurer-based case management is triggered by a physician referral or hospital, acute care or nursing home discharge. A specific diagnosis on a claim can also alert health plans that a case manager might be needed.

Internist/Family Physician: For complex cases involving multiple specialists, ask your primary care provider for a sit-down appointment, which may lead to a multidisciplinary meeting of the minds. Depending on the insurer, such an appointment may be covered under your health plan.

Patient-Centered Medical Home: Medical homes strive to make patients “active partners in their care,” with easier access to providers and more information on treatment options. See the Patient-Centered Primary Care Collaborative site at <http://www.pcpcc.net/content/about-collaborative>

Unaffiliated Case Manager: You can ask for a referral from your health care provider. Local departments of aging and disabilities or health and social services agencies may offer — or refer you to — case management services.