Professional-to-professional exchange relationships and their impact on oncology referral patterns and patient outcomes

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Dr Maruf Chowdhury and Associate Professor Gregory Fairbrother

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Certificate of Original Authorship

I, *Tony Hassan Noun,* declare that this thesis, is submitted in fulfilment of the requirements for the award of *Doctor of Philosophy*, in the *Higher Degree Research* at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Preface

For more than 30 years, Tony Noun has been dedicated to the establishment of world-leading cancer treatment centres in New South Wales, Australia, and abroad, which have helped transform the lives of thousands of cancer patients. In fact, many communities in Sydney, as well as numerous regional country areas, would not currently have convenient access to comprehensive cancer care services had it not been for Tony's vision, commitment, and ethic.

As founder and Chairman of Cancer Care Associates, Tony leads a dedicated team of medical professionals that deliver around 50,000 treatments each year, with more than a million treatments delivered over the past 30 years. This commitment to delivering quality cancer treatment means the same high level of care is provided to all patients, regardless of gender, economic status, ethnicity, or religious belief. With a view to constantly improve service delivery, Tony identified an area to explore, that aims to improve accessibility to treatment for both existing and potential cancer patients in the Australian community, which he tenaciously investigates in this thesis.

Tony is also founder and Chairman of the Cancer Care Foundation Limited, a registered not-for-profit charity, established for the purposes of promoting the prevention, treatment and control of cancer affecting human beings by,

- developing or providing aids or equipment to help cancer patients;

- supporting, funding and, providing education and training on causes, prevention, management and treatment of cancer;

- supporting and conducting medical research, including clinical trials, into the causes, prevention, management, and treatment of cancer; and

- providing relief from financial hardship for patients, whether or not in necessitous circumstances.

It is for reasons such as the above, and more, that Tony was awarded the NSW Government Community Service Award in recognition of efforts that go way beyond what would normally be expected of him in his occupation.

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List of Abbreviations

ABIM   American Board of Internal Medicine

AHPRA   Australian Health Practitioner Regulation Agency

COREQ   Consolidated Criteria for Reporting Qualitative Research

GP   General practitioner

HVC   High-value care

IT   Information technology

MDT   Multidisciplinary team

PBS   Pharmaceuticals benefit scheme

PCC   Patient-centred care

PCP   Primary care physician

RMT   Relational models theory

SDM   Shared decision-making

SMP   Specialist medical practitioner

2WW   2-week wait

Abstract

This thesis sought to understand inter-professional exchange relationships between referrers (General Practitioners [GPs] to Specialist Medical Providers [SMPs], and amongst SMPs) in the oncology context, and the impact of these relationships on referral behaviours, processes, and patient outcomes.

A pragmatic-critical qualitative methodology, informed by social exchange (SET) and relational models (RMT) theories, was employed to explore this phenomenon. A descriptive method was taken to data collection, which relied upon a qualitative interview approach. Twenty GPs and 20 SMP were interviewed. The thesis identified how trust, collaboration, reciprocity, and communication regulated inter-professional referral relationships among medical professionals; and how accessibility, cost, patient experience, competitive advantage, high value care (HVC) and medical error can impact oncology patient outcomes. Findings were contextualised to the 'here and now' via the lens of medical professionalism.

Themes arising from the data were tested against current and seminal research, and areas for change were identified. These relate to improving patient access, promoting HVC, and reducing medical error. Trust was found to be fundamentally important to the quality and longevity of the interprofessional referral relationship. Trust's key role in the exchange relationships presents a concern, as the more trusted a SMP, the longer the waitlist/wait time is likely to be, hence impacting on time-to-treatment, which has a cascading effect on HVC, and medical error.

A trust versus accessibility conundrum was identified, which highlighted the need for improvements in communication and accessibility among medical players, whilst continuing to practice evidenced-based-medicine, as well as the need for referral systems to be more patient-centric. The trust/accessibility 'dilemma' has not until now been identified as the basis of research or discussed in general terms, in relevant health and medical service literature. Solutions proffered include adopting an open-referral process; improving GP education in oncology to promote accurate referrals; designing and implementing a comprehensive referral form; and developing a national specialist database.

Executive Summary

An Executive Summary is included in this thesis presentation, to offer the reader a brief outline of key approaches taken, study results generated and theoretical and practical implications arising from the work.

Introduction

Cancer is a leading cause of death in Australia, accounting for approximately 27% of all deaths (Cancer Institute NSW 2014). The identification, treatment and care of cancer is a fundamental concern of organised private and public healthcare services. Referring between professionals in the oncological context is a dynamic, complex process. High-quality practices in relation to interprofessional referral are vital to achieving best patient outcomes. In Australia, there were about 18,000 deaths from medical error each year (Weingart, Wilson et al. 2000). Medical error often occurs in the form of incorrect and/or delayed referral. This has a negative cascading effect on patient outcomes and leads to inappropriate and replicated examinations and, more worryingly, delayed diagnosis.

In Australia, the general practitioner (GP) initiates referral to other medical services and is the primary contact for many patients. This situation creates interdependence and a unique relationship between GPs and specialist medical practitioners (SMPs). Further, relationships between GPs and SMPs are key to referral decisions (O'Donnell 2000; Piterman & Koritsas 2005; Ringberg 2014). This thesis examines interprofessional relationships between GPs and SMPs, as well as among cross-referring SMPs, and the effects of these relationships on referral, high-value care (HVC) and medical error.

High value care is the practice of medicine that brings about the best possible care in terms of both outcome and experience for the patient, while simultaneously reducing unnecessary costs to the healthcare system (Blinmen 2012). A similar contemporary term representing this construct is 'value-based healthcare'. Regardless, medicine has social contractual implications and resides in the service sector of the economy, where high-quality service is critical. Oncology is a specialty domain of medicine where HVC is sought because it has life and death implications (Stewart 2011).

Aim

This thesis' primary aim is the exploration and identification of common factors related to the professional exchange between GPs and SMPs, as well as to such exchange among SMPs, using social exchange theory (SET) and relational models theory (RMT), viewed through the professional medical lens, to develop a conceptual framework that could inform sector-wide change in specialist oncology health care.

The research objectives were:

1. to explore interpersonal, professional and sociocultural drivers of lasting professional exchange relationships that determine referral practices between medical professionals;
2. to describe medical professional perspectives on factors that underpin lasting professional exchange relationships;
3. to better understand the significance of professional exchange drivers as they relate to clinical judgement and decision-making during referral practices/ processes, and address knowledge gaps regarding how this driver-referral practice relationship operationalises in an Australian setting; and
4. to consider the implications of the results for HVC service provision in the private specialist medical sector in Australia.

Methodology and Method

A pragmatic-critical qualitative methodology (Creswell & Miller 1997), informed by social exchange (SET) and relational models (RMT) theories, was employed to explore the phenomenon of inter-professional medical referral in the context of oncology. This methodological approach was taken to position the work strongly with regards its key aim of understanding the dynamics and characteristics of social exchange and the drivers of professional relationships in GP and specialist referral practices in the oncology context. Such exchange occurs in an ethically bound, high-value service environment. SET and RMT were utilised as a theoretical frame to inform the inquiry approach. SET was chosen because of its seminal theoretical positioning as an aid to understanding exchange-based connections between people. RMT was chosen because of its emphasis on relationalities and interpersonal frames which are at play in professional and organisational relationships.

A descriptive method was taken to data collection, which relied upon a qualitative interview approach which emphasised free and open conversation between interviewer and interviewee, but which maintained a theory-driven question-set structure which sat behind the interview encounter.

Data analysis was also influenced by the 'real world' lens of medical professionalism. Barriers and enablers to achieving HVC were identified and assessed as potential contributors to medical error, and potential strategies to reduce error incidence were advanced.

Sampling and data collection

After obtaining Human Research Ethics Committee approval for this study (ETH17-1464), the lead author, as an oncology service provider-researcher, had access to a large group of potential GP and SMP interviewees and applied a purposive sample selection process to obtain a wide spectrum of inputs from participants recruited from diverse locations and backgrounds. The semi-structured interview schedule was predesigned, but each interview triggered unplanned questions, which were followed through to their conclusion.

Forty ($n = 40$) professionals were included in the study sample: $n = 20$ GPs and $n = 20$ SMPs. The justification for sample size in qualitative research primarily rests on data saturation (Francis et al. 2010; Townsend 2013). Data saturation was reached as the researchers iteratively explored transcripts as they became available. Saturation became evident as the same thematic categories already iterated in the ongoing analysis began to repeat, with no new concepts arising at $n = 18$ GPs and $n = 14$ SMPs.

Data analysis

The central concern of the study was to gain an understanding of the drivers of interprofessional relationships and how this affected both GP-to-SMP referral and SMP-to-SMP referral. Sense-making was initially sought, not entirely naively, but in light of theory thought to potentially inform or predict interprofessional referral behaviour—in particular, SET (Molm 2010) and RMT (Homans 1983). Further critical analysis was conducted to explore the findings with specific reference to the role of trust, reciprocity and collaboration in interprofessional relationships that exist in the social contractual

context. Themes seeking understanding about the enhancers and detractors of these relationships were used to help structure the qualitative analysis. In addition to manual coding and verification procedures, NVivo software was used for organising and analysing the data to ensure data integrity and validity.

Results and Discussion

This thesis sought the perceptions of GPs and SMPs about referral processes, the patient's role in referral processes, the development and maintenance of interprofessional relationships, medical professionalism and HVC provision. The key themes that emerged from the data as both drivers and maintainers were trust, reciprocity, collaboration, communication, patient experience and accessibility.

In identifying areas of development that might improve patient experience, reduce medical error and help in HVC provision, the participants from both sample groups identified key aspects for change: improving communication to reduce testing duplication; increasing accessibility to limit delays to specialist consultation; improving GP education in oncology to facilitate more accurate referrals; and exploring the potential of developing system-wide protocols to reduce negative instances arising from the effects of competition between public and private systems.

Trust was found to be fundamentally important as the strongest contributor to the durability of an interprofessional referral relationship. This result is predictable by SET and is widely found in the extant literature. However, trust's key role as a maintainer of exchange relationships raises a vital problem—the more trusted an SMP, the longer the waitlist is likely to be, as perceived trust (by referrer) and subsequent decision to refer are likely positively correlated. Hence, paradoxically, a highly trusted SMP may be less likely to generate an optimal treatment outcome for referred patients (since the treatment commencement timing is key to cancer treatment outcome). Communication was shown to be key to ameliorating wait-related dilemmas, as quality of communication between referrer and referee was related to negotiated referral decision making by the referrer. This finding is predictable by RMT. Further, collaboration and multidisciplinary team involvement were also found to be important, as was the prizing of accessibility by referrers as vital to their referral decisions. Therefore, a balance is proposed between trust, as an interpersonal moderating factor maintaining influence, and accessibility, as an

extra-personal and pragmatic influence, which may outweigh the influence of trust on decisions to refer. Here lies the theoretical contribution of this thesis, that a combined SET-RMT view can predict the complexities (and potential solutions) at play in a complex HVC operational environment.

Patient experience was also found to be a crucial element to relationship durability, since regardless of trust or perception of clinical expertise, patient feedback to GPs about their experience with SMPs was highly predictive of ongoing GP referral behaviour. This role for patient-centredness as a driver of relationship maintenance was not as strongly found in the context of SMP–SMP referral relationships, where 'tit for tat' referring in the pecuniary interest of practitioners (irrespective of patient-specific factors) remained a commonplace phenomenon. Although such material reciprocity can be predicted by a SET-informed view of this relationship, conversely, the reciprocal exchange for the GP was non-pecuniary in nature and revolved around the prospect of gaining informational access to an expert. These findings are novel to the very small body of literature concerning the SMP–SMP and GP–SMP relationships.

In addition, clinical judgement and decision-making factors associated with referral practice were explored. Significant gaps in the current Australian scene were located. GPs and SMPs both reported that GP referrals would benefit from greater GP knowledge. It has already been proposed by commentators that GP education should be improved. The thesis result supports this strategic aim. The introduction of standardisation in relation to documented communication around referral was strongly emphasised by participants and by published commentators dating to the early 1990s.

Conclusion

Modelling and understanding referral practices will likely facilitate HVC, in a period of global economic challenge and the underutilisation of scarce specialist resources. HVC seeks to provide better care for individuals and better health for populations, while driving a lower cost per capita. Essential to achieving these aims is the referral process from GPs to SMPs and from one SMP to another.

These findings have ongoing research implications. Numerous among the solutions proposed have yet to be tested in Australia. Follow up positivist studies around improvement strategies located in this work are implicated. The results of this study and

any ongoing research agenda that it inspires, will likely inform the development of optimal clinical referral pathways and timely patient-to-specialist access processes and systems, and thus, reduce medical error, which remains worryingly high in Australia (Weingart et al. 2000).

Chapter 1: Introduction

The most striking feature of Homo sapiens is our sociality. Social relationships pervade every aspect of human life and these relationships are far more extensive, complex and diverse than those of any other society. (Fiske 1991)

1.1 Overview

Cancer is one of the great 'captains of death' for humanity, and its identification, treatment and care is a fundamental concern of organised private and public healthcare services currently (AIHW. 2016). Referring between professionals in the oncological context is a dynamic, complex process. High-quality practices in relation to interprofessional referral are vital to achieving the best patient outcome.

This doctoral research explores and describes professional exchange relationships between general practitioners (GPs) and specialist medical providers (SMPs), and among SMPs, in the context of the Australian oncology private healthcare – a sector which is 'referral-sensitive', in the sense that time between GP contact and referral onwards for specialist assessment may be vital to the patient's ultimate mortality outcome. This qualitative research project explores these factors and the dimensions underlying each of them, as they relate to the social exchange relationships between medical professionals. Two seminal psychological and sociological theories, Social Exchange Theory (SET) and Relational Models Theory (RMT), are used as informants of this study of interprofessional exchange relationships and are subjected to critical review through the lens of medical professionalism. Following pragmatic and critical analyses of qualitative data arising from interview studies with SMPs and GPs, a novel model seeking to explain interprofessional exchange in the oncological setting is proposed.

1.2 Thesis Context: Interprofessional Referral in Oncology

Cancer is a leading cause of death in Australia. It accounts for approximately 27% of all deaths (Cancer Institute NSW 2014). Cancer incidence increased in New South Wales (NSW) by 2.5% during 2008–2009, resulting in 37,525 new cancer cases. In the 1999–2009 period, the rate of cancer incidence in males continued to increase significantly. Prostate cancer in men and breast cancer in women are the most common types of cancer.

Cancer care is a specialised health service. The management options to treat cancer are complex and include surgery, radiotherapy and drug treatments involving hormones or chemotherapy (cell poisoning agents) and immune modulators. Cancer mortality can be reduced through early detection and treatment. Accurate diagnosis is essential for adequate and effective treatment because each cancer type requires specific treatment encompassing surgery and/or radiotherapy, and/or chemotherapy (World Health Organization 2015). To facilitate this process, timely and appropriate specialist referrals are factors critical to patient outcomes (Macdonald et al. 2006). Hence, this thesis examines the role of professional exchange relationships as determinants of referral between GPs and SMPs, and from one specialist to another.

Referral is 'the process of sending a patient from one practitioner to another for care and may be formal or informal' (Walshe et al. 2008, p. 168). GPs' decisions about whether to treat patients themselves or to refer patients to a specialist have important implications on quality of care and patient outcomes (Hiom 2015; Shortell 1983; Sripa et al. 2019). In the context of cancer care or oncology, referral quality and timing are of profound importance because tumour growth can move rapidly and with subtle signage or symptomatology, which may not be discernible to the initial examining doctor.

Systems for access to specialist services differ across countries (Baughan, O'Neill & Fletcher 2009). In the United States (US), cancer patients have the right to select their preferred doctors, treatment facility and recommended treatments (American Cancer Society 2016). That is, US healthcare organisations offer cancer patients freer access to specialists, allowing them to refer themselves (American Cancer Society 2016; Forrest 2003). However, in the United Kingdom (UK), other than the use of screening devices to aid the diagnosis of breast, cervical and colorectal cancers, patients consult with a GP, who assesses the patterns and symptoms. If GPs suspect that a patient has cancer, they may refer the patient immediately for specialist assessment and investigation. Alternatively, the GP might undertake initial investigations, review the results and then refer the patient to a specialist. A similar protocol is the norm in Australia. The challenges involved in GPs identifying potential cancer are complex, and many patients need multiple consultations before diagnosis and referral (Hamilton 2012).

Blinman et al. (2012) undertook a cross-sectional study of adult medical oncology practice work patterns in Australia. Their main aim was to determine the existing and

projected supply, demand and shortfall of medical oncologists, and the chemotherapy utilisation rate. Their study results revealed a shortfall of medical oncologists and a low chemotherapy utilisation rate of 19%. Further, 78% (117) of medical oncology practices were located in metropolitan areas and 22% (33) in rural Australia. There were 234 Full-Time Equivalent medical oncologists in practice, with each seeing about 270 new patients per year. A demand estimation for 2014 indicated a need for 361 to 432 such oncologists.

Blinman et al. (2012) also compared national and international benchmarks and found that medical oncologists in Australia had a higher clinical workload than their Canadian counterparts, and the average number of new patients per Full-Time Equivalent oncologist was 270, well above Canadian recommendations of 160–175 and the recommended Australian benchmark of 150 new patients per year. These authors also found that the national chemotherapy utilisation rate was well below the evidence-based Australian standard of 51%. This low rate is of concern because it implies that some patients who may benefit from chemotherapy do not receive it.

Possible explanations put forth by Blinman et al. (2012) for a low chemotherapy utilisation rate included suboptimal referral rates of patients with cancer, patients referred with advanced rather than early-stage cancer and low prescribing rates of chemotherapy to new patients with cancer. These findings suggest the need for national strategies to increase the capacity of the medical oncology workforce and improve the chemotherapy utilisation rate.

Reviewing studies on cancer detection and diagnosis, Macdonald et al. (2006) stated that early detection and early-stage diagnosis improve the prognosis of many cancers. Process delay occurs at three phases, from the time of initial symptom to diagnosis:

1. patient delay: the interval between first noticing a symptom and consulting a doctor;
2. practitioner delay: the interval between first consultation and referral; and
3. hospital delay: the interval between referral and diagnosis.

These authors stated that although some cancers, such as breast and skin cancers, have quick referral, and the referral model works well for cancers that have one clear symptom, for some cancers the GP might not consider the possibility of cancer after the first consultation, despite the patient reporting symptom/s. They further noted that this may be

due to the GP's lack of awareness of the required investigation for a quick timely diagnosis. Hamilton (2012) highlighted the examples of myeloma, lung and ovarian cancers as key areas where this phenomenon occurs regularly.

The UK has a poor record in cancer outcomes, mostly ascribed to delayed diagnosis (practitioner delay). As stated, the UK has a strong 'gatekeeper' system, since access to a specialist requires a referral from the GP. This system is similar to that in Denmark, which also has low rates of cancer survival (Hamilton, 2012). Although this research project does not seek to analyse GP clinical practice, understanding the significance of professional exchange drivers in the context of clinical judgement and decision-making during the referral process is an essential element and one that is likely to affect practitioner delay and patient outcomes. Studies have revealed that referral delay and patient outcomes are linked (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012), but the knowledge of how (and where) GP–specialist exchange relationships influence judgement and decision-making as it relates to decision to refer is limited.

Of the more than 41,000 patients newly diagnosed in the UK with one of the 24 most common types of cancer, nearly 25% had three or more consultations, and the five-year survival rates for oesophageal, lung and pancreatic cancers were less than 10%; Hamilton (2012) asserted that 'GPs have long been blamed by their patients for "missing cancer"' (p. 251). While socioeconomic factors, age and ethnicity are correlated with the survival rate of treatable cancers, early diagnosis and an effective referral process could lead to improvements in cancer outcomes. A contemporary view supported by 65% of UK healthcare professionals is that early-stage diagnosis is the most important factor for improving five-year survival rates for lung cancer, and prompt access to investigative testing and quick referral of suspected cases are the greatest barriers to quick diagnosis (UK Lung Cancer Coalition 2016).

Early diagnosis has been estimated to help reduce 10,000 avoidable deaths annually in the UK (Abdel-Rahman et al. 2009). The benefits of optimal and curative treatment to patients are dependent on early diagnosis (Hiom 2015). In an important study on diagnosing cancer earlier to improve patient survival, Hiom (2015) explained how Cancer Research UK explored the routes through which patients are diagnosed with cancer. A

significant proportion of cancer patients diagnosed in 2006–2010, who were not part of the 5–10% diagnosed via screening, were diagnosed via an 'emergency' route. Less than a quarter were diagnosed within the 2-week wait (2WW) period and a similar proportion, via GP referral.

Figures 1.1 and 1.2 illustrate how the National Awareness and Early Diagnosis Initiative (NAEDI), which was launched in 2008 to help address poor cancer survival by reducing the number and proportion of cancers diagnosed and treated at a late stage, mainly concentrating on symptomatic presentation and improvements across the diagnostic pathway (HIOM, 2015; pS1). Following the mapping process that Hiom (2015) described in NAEDI. Figures 1.1 and 1.2 show the original hypothesis and the revised hypothesis, respectively.
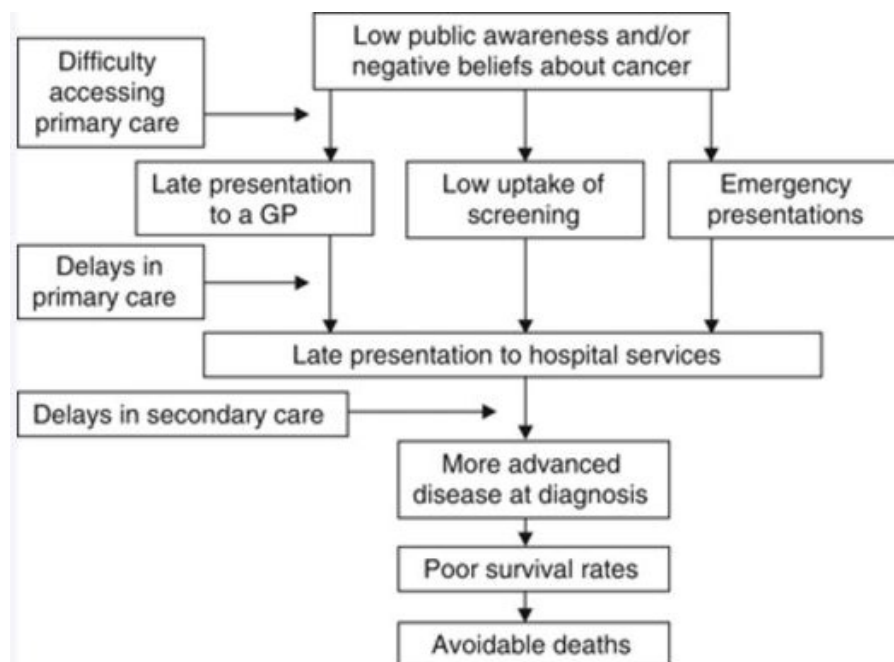
Figure 1.1: Factors Influencing Cancer Survival and Premature Mortality
(Hiom 2015, p. S2)

Age / Sex / Ethnicity / Socio-economic status ①

Difficulty accessing primary care ①

Low public awareness / Barriers to help-seeking / Negative beliefs about cancer ①

Delays in primary care interval ②

Late presentation to a GP ①

Low uptake of cancer screening ③

Access to diagnostics and 1°/ 2° care interface factors ④

Late presentation to hospital services / Emergency presentations ⑤

Delays in secondary care interval ⑥

More advanced disease at diagnosis ⑦

Treatment
Access to treatment ⑦
Other factors ⑧

Poor survival rates / Premature mortality ⑨

Avoidable deaths ⑩

Figure 1.2: Revised Conceptualisation of Factors Influencing Cancer Survival and Premature Mortality

(Hiom 2015, p. S2)

As illustrated in Figures 1.1 and 1.2, Hiom (2015) asserted that late presentation to a GP, and consequently late presentation to hospital services, as well as late presentation to hospital services because of delay in the primary care interval, are factors influencing cancer survival.

In the context of the UK health system, Banks et al. (2014) found social cohesion between GPs and SMPs to be essential for SMP services to be utilised. They also found that while there are guidelines for referral when cancer is suspected, and a shift to a patient-centred approach with the patient at the heart of decision-making, patients may not value the knowledge they bring to the consultation and may expect GPs to drive decision-making and referrals. They cited two Australian studies (i.e. Davey et al. 2004; Pascoe et al. 2013) on shared decision-making (SDM), whose results indicated that some patients believed they should not be involved in the referral decision-making process and that others felt

they lacked the information to make an informed decision. Such findings reinforce the importance of putting the onus on the GP to make timely referrals to the appropriate SMP.

An Australian national survey of oncologists, clinical haematologists, respiratory physicians and colorectal surgeons regarding referral to specialist palliative care was undertaken by Johnson, Girgis and Paul (2008). Results indicated a high emphasis on physical symptoms and the disease process when considering referrals, but the review did not address other factors affecting the referral decision-making process.

1.2.1 Oncology Referral Pathways in Australia

The field of oncology has three major areas of specialisation, namely, medical, surgical and radiation (American Society of Clinical Oncology 2015). In the medical branch of oncology, specialists in medical oncology, haematology and endocrinology use targeted and chemotherapy medications as well as other treatment protocols including, but not limited to, bone marrow transplants to treat cancer. A radiation oncologist uses sophisticated radiation emitting equipment to irradiate an affected area. A surgical oncologist specialises in removing tumour through surgery. This group of specialists referred to as surgeons includes those from several specialities and subspecialities, such as general surgeons; neurosurgeons; thoracic, breast, maxillofacial, plastic and reconstructive surgeons; gynaecologists; gastroenterologists; urologists; and paediatricians.

Cancer treatment often entails a combination of surgery, chemotherapy and radiation therapy. Other specialist professionals are also involved in the diagnosis and differentiation of cancer. The diagnostic group includes pathologists, radiologists and other health professionals. This network of medical professionals, who engage in the social exchange processes of referral, diagnosis, treatment, further referral and reviews by medical experts, forms the research context.

Following referral from a GP, the oncologist helps in cancer diagnosis and treatment using a multidisciplinary team (MDT) approach with referral to one or more oncology specialists. An MDT approach entails the cooperative involvement of medical, nursing, and allied health professionals in assessment and ongoing care and treatment processes. The choice of medical, radiation or surgical intervention depends on the specific type of cancer and its characteristics, such as location, size, spread and aggressiveness. In almost

all cases, as part of the diagnosis and differentiation of the cancer, pathology and/or radiology specialist diagnostic services are used. The patient may be referred back to the oncologist but is almost always referred back to the GP for ongoing care monitoring and coordination.

The formation, development and maintenance of strong relationships between the SMP, the referring GP and the patient are likely to be of significance in providing excellence in health care. Building and maintaining a strong relationship between these individuals may be significant in the provision of excellence in health care. The issues of trust, reciprocity, loyalty, interprofessional collaboration/relationships and agency are central to these processes (Bakker et al. 2000; Diekmann 2004; Gobel, Vogel & Weber 2013; Molm 2010; Thorne & Robinson 1988; Uhl-Bien 2003; Walshe et al. 2008; Yilmaz, Sezen & Ozdemir 2005), and these are likely to influence outcomes for all stakeholders. Figures 1.3 and 1.4 provide a descriptive picture of contemporary Australian oncology referral pathways. Importantly, process diagrams clearly emphasise the fundamental importance of the GP as 'lynchpin' to ongoing referral processes.

Patient

GP

Referral

Medical Oncologist

Referral

Surgeon

Referral

Haematologist

Referral

Referral

Best Patient Outcomes

Referral

Referral

Pathologist

Radiologist

Multi Disciplinary Team Coordinator

Radiation Oncologist

Referral

Oncology Nurse

Social Worker

Palliative Care Physician

Dietician

Psychiatrist/ Psychologist
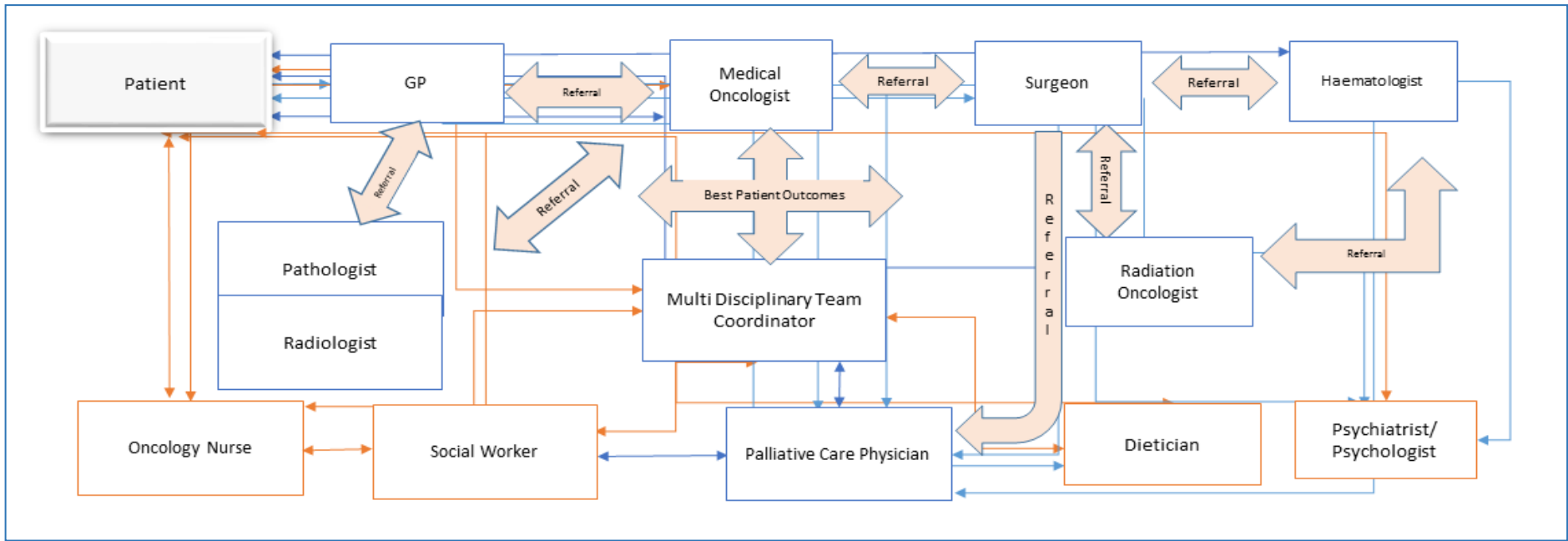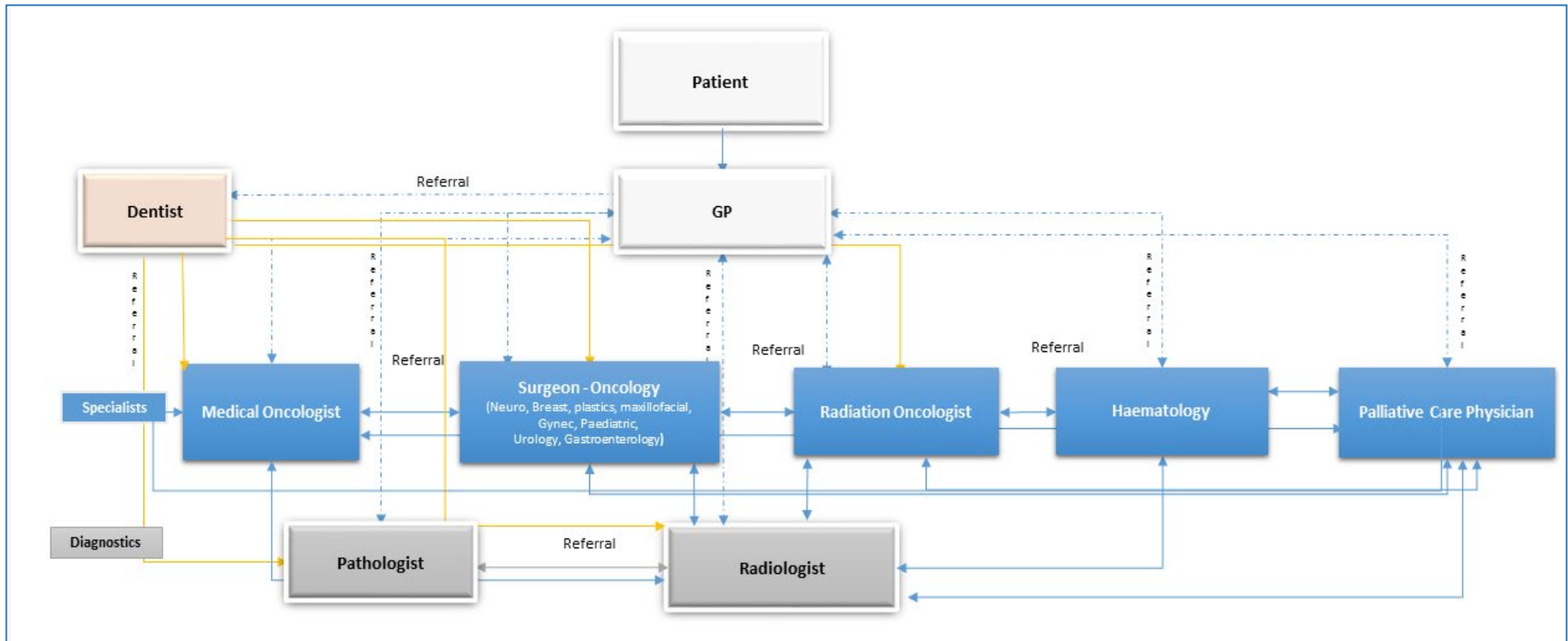
1.3 Gaps in the Research Base around Interprofessional Referral

The rate of cancer-related deaths in Australia has been documented (Cancer Institute NSW 2014). Factors such as delayed referral, inappropriate examinations and delayed diagnosis have resulted in poor patient outcomes (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). Meanwhile, many patients cannot bear the cost of cancer treatment, which results in their early deaths. Yet, limited research has been conducted to address these issues.

Studies investigating the referral-related decision process are scarce, and research around the factors affecting GPs' decision to refer cancer patients to a specialist is still at the embryonic stage (Delva et al., 2011). Government, employers, and non-profit agencies have been engaging managed healthcare organisations around cost constraints and offer incentives to GPs in order to control cost (Grembowski 1998). GPs have become gatekeepers since they coordinate access to a specialist in cancer treatments (Hamilton 2012). GPs' role in cancer treatment is very important. They decide whether to refer a patient to a specialist. They also decide to which specialist to refer patients, and the care patients receive may vary in quality depending on the specialist the GP choses (Garåsen & Johnsen 2007).

The cancer treatment system in Australia limits GPs' referral behaviour, and many GPs have been referring cancer patients to a specialist within their business networks (Piterman & Koritsas, 2005). The country does not have a central databank that reliably matches a specialist to a specific disease or problem. GPs in Australia operate solely within their 'known universe'. As Anthony (2003) noted, in many managed healthcare systems, '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' (p. 2035). In this case, professional and social exchanges are likely to affect referral practice among GPs in the cancer treatment environment in Australia.

A European study by Hackl, Hummer and Pruckner (2015) on the role of old boys' networks in GP referral behaviour found that GPs referred patients to a specialist within their personal networks. They also noted that GPs often referred patients to specialists who had graduated from their alma mater. Although this study showed the importance of

social networks in referrals in medical practices, it did not show the benefits the GPs gain from the specialist and whether the practice of GPs referring patients to a specialist within their personal network has a cost. In addition, the study did not show how the strength of the GP–specialist tie affected GP referral behaviours.

Moreover, most of the studies referred to thus far as well as meta-analyses on medical professionalism and referral practices for cancer patients (Delva et al. 2011; Mitchell et al. 2008; Passi et al. 2010) have been positioned in the UK, the US and the Canadian healthcare settings. To date, studies on referral in the Australian context are limited in number and scope as well as sample size, rigour, and generalisability. A comprehensive review of these studies is presented in Chapter 2 (2.2 Referral: Purpose, Process and Significance for the Present Research)

To address gaps in the literature about factors that drive GP-to-specialist referral practice (and also specialist-to-specialist referral practice), this thesis employs two theories: SET and RMT. Studies on the impact of social exchange and professional relationships on referral practices in the context of cancer care have not been attempted to date, and more importantly, the factors determining doctor (GP and SMP) to SMP referral practices have only been researched in the immediate operational context and have not drawn on theoretical understandings relating to human exchange behaviour. Little is known to date as to how seminal social exchange and relational theories can help to understand and predict how the GP-SMP driver-referral practice relationship operationalises in an Australian setting.

Thus, this thesis seeks to deepen the understanding of the drivers of effective social exchange between professionals in the healthcare context, and the impact of relational factors on referral processes. The referral process is a key component in determining health outcomes for patients with both diagnosed and undiagnosed cancer; hence, it is important to examine the factors influencing this process. Although many factors may affect the quality of the professional relationships between the referrer and SMP, clarity about the specific factors that determine referral practices between a GP and a specialist, and between SMPs, is lacking. The thesis intends to gain an understanding of the professional relational factors underpinning referrals from GP to SMP, and between SMPs, to enhance patient outcomes.

1.4 Introduction to Theoretical Frameworks Informing the Research

An examination of theories relevant to interprofessional communication suggests that SET may offer a framework for examining the referral process (Anderson & Narus 1990; Anderson & Weitz 1989; Blau 1964; Gouldner 1960; Grönroos 2001; Homans 1983; Lawler & Yoon 1996; Mauss 1923; Molm 2003; Sheth & Parvatiyar 1995; Wernerfelt 1985, 1995). The SET literature has suggested that from a social perspective, trust, social identification and perceptions regarding status might be important decision-framing elements for the primary care doctor (Axelrod & Goold 2000; Baier 1986; Barnett, Song & Landon 2012; Hall, M. et al. 2002; Illingworth 2002; Kinchen et al. 2004; Langley, Minkin & Till 1997; Manca, Breault & Wishart 2011, Manca et al. 2008; Newman 1998; Offe 1999; Patterson 1999; Pearson, S. & Raeke 2000; Pellegrino & Thomasma 1993; Probst et al. 2013; Sparrowe, Soetjipto & Kraimer 2006; Spence 2013; Thom, Hall & Pawlson 2004).

SET conceptualises human behaviour as underpinned by social exchange, leading to interpersonal relationships based on reciprocity, trust, loyalty, commitment, status, power and cohesion (Blau 1964; Cropanzano & Mitchell 2005; Dunford, Snell & Wright 2001; Emerson 1976; Foa & Foa 1980, 2012; Gouldner 1960; Homans 1983; Kinchen et al. 2004; Mauss 1923; Molm 1994; Molm, Takahasi & Peterson 2000; Wernerfelt 1985, 1995). For social exchange relationships to endure, unspecified obligations must be honoured (Blau 1964). Emerson (1976) viewed SET as a framework comprising multiple theoretical understandings of exchange. In fact, SET has evolved over the course of a century and straddles the disciplines of anthropology, philosophy, sociology, psychology, economics, organisational behaviour, and management.

Another notable relational theory, which has relevance to interprofessional referral practice, is RMT. The RMT literature has suggested that communicative aspects and affective and instrumental commitment to the interprofessional relationship may also be important (American Board of Internal Medicine [ABIM] 2004; Barnett, Song & Landon 2012; Freidson 1967, 1984; Heskett, Sasser & Schlesinger 1997; MacDonald et al. 2006; Kinchen et al. 2004; Payne & Holt 2001; Pellegrino 2002).

Similarly, to SET, RMT is a theory of social relationships. First postulated by Alan Fiske in the 1991, RMT proposes social life as comprising individuals developing relationships,

remaining committed to the same and working to sustain them. Fiske provided an elementary four-model framework to classify all social relationships, including moral behaviour (Fiske, 1991). The significance of RMT for this thesis research is that it introduces further domains of social exchange, such as cognitive foundations, resource exchange, moral judgements, and decision-making, all of which are significant in assessing the role of professional-to-professional relationships in referral practice.

Put simply, SET seeks to explain and predict exchange related behaviours, based on gains, losses, reciprocities etc. RMT does not sit in opposition to SET, but rather adds further potentially important explanatory/predictive factors including affect, interpersonal communication, and the like. SET and RMT are reviewed in greater depth in Chapter 3.

1.5 Purpose

The purpose of this research is to unravel the drivers of professional-to-professional relationships, which underpin referral practices, to understand the social exchange and relational factors that lead GPs to refer a patient to specific SMPs, and subsequently, one SMP to refer to another, and thus, to identify the elements that enable timely and efficient referral, diagnosis, and treatment.

The term referral as operationalised in the present research denotes a medical professional's action of directing a patient to a particular specialist. It is acknowledged that many factors determine referral, such as patient factors, location, convenience, access, wait time and costs involved. In the thesis research, a stronger understanding is sought with regards medical professional perspectives on the role of longstanding professional exchange relationships as a determinant of the initial choice of specialist, and the different factors that influence lasting professional-to-professional relationships and referral practices.

Referral is 'the process of sending a patient from one practitioner to another for care, and may be formal or informal' (Walshe et al. 2008, p. 168.). Decisions by GPs about whether to treat patients themselves, or to refer to a specialist, have important implications on the quality of care and patient outcomes (Hiom, 2015; Shortell 1983; Sripa et al. 2019). In his seminal work, Shortell (1983) highlighted the significance of the choice of a specialist, including technical competence, and clear two-way communication between the specialist and the referring physician, as affecting the quality and continuity of care.

It is likely that a major contribution of this study—based on the comprehensive literature review undertaken and the feedback from the field research component—will be the identification of common variables on professional exchange arising from an application of SET and RMT to the professional oncological environment, which is bounded by the social contract of medical professionalism. It is anticipated that through this research, I will be able to develop a hypothetical conceptual framework of professional exchange in the healthcare context, which is inclusive of the key factors and variables that determine referral practice.

Subject to the findings, a new theory may be developed and put forward on sustained professional-to-professional social exchange relationships between medical professionals that determine referral patterns and, ultimately, implications for best patient outcomes in the field of oncology. It is hoped that a better understanding of the determinants of professional exchange that underpin referral relationships between specialists in the field of oncology, and between GPs and specialists, will inform efforts to improve clinical referral pathways. Such improvements may contribute to reducing the overload on some specialists, to optimising 'best fit' patient referral practices and to achieving best patient outcomes. The findings might inform efforts to reduce clinical risks and foster a collaborative and mutually reinforcing service orientation approach among SMPs, GPs and allied health professionals.

1.5.1 Aim

This thesis aimed to examine the role of professional exchange relationships as determinants of referral between GPs and SMPs, and from one specialist to another.

1.5.2 Objectives

The objectives of this thesis are:

1. to explore the drivers of lasting professional exchange relationships that determine referral practices between medical professionals;
2. to ascertain medical professional perspectives on factors that underpin lasting professional exchange relationships;
3. to understand the significance of professional exchange drivers as they relate to clinical judgement and decision-making during referral practices/processes; and

4. to consider the implications of the results for high-value service provision in the private specialist medical sector in Australia.

1.5.3 Research Questions

In light of SET's focus on exchange dynamics and RMT's focus on relationalities, this thesis explores the following research questions:

1. What are the factors that determine long-term professional exchange and relational drivers between medical professionals?
2. What are the views of medical professionals on the significance of trust and reciprocity as determinants in professional-to-professional relationships?
3. What is the role of professional-to-professional relationships on clinical judgement and decision-making with regard to patient referral?
4. What are the implications of the findings from the thesis research on the role of professional exchange relationships between GPs and SMPs, on the provision of high-value health care in oncology for patients in private and public health sectors in Australia?

1.5.4 Definitions

Referral is the formal process of sending a patient from a GP to a specialist, or from one specialist to another.

Social exchange/Professional exchange is defined as an enduring series of interactions between two medical professionals, which is mutually rewarding, based on shared professional norms, driven by trust, commitment, reciprocity, a certain amount of altruism and the exchange of knowledge and resources.

Trust includes ethical, collegial, reciprocal, agentic and communitarian dimensions that underpin stable and ongoing social exchange and referral relationships between GPs and SMPs, and among SMPs.

Professionalism in the medical environment is defined as interprofessional relationships based on shared values and concepts, such as commitment to compassion and patient care, trust, integrity, social justice, collaboration, and excellence.

Agency is the capability of the professional to make timely decisions that reflect social and moral responsibility as well as adherence to the ethics of medical professionalism.

High-value care (HVC) refers to the provision of timely referral to ensure the best possible care for a cancer patient by correct diagnosis, the ease of access to specialist/s, the provision of the best treatment and continuing care services with coordination between primary and specialist care providers.

Competitive advantage is a unique and difficult to replicate attribute of a health service provider, which articulates the mission and vision of HVC provision and excellence in care and interprofessional collaboration.

1.6 Methodological Approach

For the empirical component of the research, the thesis utilises the general practice and private specialist medical service environment in Australia to explore how long-term interprofessional exchanges occur between medical professionals, namely, GPs and specialists, and among specialists. Two separate qualitative interview studies are conducted. The first, focusing on the GP–SMP relationship is conducted using a sample of GPs and SMPs. The second (using a sample of SMPs of varying types, namely, treatment-focused, and diagnosis-focused) is focused on relationships between and among SMPs.

The inquiry position for both studies is informed by applying SET- and RMT-related constructs to the oncological and primary health practice setting, which is considered to be bounded by the social contract related frame of medical professionalism. In this sense, the inquiry is inspired by, and starts with, a problem or issue (Easterby & Lowe 1991, p. 35)—interprofessional referral in healthcare and oncology. Then, this thesis research seeks to understand the dynamics of the problem with the aim of shedding light on it/solving it/generating improvements around it (Denzin 1989, p. 4). In methodological terms, such an approach to research-based inquiry can be termed as pragmatic (Creswell & Miller 1997). Such an approach places the problem/issue, and the imperative to highlight it, first, and the philosophical location of the knowledge generated, second (Guba & Lincoln 1989, p. 398). However, sociological/psychological theory, in particular SET, is key to framing the thesis research problem and developing a qualitative research approach, which might help to shed light on it. The project is largely a descriptive study,

which is carried out against the backdrop of prior knowledge of the research problem in both theoretical and personal experiential terms. The researcher is an active participant in oncological health care in Australia. In this sense, the study is undertaken to ascertain and be able to describe the characteristics of the factors of interest (Cavana, Delahaye & Sekaran 2000, p. 109).

Further, my SET/RMT-informed positioning as a researcher of interprofessional referral is framed more widely by the 'meta-theory' of medical professionalism. Medical professionalism can be understood as a societal contract between healthcare providers and society. Such a contract embodies sociocultural power of one type or another, and for this reason, I have layered a critical approach over my pragmatic (or sense-seeking) approach in my research methodology, to ultimately progress a pragmatic–critical qualitative study design. To implement such a design, two qualitative analyses are offered. First, a pragmatic analysis about how and where SET and RMT are realised in the talk of the study participants, and what other thematically identified factors are also at play, is conducted. Second, a critical analysis is pursued to explore the findings further, with an explicit emphasis on locating where and how socioculturally defined power relations are replicated in the talk of participants. Thus, the critical search seeks to understand people's motives for their actions (Rice & Ezzy 1999).

Critical theory assumes that reality arises out of social interaction and is thus socially constructed in such a way as to constrain human interaction (Neuman 2006). The purpose of using the methodology is to conceptualise behaviour in relation to the desired outcomes (e.g. a more even distribution of referrals among SMPs working in the same environment). The critical approach is somewhat inductive/interpretive, in order to obtain a better understanding/clarity, but it is also one that is founded on argument (Denzin & Lincoln 2003). Implicit to the critical approach to studying the 'problem' of interprofessional referral is a belief that 'objectivity' is a myth and any interpretation of data by a researcher is 'subjective'. Nevertheless, the onus is on the researcher to provide sound reasons for their interpretation. Critical theorists generally employ qualitative methods, such as interviews and questionnaires that are qualitatively analysed (Babbie 2001; Becker 1992; Cavana, Delahaye & Sekaran 2000; Easterby & Lowe 1991; Neuman 2006; Porter 2003; Rice & Ezzy 1999). The purpose is to clear away the myths and ideology associated with the social phenomena and bring about understanding and, ultimately, change, through critical reflectivity (Neuman 2006; Porter 2003).

Having investigated the various approaches, the researcher formed the view that a pragmatic-critical qualitative methodology (Creswell & Miller 1997), informed by social exchange (SET) and relational models (RMT) theories, was the best approach to explore the phenomenon of inter-professional medical referral in the context of oncology.

Importantly, this thesis research will propose a new model of interprofessional referral, which draws from both pragmatic (sense-seeking) and critical analytical (meaning-seeking) approaches to textual data. The drive to conduct the research and contribute to understandings is founded on the belief that change is both needed and possible in the researched area.

1.7 Chapter Summary

Interprofessional referral practice is a key factor that drives patient outcomes. This is likely to be even more so in the context of oncology, where speedy referral from GP to SMP may be key to optimising treatment commencement. Available evidence suggests that referral practices are not optimal in the sector and that little work seeking to shed light on referral processes and behaviours has been performed in the Australian context.

SET is a key theoretical lens for exploring the drivers underpinning interprofessional relationships that might prompt one professional to refer to another. Central to social exchange is the creation and maintenance of reciprocity (Gouldner 1960, Molm 2003); because reciprocal exchange is largely non-economic and usually involves social structures, it leads to the experience of gratitude and trust, and the obligation to repeat (Masterton et al. 2000; Molm 1994; Price & Arnould 1999). It is also likely to be long term in nature (Lawler & Yoon 1996) and value needs to be perceived (Sparrowe, Soetjipto & Kraimer 2006).

The key elements of any reciprocal exchange between professionals relate to the nature of the relationships created and the nature of the resource exchange, which is implicated in the relationship (Foa & Foa 2012; Organ & Konovsky 1989). Although much professional activity is business activity (in the sense that profit seeking is implicit), it is also high-value activity, which operates at the societal level in the service of the community (Porter & Lee 2013; Stewart 2011). The SET literature has suggested that from a social perspective, trust, social identification, and perceptions regarding status might be important decision-framing elements for the family/primary care doctor. The

RMT literature has suggested that communicative aspects and affective and instrumental commitment to the interprofessional relationship may also be important (Coquillette 1994; Engestrom 2000; Fiske 1991, 1992, 2004; Freidson 1984; Payne & Holt 2001; Pellegrino 2002).

Understanding professional drivers and how these might be mediated by the core social contract of medical professionalism should be important in isolating factors determining referral patterns from GP to SMP, and between SMPs. To shed light on the 'problem' of interprofessional referral in cancer care, this thesis research seeks to model interprofessional referral via the use of both pragmatic and critically informed qualitative research methodologies. Key participants are GPs and SMPs working in oncology in Australia. Figure 1.5 represents a conceptual model of the research framework outlining the independent and the dependent variables as presupposed from an examination of SET and RMT literature. Chapter 2 discusses the study context and interprofessional referral in greater depth, and Chapter 3 discusses the theoretical frame chosen to explore the thesis topic.

Theoretical lens	Relational factors	Outcome

Theoretical lens

(Professional Lens)

Social Exchange Theory

&

Relational Models Theory

Relational factors

General Practitioner–Specialist

&

Specialist–Specialist

Professional exchange relationship

- Medical professionalism
- Trust
- Reciprocity ~ Relationship engagement, Motivations & Agency:
  o Service orientation/Quality;
  o Positive emotions;
  o Knowledge/Skill set;
  o Relational dependence (mutual & reciprocal);
  o Cohesion/Commitment;
  o Loyalty; and
  o Status/Reputation in the community.
- Reputation for professional excellence

Outcome

Referral

Choice of Specialist Medical Provider

Patient outcomes/Provider outcomes

Figure 1.5: Research Framework—Preliminary Findings/Views

Chapter 2: Literature Review—Evidence

2.1 Overview

> *[R]eferral decisions by primary care physicians have an enormous impact on the cost and quality of care that patients receive. Patients' health is also certainly affected. Appropriate consultation and referral may lead to prompt diagnosis and treatment of conditions that were beyond the immediate expertise of the primary care physician. Inappropriate referral, however, may lead to unnecessary testing and a cascade of increasingly expensive, invasive, and risky procedures in an often futile search for diagnostic certainty.* (Nutting, Franks & Clancy 1992, p. 21)

2.2 Referral: Purpose, Process and Significance for the Present Research

Australian medical provider procedures and Australian Medicare regulations require that a patient be provided with a referral from a PCP to an SMP, prior to the initial consultation by a specialist. The patient requires the services of both specialist and referrer; the specialist cannot operate without referred patients, and the referrer does not have the requisite skill to attend to certain specific ailments. In oncology, once a patient is under the care of an SMP, referral between medical and surgical SMPs often occurs.

Despite a substantial volume of research presenting the unfortunate reality of delayed referral, inappropriate examinations, delayed diagnosis and poor patient outcomes in regard to cancer (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012), little is known about the types of decisions referring doctors and their patients make when choosing an SMP (oncologist), or the doctor–specialist relationship, which most likely influence referral practices and, ultimately, patient outcomes.

Most patients assume that if their family doctor cannot treat their ailment successfully, they will be referred to a specialist who has been vetted by their own doctor, professionally, if not personally. However, the correct referral of patients has been further complicated over the past few decades by a near doubling of the number of specialist and

subspecialist categories (Sullivan 2012). O'Donnell (2000) stated that the real cost to the health service may lie not with the small number of patients who are referred unnecessarily, but with those who are referred later or not at all. This is a very challenging issue in cancer care, since diagnosis and timely treatment are the keys to best patient outcomes, both of which are dependent on a GP's clinical judgement and decision-making about timely referral, and to a specialist who provides timely access to the appropriate treatment.

2.3 GP-to-Specialist Referral

The factors influencing GPs' referral decisions were first explored by Newton, Hayes and Hutchinson (1991), who viewed referral as a type of social action best understood by interpreting the meanings and motives of those involved:

> When a patient is referred to see a consultant, this means that a doctor …has come to define a set of symptoms together with other information in a particular way. Each referral decision may depend on the way in which unique constellation of factors are interpreted. Studying referral, therefore, requires that investigators get as close to the interactional processes through which it is constituted. (p. 309)

In their qualitative interview study, they interviewed 15 UK GPs twice. The first round of interviews focused on three randomly selected referrals made four weeks prior to the interview. Qualitative analyses of the interviews led to sentinel themes, such as clinical and non-clinical factors, and patient-associated and doctor-associated factors. Most of the decisions to refer were rarely, if ever, based on clinical factors alone. The reasons involved a complex interaction of clinical and non-clinical factors. For example, some of the non-clinical factors related to the personal characteristics of the referring doctor, such as how the consultant would evaluate the referral and their propensity to take risks or tolerate uncertainty. Patients' expectations and their ability to assert their views were other non-clinical factors. A major non-clinical variable was the relationship between the GP and the patient, and between the GP and the specialist.

The factors influencing referral decision-making were categorised into four groups: factors associated with doctors, patient factors, case-specific factors, and structural factors. The last group comprised factors such as resources, wait times and workload. Newton, Hayes and Hutchinson suggested that they are a long way from being able to

explain patterns of referral and stated that an understanding of the meanings and motives of those involved in the process of referral is needed:

> The indications are that a large number of referral decisions are not only difficult to make from a clinical view, but are also further complicated by the personal values, skills, and experiences of those involved as well as the nature of relationships between them. (p. 312)

O'Donnell (2000) reviewed 91 studies on GP referral decision-making processes to identify variations in GP referral rates in different countries across Europe and likely explanatory variables. They selected studies examining GP referral rates, variations in referral rate, possible explanations of those referrals and decision-making in the context of referral. A key conclusion of this review was that each GP might have a unique 'referral threshold' that may influence a referral decision. Relevant factors included training, experience, tolerance of uncertainty, sense of autonomy and personal enthusiasm. A major cause for the variation in referral rates lay in GPs' cognitive processes, which included confidence in their clinical judgement, their awareness of the chance of life-threatening events occurring, their current medical knowledge and their need to sustain the esteem of colleagues with whom they consulted.

Harris et al. (2016) investigated factors influencing referral decisions about patients who may have cancer. They aimed to identify the systemic and other non-clinical factors that may influence a GP's decision as to whether or not to refer a patient suspected of having cancer. Using expert group discussion and consensus formation, a group of eight European GP researchers worked together to identify the factors that could affect GPs' decision-making when faced with patients who might have cancer. Results revealed many non-clinical factors likely to significantly affect referral decisions, such as gatekeeping responsibility, funding systems, access to special investigations, fear of litigation and relationships with specialist colleagues.

To summarise, the findings reported in this section emphasise the range and complexity of factors influencing GP to SMP referral. Also, non-clinical factors have been found to be at least as significant as clinical factors.

2.3.1 Linking GP Referral Practice and Survival

Buccheri and Ferrigno (2004) undertook a retrospective study on a large consecutively presenting group of lung cancer patients ($n = 1,277$) over a 13-year period (1989–2002). All tests that patients underwent were recorded, together with symptoms that triggered alarm in the patient and time taken to specialist referral. Results showed a significant association between late referral and the presence of cough, poor performance status, increased weight loss, advanced stage of disease and less effective therapy (palliative and chemotherapy treatments). Analyses of survival showed that the shorter the time taken to referral and providing an incidental diagnosis, the better the clinical outcomes.

Causes of delay in referral included the patient, the family doctor, and the referral specialist. The median delay was about two months, and considering the fact that lung cancer mortality did not change significantly over the decades studied, Buccheri and Ferrigno (2004) stated:

> The recently observed increase in the time from the first symptom to the first specialist visit is a truly harmful signal, if one considers the global efforts that are directed to its direction and the critical importance of early diagnoses. (p. 903)

Harris et al. (2016) highlighted the poor rate of survival outcomes for cancer patients in the UK and the wide variation across European countries, leading to substantial excess mortality. Poor one-year survival rates are generally taken to be an indicator of a more advanced stage of disease at the time of diagnosis. For those patients who survive at least a year after their initial cancer diagnosis, there is less national variation. While overall cancer survival trends are improving in Europe, there is little narrowing in the differences between countries. International variations in cancer outcomes are related to differences in the stage at diagnosis. This may be due to differences in diagnostic delay as well as GP awareness of symptoms. Clearly, the need to achieve a timelier diagnosis warrants priority. A GP will see only a handful of new cancers in any one year, and GPs may go many years, or indeed a lifetime, without seeing certain rare cancers.

Healthcare systems with gatekeepers have a significantly lower one-year relative cancer survival rate than systems without gatekeeper functions (Hiom, 2015). Harris et al. (2016) highlighted the GP–specialist relationship as key to cancer outcomes. In some health systems, whereas specialists were observed to welcome referrals from GPs, in others, they

were perceived as discouraging them. The ease of being able to telephone or email a specialist for informal discussion and advice facilitates the care of patients who could have cancer, as does the ability to refer to a specialist whom the GP knows personally. In this study it was claimed that having a system that prevents the GP from referring to a named specialist may inhibit referrals. A high workload may make GPs more likely to refer, in an attempt to reduce follow-up appointments. However, if there is an expectation that the GP will write a detailed, comprehensive referral letter, the time taken to do that may discourage the GP from making a referral at that appointment. In Sweden, where a typical GP appointment is 30 minutes, patients have more time to mention symptoms that concern them and the GP has more time to consider whether investigation or referral is needed, compared with those in many other countries.

Harris et al. (2016) highlighted clinical guidelines as potential facilitators of a GP's decision to refer, by giving advice on which patients need referral because of a risk of cancer. GP decision-making was also affected by how much local specialists welcome, or discourage, referrals. The level of rapport between GPs and those specialists was considered an important factor, as well as the ease of access to specialists for advice before a referral decision is made. A consensus from Harris et al.'s small study was that reducing the time from presentation to specialist referral or investigation is likely a crucial step in improving cancer survival. Their findings highlighted the significance of non-clinical factors to be considered in relation to referral practices and patient outcomes in cancer care. One suggestion to improve outcomes was for a better understanding of interactions between professionals irrespective of the health system at play.

The *Health Insurance Regulations Act* 2007 has stated that a practitioner must 'consider the need for the referral', and then provide the SMP all relevant information pertinent to the patient's diagnosis. The referral must be given in writing, dated and signed by the referring practitioner, unless in an emergency. The Royal Australian College of General Practitioners (2019) has further expanded on this proposition by requiring its members to ensure continuity of care for the patient, and that processes are in place for a distinct handover of the patient's up-to-date treatment status that exists beyond the initial referral letter, and for the patient to be sent back to the referrer for ongoing management after referred service. The regulations suggest that referrals *should be* addressed to a 'specialist or consultant physician', but the legislation specifies that the SMP does not need to be identified by name (*Health Insurance Regulation Act* 2007; *Health Insurance Regulations*

1975; *Health Insurers Act* 1973). Nevertheless, it is accepted practice to refer to a named SMP.

It is hypothesised that in the Australian context, if referrers were to consider SMP availability in their decision-making process, the critical early diagnosis component, as discussed by Buccheri and Ferrigno (2004), could improve patient outcomes. To achieve this goal and maintain continuity of care, a referrer could write a generic-style referral letter to a specialty, not a specific SMP, and provide the patient with a list of suitable SMPs. The patient could then contact the first-named SMP and if there are barriers to entry, such as financial considerations or a time delay to access, the patient could select the next SMP on the list. Although providing an open referral is not encouraged under the rules, nor generally practised, it is in fact allowable under present legislation (*Health Insurance Regulation Act* 2007; *Health Insurance Regulations* 1975; *Health Insurers Act* 1973) and is currently accepted widely in the field of pathology (*Health Insurance Regulations [Pathology Services]* 2018). This proposed approach could promote faster time to consultation and reduced time to treatment and, thus, reduce medical error caused by treatment delay (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012).

2.3.2 Factors Influencing GP Referral Practice

In its synthesis of findings, the O'Donnell review (2000) proposed that patient characteristics explain about 40% of the observed referral rate variation and that practice and GP characteristics accounted for less than 10%. The availability of specialist care was found to be a factor affecting referral rates; however, its influence on the observed variation of referral rates was unclear. Intrinsic psychological variables such as amiability were found to be important in the choice of referee. In terms of patient characteristics, O'Donnell (2000) noted that age, gender, and social class did not count as major factors in explaining referral rate variations. In terms of practice characteristics, there was conflicting evidence about the relationship between practice size and variation in referral rates. While some studies showed no significant differences in referral rate between high- and low-referring GPs in terms of list size or number of partners, others showed high referral rates in single-handed practices. Another study showed a significant relationship between referral rate and practice size, with a drop in referral rates as the size of the

practice increased. Conversely, in the Netherlands, referral rates were found to increase as the number of GPs in the practice increased. Another practice characteristic—distance to a hospital—was found to influence referral rates. Higher referral rates were associated with shorter distances from the practice to the specialist. Rural GPs had lower referral rates than did urban GPs.

Regarding 'within-GP' factors, O'Donnell (2000) found few robust findings and noted that policymakers tend to regard high levels of referral as inefficient and many of these referrals as inappropriate. However, little is known about what is 'appropriate'. An appropriate referral must be timely and effective in achieving its objectives for the patient, as well as be cost-effective, in the sense that it isn't clinically unwarranted.

The O'Donnell (2000) review found that the availability of specialist care influenced referral rates. Judging the appropriateness of a referral decision was complex. In some studies, hospital consultants were critical of GPs' referral behaviour, and a majority of them felt that the GP could have done more before referring the patient. Other studies among SMPs revealed more favourable views regarding the appropriateness of GP referring behaviour. Importantly, any true judgement about whether or not a referral is appropriate requires data on patient outcomes.

Further, O'Donnell (2000) found that in studies that followed up referrals, investigations and treatment were carried out for the majority of cases. He stated that it is difficult to judge the appropriateness and outcome of referrals with an incomplete cohort, there were some patients who were referred, but a key group of patients with similar symptoms and conditions to those who were referred, who were not referred. This is an important issue, particularly since it has been suggested that the main problem with variation in referral rates may not be one of over-referral, but of under-referral (Forrest et al, 2006). Indeed, it has been suggested that the real cost to the health service may lie not with the small number of patients who are referred unnecessarily, but with those patients who are referred later or not at all.

In a qualitative study on decision-making by urban GPs in NSW, Hespe (2010) highlighted the limited research into why and how GPs choose to refer a patient to a gynaecologist in the Australian healthcare context. Hespe's study had 12 GP participants where the primary investigation was between gynaecologist and subspecialist

gynaecologist, not between two equally qualified SMPs. Drawing conclusions from her own literature review, Hespe noted that even for issues pertaining to a highly specialised gynaecological problem, in the first instance, GPs often referred patients to the gynaecologist of their own personal choice, rather than being driven by subspecialisation.

Most GPs in Hespe's (2010) study reported that the main driver of referral was the communication that occurred alongside the referral, before, during and after the consultation. They responded to good communication from both the specialist and the subspecialist. Hespe concluded that GPs will refer if they are confident of receiving good letters, prompt feedback and personal contact if required, either by phone or email. She also proposed some criteria that might guide GPs' decision-making, five of which were related to communication by the SMP with the GP and staff. These criteria relate to SMPs' willingness to:

1. provide timely and relevant information back to the GP regarding the specialist's opinion following any consultation investigation or intervention, including information regarding an urgent need for hospitalisation or referral to another specialist for a second opinion;
2. ensure effective interactions with the front desk staff/receptionist, which include both the GP interaction with the frontline phone service and the patient's experience with appointment making and attendances at the rooms;
3. communicate with the GP over the phone regarding potential referrals, difficulties with the management of current patients under care and/or how to manage a patient who may or may not actually need to be referred;
4. educate the referrer regarding management of gynaecological problems; and
5. communicate using data files and emails that can be downloaded into patient files; with the increasing computerisation of GP practices, specialists who can do so are preferred.

The other criteria Hespe (2010) reported to be helpful in directing referrals are the alignment of the patient problem with the gynaecologist's interests and skills; access to timely services in the geographic catchment zone with public transport accessibility and having public and private hospital access; patient demographics and their own personal preference and ability to pay. Hespe concluded that even for a highly specialised gynaecological problem, in the first instance, GPs refer their patients to the gynaecologist

of their own personal choice based on prior experiences, and communication that takes place alongside referral, rather than being driven by subspecialisation. Patient expectations were also a strong driver of referral choice. Such findings highlight the significance of social exchange and professional relationships in referral practices.

Delva et al. (2011) researched factors influencing the GP referral of elderly French cancer patients following a case of suspected or clear diagnosis of cancer, using a cross-sectional survey design ($n = 1,500$ GPs). GP respondents reported having been influenced by patient-related factors (patient and/or family wishes, comorbidity, unsuitability of invasive investigations and the degree of physical and mental autonomy), cancer-related factors (severity of symptoms and expected side effects) and one organisational element (whether the GP was used to collaborating with oncologists). Following regression, two predictive models were put forward regarding the strongest influences on GP decision to refer patients to an SMP. Results indicated that the cancer site and organisational difficulties in patient management such as GP collaboration, physical location, waiting time for treatment, were significantly associated with the decision to refer elderly patients with early-stage cancer. For advanced-stage cancer, oncology training, patient age, organisational difficulties in patient management and cancer stage were significantly associated with the decision to refer elderly patients.

In Delva et al.'s (2011) study, 30% of GP respondents had received training in geriatrics and 15% in oncology. Nearly 50% of the GPs considered it difficult to refer a patient to a team of cancer specialists, and more than three-quarters of referring and non-referring GPs reported being influenced by five patient-linked factors:

1. wish or reluctance on the part of the patient;
2. wish of the family if present;
3. presence or absence of serious comorbidity;
4. unsuitability of conducting invasive investigations due to co-morbidities, and other health factors; and
5. the degree of mental and physical autonomy.

Three-quarters or more of the GPs were influenced by two disease-linked factors—the seriousness of the cancer symptoms and the expected side effects and tolerance of the treatment.

As regards organisational factors, more than 75% of the GPs reported that being used to collaborating with specialist cancer teams was influential. Confronted with a case of prostate cancer in the survey design, 75% of the GPs tended to refer this patient to a specialist, whereas when faced with a sigmoid colon cancer, 45% of GPs reported that they would refer to a specialist and 40% to an oncologist. For both of these types of cancer, the seriousness of the symptoms appeared to influence GPs the most. Another factor was the difficulty involved in organising care. For advanced cancer, GPs who had not attended courses in oncology were influenced by the patient's age. Oncology training was found to increase referral rates (Delva et al. 2011). Delva et al. (2011) concluded that specialist attitudes towards onco-geriatrics and established collaboration relationships significantly affected the initial management of patients.

Again, via a cross-sectional survey, Forrest et al. (2006) investigated the role of the PCP in specialty referral decision-making and the effect of patient, physician and healthcare system characteristics. The participant group comprised 142 US physicians. Data were collected for all patient visits ($n = 34,069$) made during 15 consecutive workdays. Results showed that a specialty referral was made during 5.2% of the physician visits considered in the study.

The psychological variables associated with specialist referral were higher reluctance to disclose uncertainty to patients and lower reluctance to disclose uncertainty to other physicians. A further key determinant was the level of training. Practitioners in solo or small group practices were less likely to refer than were physicians in larger practices. Forrest et al. (2006) hypothesised that practitioners in small groups or in solo practice defined their scope of practice more broadly than their counterparts did.

Further, patient characteristics had the largest impact on referral. Patient variables that increased the chances of referral occurring during a visit were age (> 17 years), gender (male), presenting problem uncommonly cared for by referring physician, high burden of comorbidity managed during the visit, being insured and health plans having gatekeeping arrangements (Forrest et al. 2006). Other variables associated with an increased chance of resulting in specialist referral included lower physician tolerance of uncertainty, larger practice size, health plans with gatekeeping arrangements and practices with high levels of managed care. These findings demonstrate that US GPs' referral decisions are

influenced by a complex mix of patient, physician, and healthcare system structural characteristics (Forrest et al. 2006).

2.3.2.1 Variation in GP Referral Practice Relating to Inequality

McBride et al. (2010) explored the reasons for variations in GP referral practices in the UK by investigating the extent of inequality-related variation at play. The key variables they focused on were patient age, gender, and social class. They noted that UK's National Health Service is publicly funded. Its central tenet is to provide universal health care to all those in need, irrespective of their social characteristics. The research design was a medical record-based cohort study of 130,000 patients from 326 UK primary care practices. Three conditions were focused on: postmenopausal bleeding, hip pain and dyspepsia.

Results revealed associations between patients' socio-demographic characteristics and their likelihood of referral. After adjustment for comorbidity (defined as the number of drug types prescribed), older patients were less likely to be referred for the three conditions examined. This gradient with age was particularly noticeable for postmenopausal bleeding. In addition, women were less likely than men to be referred for hip pain. There was also evidence of decreasing rates of referral with increasing deprivation for patients with hip pain and decreasing rates of referral for those aged less than 55 years with dyspepsia (McBride et al. 2010).

A secondary analysis showed that in the case of hip pain, the effects of age and gender were not explained by variations in overall referral rates between practices but were instead related to younger patients and men being more likely to be referred than their older, female counterparts within the same practice (McBride et al. 2010). Variations in referral rates by age occurred regardless of the criteria for referral or the risk of cancer. These findings of lower referral rates with increasing age have also been shown for patients presenting with symptoms of ovarian cancer, and it has been suggested that this may partly explain poor survival rates of older people with cancer in the UK. The variations may be explained in part by clinical uncertainty about the likely trade-off between benefit or harm related to the treatment of older patients and/or by patient preference (McBride et al. 2010).

The lack of information on disease severity and patient preference meant that it was not possible to ascertain whether differences in referral rates reflected clinically appropriate joint decision-making or inequity (McBride et al. 2010). The conditions studied differed for both the presence of explicit referral criteria and the need to exclude a cancer diagnosis. Both criteria were present for postmenopausal bleeding and dyspepsia in patients aged above 55 years, and socioeconomic variations in referral rates were not observed. Neither criterion was present for hip pain or dyspepsia for those aged less than 55 years, and socioeconomic gradients in referral rates were shown. In common with other research presented herein, McBride et al. (2010) reported that these gradients may in part be explained by a lower likelihood of referral by practices serving socially disadvantaged communities, having poor access to particular specialties. However, this is unlikely to completely explain the results because the focus was on common symptoms requiring access to the services of widely available gynaecologists, orthopaedic surgeons, gastroenterologists and endoscopists.

Other possibilities are that practices serving socially disadvantaged communities tend to have higher workloads than those serving more advantaged areas and that the patients often have multiple, chronic and complex health and social problems (McBride et al. 2010). Within-person factors related to the GP themselves may partly explain the findings. However, no relationship has yet been found between referral rates and the individual characteristics of GPs, such as age, years of experience or professional membership. Hence, McBride et al. (2010) recommended more research, in particular in-depth qualitative studies, to understand the complex determinants of inequalities in referral from primary care.

Gouda et al. (2013) researched factors affecting GP referral decisions in Ireland using a sample of 80 GPs. Each GP recorded the information of 100 consecutive patients relating to demographics and whether or not the patient was referred. The average GP referral rate was about 12% with a wide-ranging variation—as low as 1% and as high as 26%—that the authors found these results to be in line with the findings reported in UK studies. In comparison with Australia, studies examining individual GP referral rates reported variation ranging from two to twentyfold, and variation ranging from three to fourfold at the practice level (Piterman and Koritsas, 2005).

The Irish state pays for about 80% of all medicines, with the cost to the state of medicines dispensed depending upon the community medicine scheme that the patient uses. People who are unable to arrange GP medical and surgical services for themselves and their dependants are granted a medical card, which is referred to as a General Medical Services or GMS card. These medical cards provide subsidised medicines after the cardholder pays a small amount per prescription and a dispensing fee to the pharmacist.

A significant association was found between GMS eligibility and referral rates, with GMS ineligible patients being 1.6 times more likely to be referred than GMS eligible patients (Gouda et al, 2016). Interestingly, it was further demonstrated that the GMS status of the patient was the only patient characteristic that predicted referral patterns. Among GP characteristics, female GPs had a significantly higher rate of referral than did males.

Distance from primary to secondary care was found to influence the rate of referral, with decreasing referral rates as the distance to secondary care increased. This trend did not hold true for referrals to emergency services, with the referral rate being inverse. In this regard, Gouda et al. (2013) reasoned that patients accessing GP services that were farther from secondary care were willing to travel long distances to access emergency services. Another explanation was that the patient population referred to emergency services had a higher proportion of younger patients owing to an increased likelihood of acute illness resulting from accidents and injuries.

2.3.2.2 Variation in GP Referral Practice Based on Interprofessional Relationships and Relative Status

Another aspect of the referral decision process explored in the literature is interprofessional collaboration. Collaborative behaviour may occur when the parties establishing the relationship trust each other and believe the collaboration will yield some benefits to each party (Das & Teng 1998; Dyer & Singh 1998). Berendsen et al. (2006) sought to explore factors that motivate medical specialists to initiate and sustain new ways of collaborating with GPs. The aim was to bring about changes in collaborative models, to facilitate better patterns of working together and decrease wait times and pressure in outpatient clinics. They invited 18 Dutch medical specialists to participate in the qualitative interview study. Results revealed that 'teaching GPs' and receiving referrals were the main motivating factors for specialists to initiate collaboration. While they

wanted to develop the relationship in greater depth, most specialists believed that there was not much they could learn from GPs. Major factors that precluded collaborative care practices included 'lack of time', 'no financial compensation' and 'no support from colleagues'. In addition, projects targeting improved collaboration were reported as too complex and time-consuming, and guidelines as too restrictive. Berendsen et al. (2006) concluded that while SMPs were interested in collaborating because the GP is the gatekeeper for access to an SMP, and believed they are able to teach GPs something, they did not feel that they had anything to learn from the GPs and did not consider GPs to be professional equals.

Berendsen et al. (2006) also observed that once personal relationships with GPs had been established, an informal network with incidental professional contact seemed to be sufficient to satisfy the collaborative needs of the SMP. Such a scenario may relate to more than any difference in expertise, it may also indicate an underlying difference in the perception of status. Such a hierarchy could cause asymmetry between SMPs and GPs, which may become a barrier to collaborative practices. Berendsen et al. (2006) recommended that since SMPs considered it important to develop interprofessional relationships with GPs, initiatives to develop and foster such relationships should be stimulated, but they also cautioned that these motivational forces will probably not last, unless problems concerning access to specialist care are overcome.

Noting that most of the SMPs interviewed raised concerns, Berendsen et al. (2006) concluded that for new collaborative practices to be developed and succeed, the cost–benefit ratio must be improved, because the concerns voiced by SMPs seem to outweigh the positive motivational factors. The collaboration between SMPs and GPs has important implications for healthcare systems in which the GP controls patient access to specialist care. This is of significance to the Australian healthcare and referral context.

Berendsen et al. (2006) opined that new models of collaboration between SMPs and GPs should help improve the efficiency of patient care and contribute to decreasing costs, particularly in the case of chronic illness. While SMPs and GPs are both professionals, professionalism is characterised by clearly demarcated work and knowledge domains, special training, and assessment. Autonomy, which also includes participating in management or medical leadership, is an important motivating factor for professionals

(Beredsen et al. 2006, p. 2). Therefore, when developing new models of collaboration, it is important to take into account professionals' interests and needs.

Berendsen et al. (2006) highlighted the barriers to collaboration in the UK and the Netherlands. These include structure, procedures, finance and legitimacy at the system and institutional levels, and professional self-interest at the operational level. Professional barriers flagged were competing ideologies and values, professional self-interest and autonomy and interprofessional competition for domains. The existence of conflicting views about patients' interests and roles was also noted. These findings are of significance, considering that the UK has the poorest rate of cancer survival, despite ranking first in the world in terms of efficient delivery of health care (Organisation for Economic Co-operation and Development 2013). Berendsen et al. recommended change in the way physicians carry out their professional duties and how they perceive their role in the medical profession. This is a recommendation relevant to the Australian healthcare context and is discussed by Piterman and Koritsas (2005) where there was a progressive increase in open access specialist investigation without a specialist consultation. The GP refers the patient solely for the purposes of a diagnostic test without the specialist who performs the test determining the management that results from it; without a specialist interpretation of the results the patient is not receiving the best care, and the role of the GP and SMP has a diminished demarcation.

Moreover, Berendsen et al. (2006) discussed new collaborative practice models as types of contact about a patient, other than the conventional contact through correspondence or telephone. The topics for discussion were positive and negative experiences with GPs, new forms of collaboration and personal objections and preferences when working collaboratively. The subjects were asked to use concrete examples to illustrate their opinions. The questions did not follow a specific order in order to allow the subjects to freely associate among different topical areas. Consequently, some topics were discussed in depth. The resultant themes were patients' interests, regulating patient flow, the transfer of knowledge, increase in the knowledge of specialists, the personal relationship between the GP and SMP, insight into the manner of collaboration and reciprocity.

Numerous SMPs said that through collaboration, care can be improved along with the quality of life of the patient. Some specialists preferred incidental collaboration rather than a structured setup. Although SMPs viewed the GP to be in a central role in the

provision of patient care, they felt that patients should be cared for by a qualified team, with multidisciplinary clinics, including geriatrics, palliative care, oncology, and nursing for chronic wounds, coupled with comprehensive diagnostics. GPs would be able to contribute by overseeing possible complications of a treatment with their background knowledge of patients and the patients' social and family circumstances. A common set of guidelines was preferred for referral, which would encompass diagnostics and the assessment of patients in a single day to reduce the need for multiple visits. Solving problems to provide the best possible outcome in primary health care was preferred by almost all the specialists, who believed that this approach would reduce wait times and waiting lists in the patient's best interests.

Many SMPs found it important to know their GP colleagues personally. This would make their work easier and more pleasurable, and if they could reach each other for consultation, the quality and efficiency of telephone consultations would improve, and the patient would benefit. A number of specialists enjoyed working collaboratively with GPs. While most specialists did not experience any difference in status between them and GPs, they did report that they had observed an arrogant attitude among their colleagues towards GPs. No doubt subjective biases based on experience are at play here, though the point made by the authors stands. While historically there was a big difference in status, with more recent changes in specialty training focusing increasingly on working in a team setting, the SMP perception was that this difference has considerably reduced. However, many specialists said they noticed that GPs regarded specialists as having a higher status, ascribing this to a certain amount of defensiveness in GPs' attitude and behaviour.

Some specialists felt that in the present-day context, the relationship between the GP and the patient was becoming more distant, with GPs becoming increasingly busy owing to changes in primary care. The SMP view was that with more GPs now working part-time and following a strict time schedule, GPs are becoming less involved. The notion of the trusted physician who makes home visits after hours was viewed as gradually disappearing, and Berendsen et al. (2006) suggested that this is the reason some specialists find it difficult to form a network with the GP around a particular patient and family. For SMPs in the study, this trend was seen to preclude the development of a close collaborative relationship. Specialists reported being particularly interested in collaborating because the GP is the gatekeeper to secondary health access. The intent for collaboration is to decrease wait times and the pressure on outpatient clinics. Berendsen

et al. concluded that SMP concerns outweighed the benefits associated with developing new successful collaborative practices. In their view, the cost–benefit ratio needs to be improved, if specialists are to be motivated whereby their time and effort are financially rewarded.

2.3.2.3 Communication as a Factor Driving GP Referral Practice

The role of communication between GPs and specialists was investigated by Berendsen et al. in a quantitative cross-sectional study in 2009, using a random sample of 550 Dutch GPs and 533 specialists. The research question was 'How do GPs and specialists assess their mutual communication through telephone, letters, and postgraduate courses? Results suggested that specialists rated GPs' telephone accessibility as poor, whereas GPs themselves did not. There is no doubt that bias is at play here, though the results merit consideration. Specialists also rated the GPs' referral letter practices as poor and felt that GPs often do not follow the advice given by specialists, whereas GPs rated their compliance much higher. Half of the GPs felt that their queries were addressed appropriately by the SMP, while the SMPs believed this number to be much higher. Less than a quarter of the GPs felt that the SMPs' letters arrived on time; however, SMPs felt otherwise. Although both parties expressed a desire to receive feedback from each other, this was seldom the case when it came to real-life practice. The authors concluded that GPs and SMPs disagree on many aspects of communication, which impedes improvements. Accessibility by phone and the time span for the GP to receive reports from the specialist could be used as performance indicators. Berendsen et al. recommended that GPs and SMPs discuss among themselves how best to compose a format for the referral letter and the SMP report, as well as the mutual feedback exchange processes.

Hypothesising that the communication between PCPs and specialists regarding referrals and consultations is often inadequate, leading to adverse consequences for patients, O'Malley and Reschovsky (2011) examined the communication between PCPs and specialists in the US, by analysing the results from a nationally representative survey of 4,720 physicians. Physicians who had practised for at least 20 years and those in small and non-metropolitan practices reported higher rates of two-way communication regarding referral and consultations. There was a negative association between the number of managed care contracts and communication to specialists regarding referral.

For PCPs, the number of referrals decreased with increases in managed care contracts. Those PCPs and specialists who reported inconsistencies in communication reported challenges to ensuring high-quality care as being caused by delays in timely reports. Apart from process failures, such as misdirected reports and reports not documented in the patient's file, the authors highlighted a tendency to overstate the sending of reports and to understate their receipt, as a limitation of the study. Further, in the US context there are also self-referrals to specialists. The most important factor considered by PCPs as well as SMPs as facilitating better communication was the adequacy of time spent with the patient during consult. Other factors included the receipt of quality reports, and support from allied health staff and nurses, in monitoring and reporting.

Barnett et al. (2011) investigated the choice of referral physician by PCPs and specialist physicians in the US healthcare context. A potential referral relationship was identified in the sample of participating PCPs and specialist physicians if two doctors had a significant encounter (face-to-face encounter, hospital visit or a meaningful procedure code) with one or more common patients. Participants were asked to choose from an array of responses the reason that they chose a particular physician for referral. They were also specifically instructed to choose two reasons other than clinical expertise. Resultant reasons for referral were ultimately grouped into three categories: patient experience with the physician, patient access and physician communication. The study result highlighted the significance of patients' experience with the referred to physician as the main factor determining referral. Unlike specialists, GPs cited physician communication as a major reason for their referral choice, as well as working in the same hospital and sharing medical records. These findings are perhaps indicative of the GPs' focus on the integrated care of the patient.

2.4 Specialist-to-Specialist Referral

In addition to the lack of understanding about the initial processes of both the patient and the PCP in choosing a medical specialist (e.g. in the thesis context: medical oncologist, surgeon and radiation oncologist), there is a lack of knowledge about the choices made by a medical specialist when choosing another SMP. There is ambiguity surrounding the factors that influence the choice of specialist providers, as well as the relationships that underpin referral, which are formed around these circumstances.

The relationship between the SMP, the referring GP and the patient is a reciprocal, mutually dependent relationship, where each participant values outcomes under the control of the other. Clearly, multiple professional service relationships of depth and importance are actioned and progressed as part of the oncology SMP care process. Other factors that affect referral practices are likely to include, but are not limited to, those relating to the patient, family, disease characteristics and community values (Forrest et al. 2005).

According to Barnett et al. (2011), the choice of a referring physician for a given clinical problem may have important downstream effects. However, research on reasons for referral to a specific specialist is scant. To date, only one study—that by Barnett et al.—has scoped this topic. They investigated the reasons for the choice of referral physician among GPs and specialist physicians, and in particular, why the referrer chose a specific colleague to refer to. Results revealed that GPs mostly referred to colleagues within their professional network, while medical and surgical specialists referred patients to known colleagues less often. After excluding clinical skill as a criterion, patient experiences, communication and patient access ranked foremost for GPs. For specialists, referral was based on collegial relationships, which incorporated shared workspace, and patient rapport with the specialist (Barnett et al. 2011)

As with GP-to-specialist referral, specialist-to-specialist referral also significantly influences patient outcomes. Given the limited research in this area, this thesis research seeks to break new ground in this regard. Barnett et al.'s study was the first to explore the reasons for referral to specialists by GPs and specialists. They recommended research of a broader scope in terms of physician populations and study context.

2.5 Referral and Patients' Role

Central to the professional-to-professional relationship is the patient. The following section reviews the literature on the professional relationship between the doctor and the patient. It is accepted that doctor-to-specialist professional relationships will affect the referral of patients and that the professional relationship between the GP and the patient will affect the referrer-to-SMP professional relationship. Hence, although patients are not participants in the present study, as significant stakeholders in the research and as the purpose for driving referral relationships between medical professionals, a consideration

of the GPr–patient relationship, as it affects patient outcomes is needed (Piterman & Koritsas, 2005).

According to Heritage and Maynard (2006), 'Reflection on the doctor-patient relationship is undoubtedly as old as medicine itself, and recognition of its therapeutic power goes back to Hippocrates' (p. 354). In an exhaustive critique of research on the doctor–patient relationship over a 30-year period, they described the twentieth-century phenomenon in the biomedical paradigm that entailed a shift away from the patient and their concerns towards a preoccupation with disease and its evaluation. They proposed a reprise in focus on the medical interview as a way forward to offset the prevailing biomedical/diagnostic approach, via its attention to the patient's psychosocial context.

Drawing attention to research by Emanuel and Emanuel (1992) and their conceptualisation of the medical interview as a three-function process, Heritage and Maynard (2006) proposed a framework to assess the medical visit:

1. Who determines as to who sets the goals of the visit? The patient, the physician or both through negotiation?
2. Are the patient's values, as assumed by the physician, jointly explored or unexamined?
3. What is the functional role of the physician? Is it as guardian, advisor or consultant?

In relationships based on mutuality, the power of each participant is broadly balanced, the agenda for the visit is negotiated and the patient's values are explored; the role of the physician is that of an advisor in relation to the patient's goals and decisions (Heritage & Maynard, 2006). In paternalistic relationships, the physician's power outweighs that of the patient, and the physician controls the agenda, goals and outcomes in the doctor–patient relationship. Exploration of the patient's role in the referral process is explored in this thesis from the referring doctor's perspective.

Under a paternalistic approach, a biomedical and guardianship approach is adopted, whereby the physician determines the best interests of the patient without explicit consultation, assuming them to be in congruence with those of the patient. The opposite is true in a consumerist relationship, with the patient determining the goals, agenda and decisions about treatment and outcomes. The patient's values are made explicit without

discussion, and the physician is a technical consultant in a market relationship. Heritage and Maynard (2006) reported that in the chronic care context, only 20% of patient visits approximated the mutual model, while 66% were physician-driven and 8% were consumerist or market relationship based. Of importance here is the high proportion of physician-driven visits.

The dimensions of concordance, trust and enablement in the doctor–patient relationship, were investigated in an inpatient setting using a cross-sectional design by Banerjee and Sanyal (2012). Results indicated that 85% of patients reported concordance with their physician, and 15% reported varying degrees of disagreement with their doctors regarding their health issues. Patient trust in their physician was lower, with 61% of patients reporting complete trust and 39% having varying degrees of doubts regarding the trustworthiness of their doctors. A large proportion of patients (85%) reported feeling enabled, that is, able to cope with their illness, after the medical consultation. Higher socioeconomic status yielded higher concordance as did male gender, urban residence and higher education. Better trust in the physician was correlated with better patient enablement.

Since the early 2000s, the patient-centred care (PCC) movement has emerged as a policy driver in mainstream healthcare. In essence, PCC seeks better partnerships between health providers and consumers. Journal and web-based opinion and commentary in support of PCC is currently commonplace. Evidence linking a patient–provider partnership approach to clinical, cost and satisfaction outcomes has also emerged (Foot et al. 2014; Luxford et al. 2010; World Health Organization 2015). The widely accepted subject dimensions of PCC include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care (Luxford et al. 2010).

The movement can be sourced to healthcare professional groupings (clinical and organisational) and to healthcare consumer/community groupings. Closer and more genuine/holistic partnership relationships between providers and consumers are sought under PCC approaches, which have colonised the healthcare institution setting in particular, although patient partnership under a PCC model is also currently a routine aspiration in primary healthcare settings, such as the GP practice (Stokes-Lampard & Openshaw 2018).

2.6 Medical Professionalism: Professional Lens in Medical Practice

In the present research, the major factors investigated are those determining long-term professional-to-professional exchange relationships, their influence on referral practices and the resultant impact on HVC and patient outcomes. Thus, it is important to review the theoretical and empirical components using a professional (medical professionalism) lens. Eliot Freidson, a pioneer of medical sociology, is credited with studying the medical profession as if it were any other occupation that had the status of a profession (Conrad 2007).

Professions are defined as occupations that perform tasks of high social value because professionals possess both knowledge and skills that set them apart from other types of workers (Freidson 1984, p. 2). A profession is characterised as a community that shares a common experience and identity. Freidson stated that this conceptualisation is significant for professions such as law and medicine.

Pellegrino (2002) defined professionalism as a watchword for those qualities and modes of conduct appropriate to professions. He distinguished profession from professionalism. Professions have often been defined in terms such as the possession of a body of special knowledge, practice within some ethical framework, the fulfilment of some broad societal need and a social mandate that permits significant discretionary latitude in setting the standards for education and performance of its members (Pellegrino 2002, p. 378).

Medicine together with law, ministry and, at times, the military have been categorised as the 'learned professions' as they have occupied positions perceived as fundamentally important over many generations in human society. This special status is accorded based on the commitment by practitioners to something other than self-interest while providing their services. They are 'professed', that is, publicly committed to the welfare of those who seek their help, and thereby become ethical enterprises. Integral to a professional, is the act of 'profession': a promise, commitment, and dedication to an ideal.

The term profession has been linked to ethics from the earliest times, and the ethics of the medical profession was and is a virtue-based ethic (Pellegrino 2002, p. 380). A good physician was and is expected to display certain virtue-based character traits, such as fidelity to trust, benevolence, courage, compassion, truthfulness, and practical wisdom. These virtues are to be practised in the professional relationship with patients during

treatment, and in the practice of preventive medicine to fulfil the physician's responsibilities to society, in public health and organised medicine.

> For the virtue-based physician, the relationship with the patient could not be a contract or a commodity transaction. It is a covenant of trust, a special kind of promise to serve those who require their expertise. Suppression of self-interest to some degree would be a natural corollary of a virtue-oriented physician. (Pellegrino 2002, p. 382)

The term professional can be traced to the Latin term 'professio', or the declaration of belief or the affirmation of the rules and regulations of the profession that the professional has to uphold and obey (Coquillette 1994). According to Coquillette (1994), 'This obligation is a deeply personal one. It is a delusion of young, inexperienced … to think that they can separate their personal from their professional lives and their personal from their professional morality' (p. 1271).

The fundamental principles of medical professionalism, as outlined by the American Board of Internal Medicine ("ABIM") (2004) and endorsed by countries worldwide, including Australia, highlight the major goals of the healthcare system as patient welfare and social justice, to attain which the medical professional has to be committed to an array of responsibilities, such as to professional competence, honesty, patient confidentiality, trust and access to quality of care. The findings of studies that have tested the attitudes and beliefs of medical practitioners about professionalism have by and large supported these domains of responsibility (Campbell et al. 2007; Jha et al. 2007).

The Royal College of Physicians, London Working Party on Medical Professionalism, has defined medical professionalism as 'a set of values, behaviours and relationships that underpin the trust the public has in doctors, with doctors being committed to integrity, compassion, altruism, continuous improvement, excellence and teamwork' (Passi et al. 2010, p. 20). Medical professionalism has been defined by medical organisations around the world in general as centred on the duties of the doctor. For instance, in the US and Europe, the General Medical Council has described the duties of a doctor as providing good clinical care, maintaining good medical practice, teaching, and training, relationships with patients, working with colleagues, probity and health (Passi et al. 2010, p 19). ABIM (2004) has defined professionalism as comprising six components: altruism, accountability, excellence, duty, honour/integrity, and respect. The Royal College of Physicians and Surgeons in Canada (2007) defined professionalism based on a

competency framework, specifying seven roles for the competent specialist—medical expert, communicator, collaborator, manager, health advocate, scholar and professional. Most of these involve social exchange and relational components (Frank and Danoff, 2007).

Practising medical professionals are regulated by the Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia, as well as the various State Medical Boards. AHPRA (2014) comprehensively described the Code of Conduct for practising doctors, which is in alignment with the *Declaration of Geneva* and the *International Code of Medical Ethics* of the World Medical Association. The code on professional values and qualities has highlighted the duty of doctors to make the care of patients their first concern and to be ethical and trustworthy. Engaging in clear communication, being abreast of the latest skills and knowledge and refining and developing clinical judgement are some of the professional qualities emphasised in the code. Delegation, handover and referral are terms used to refer to the transfer of patient care by a physician to another medical professional, and section 6.3 of the code states:

1. *Delegation* involves you asking another healthcare professional to provide care on your behalf while you retain overall responsibility for the patient's care (Section 6.3.3);
2. *Referral* involves you sending a patient to obtain opinion or treatment from another doctor or healthcare professional. Referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose, such as care that is outside your area of expertise Section 6.3.1, and 6.3.2); and
3. *Handover* is the process of transferring all responsibility to another healthcare professional (Section 6.3.4).

Good medical practice, as outlined by the Medical Board of Australia involves:

1. taking reasonable steps to ensure that the person to whom care is delegated, referred or handed over has the qualifications, experience, knowledge and skills to provide the care required;

2. understanding that when one delegates, although one will not be accountable for the decisions and actions of those to whom one delegates, one remains responsible for the overall management of the patient;

3. always communicating sufficient information about the patient and the treatment they need to enable the continuing care of the patient;

4. coordinating between all treating doctors through:

   i. communicating all the relevant information in a timely way; and

   ii. facilitating the central coordinating role of the GP;

5. advocating the benefit of a GP to a patient who does not already have one;

6. ensuring that it is clear to the patient, the family and colleagues who has ultimate responsibility for coordinating the care of the patient. (Medical Board of Australia 2014, p. 16);

7. ensuring that patient access to care is free from bias and discrimination, including when making referrals; and

8. during conclusion of the relationship with a patient, making all arrangements for the continuing care of the patient and passing on all relevant clinical information to relevant providers.

The code has also detailed the code of conduct to maintain good relationships with colleagues and other practitioners to strengthen the practitioner–patient/client relationship and enhance patient care. In doing so, it espouses that good practice involves:

1. communicating clearly, effectively, respectfully and promptly with colleagues and other practitioners caring for the patient or client;

2. acknowledging and respecting the contribution of all practitioners involved in the care of the patient or client, and

3. behaving professionally and courteously to colleagues and other practitioners at all times, including when using social media.

Another significant aspect of professional standards for medical practitioners is the necessity to display a standard of behaviour that warrants the trust and respect of the community. This includes observing and practising the principles of ethical conduct.

A Physician's Charter was published in 2002 by the North American and European Internal Medicine Boards and has been endorsed by more than 120 medical organisations

including Australian organisations. The Charter made a declaration on medical professionalism for the new millennium, comprising three fundamental principles: patient welfare, patient autonomy and social justice. The Charter also outlined a set of 10 professional responsibilities: commitment to competence, honesty, confidentiality, relationships, quality and access to care, distribution of finite resources, scientific knowledge, managing conflicts and responsibilities. Again, social exchange and relational components figure strongly in this list of attributes.

The Australian Medical Council (2009) in its Code of Conduct for doctors in Australia lists the professional values and qualities of doctors, all of which can be considered to be functional constructs within SET, RMT and medical professionalism conceptual frameworks, as outlined in Figure 2.2. Significant role-related attributes and responsibilities include patient welfare, ethical and moral responsibility to practice medicine with commitment to safety, cultural awareness, self-awareness and self-reflection. Further, 'Good communication underpins every aspect of good medical practice' (Australian Medical Council 2009, p. 2). They have a duty to keep their knowledge and skills up to date, refine and develop in their clinical judgement as they gain experience, and contribute to their profession' (p. 2–3). Professional behaviour also includes 'a standard of behaviour which warrants the trust and respect of the community. This includes observing and practising the principles of ethical conduct …maintaining professional boundaries …and reporting obligations' (p. 23).

In a comprehensive meta-analysis on developing medical professionalism in students of medicine, Passi et al. (2010) highlighted that there still remains uncertainty regarding what professionalism actually is. They stated that professionalism is a multifaceted concept and the lack of a consensus definition of the construct presents a challenge when designing curricula. Further, evidence-based strategies are unavailable for the teaching and assessment of professionalism. In the view of these authors, sociologists might prefer theories that incorporate the political, economic, and social dimensions in understanding professionalism and seek to map the evolutionary progression of medical professional exchange as multidimensional and encompassing the social, psychological, political and economic domains of health care. Moralists might consider professionalism an aspect of personal identity and character that develops over time.

AHPRA (2014) has defined medical professionalism as the values and skills that the profession and society expect of doctors, encapsulating both the individual doctor–patient relationship and the wider social 'contract' between the profession and society. Its members must adhere to certain values, such as respect, trust, compassion, altruism, integrity, advocacy, justice, and collaboration. The ongoing commitment to medical professionalism will maintain trust that doctors will serve the public's interests above all else.

Borgstrom, Cohn and Barclay (2010) researched new values and practices associated with medical professionalism. They aimed to determine how final year medical students experience and understand new values of professionalism as they arise in relation to confronting dying patients, and as they possibly conflict with older values that emerge through hidden aspects of the curriculum. For many years, sociological studies have identified cultural aspects of medical education that influence ways in which the next generation of doctors are socialised, including issues of hierarchy and working in teams, detachment, features of authority and dealing with uncertainty. For decades, attempts to reform medical curricula have been constrained by the resistant nature of the overall 'learning environment', which has proven difficult to change by simply introducing a formal curriculum. This argument was the starting point for examining the different ways in which the features of the hidden curriculum lag behind and are experienced as conflicting with newer values that currently underpin education reform. One hundred and twenty-three ($n = 123$) final year undergraduate medical students from the University of Cambridge, School of Clinical Medicine, supplied 116 portfolios from general practice and 118 from hospital settings about patients receiving palliative or end of life care (Borgstrom, Cohn & Barclay 2010).

Analysing the portfolios revealed professional values to be prevalent in all the portfolios. Students emphasised patient-centred, holistic care, synonymous with a more contemporary idea of professionalism, in conjunction with values associated with the 'old' model of professionalism that had not been directly taught to them (emotional disengagement and detachment). Integrating 'new' professional values was at times problematic. Three main areas of potential conflict were identified: ethical considerations, doctor–patient interaction and subjective boundaries. The conflicts emerged from the mix of values associated with the different professionalism models. Analysis indicated that 'new' models were not replacing existing elements.

The 'old' model, characterised by paternalism, emotional disengagement and establishing certainty, is being replaced by a 'new' model that emphasises patient-centeredness and collaboration. While in the past, detachment was viewed as a key feature of patient encounters, in the present, empathy and SDM require doctors to consider their own emotions as a resource for providing more holistic forms of care. Reflective practice, comprising written as well as oral exercises that incorporate critical learning, is claimed to foster these qualities/attributes, and is becoming part of medical education, doctor appraisal and revalidation in the UK. Analysis focused on the topic of 'professionalism', viewing the content of the portfolios as representative of the general values imparted to students throughout their education. Although reference to professional values was prevalent in all the portfolios, students emphasised the importance of choice and PCC as well as values more associated with the 'old' model of professionalism, such as detachment and the importance of extensive technical knowledge. Reflections on practice-based experiences frequently highlighted instances in which such values proved challenging.

Three main areas of potential conflict were identified: ethical considerations, interactional issues, and unease around establishing subjective boundaries. This study demonstrates that overt commitment to more empathic and patient-centred approaches to medical care do not necessarily replace other more prescribed values and behaviours that remain part of a hidden curriculum embedded in institutional practices. The bringing together of new values-in-practice into the existing professional curriculum is not a smooth or simple transition. Further, the reality of medical encounters is likely to be far different from the values recommended in the curriculum. Borgstrom, Cohn and Barclay (2010) believed that the individual desire to seek balance and resolution across a wide range of issues may themselves be the key and lasting features of medical professionalism. They highlighted the significance of professional exchange relationships between GPs and specialists, and among specialists, to address the issues of timely and correct referral, which are an essential component of medical professional practice and best patient outcomes.

2.7 Medical Error

An error (in medicine) is defined as the failure of a planned action to be completed as intended (Reason, 1990). In the oncological paradigm, an error can be a delay in diagnosis and treatment as well as the obvious error of incorrect diagnosis and administration of

treatment. Cancer prognosis is greatly improved when diagnosed early so that appropriate treatment can commence in a timely fashion. This thesis postulates that delayed or incorrect referral is a form of medical error because of the chain reaction of delays it creates for the cancer patient. A considerable amount of research portrays the dangers of late referral, inappropriate examinations, deferred diagnosis, and poor patient outcomes in those diagnosed with cancer (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2014; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012).

O'Donnell (2010) stated that the real cost to the health service may lie not with the patients who are referred unnecessarily but with the patients who are referred later or not at all. Maringe et al. (2020) recently postulated that oncological treatment delays created by the COVID-19 pandemic will cause an increase in deaths over a five-year period. By creating a conceptual framework, the researchers estimated the subsequent impact on survival by moving patients from the non-urgent referral pathways (from GPs and secondary care) to urgent referral pathways, such as 2WW and emergency departments. The 2WW and emergency department pathways are both associated with a later stage of diagnosis and enabled Maringe et al. (2020) to estimate the impact of diagnostic delay on stage migration and survival outcome.

Improved accessibility to treatment can positively affect the referral pathway (Kwon et al. 2014). Blinman et al. (2012) discussed the impact of a small population of oncologists on the referral process and the accessibility to a consultation. The lack of understanding about the factors underlying referral processes from the GP and other specialists to SMPs has led to an underutilisation of what can only be described as a scarce resource, especially in the Australian context. For example, Australia has 1.4 Medical Oncologists per 100,000 head of population, compared with 3.5 in the US (Blinman et al. 2012). Apart from the fiscal impact this has on private practice and the healthcare system generally, this has implications for patient outcomes. Makary (a surgical oncologist) and Daniel (2016) analysed scientific literature on medical error deaths in the US and estimated that medical error (251,000) was the third most common cause of death in 2013, after heart disease (611,000) and cancer (585,000). From such analyses, it is reasonable to conclude that overworked doctors and prolonged waiting times for specialist medical care are likely factors that lead to medical error.

In Australia, there were 18,000 deaths from medical error in 1999 (Weingart et al. 2000). The increase in errors is particularly noticeable when compared with a 1995 study by Wilson et al., who undertook a review of the medical records of over 14,000 admissions to 28 hospitals in NSW and South Australia. Results revealed that 16.6% of these admissions were associated with an 'adverse event' that resulted in disability or a longer hospital stay for the patient and were caused by healthcare management/mismanagement; 51% of the adverse events were considered preventable. Such results compare poorly to the likes of Denmark, New Zealand, and Canada, who consistently benchmark at a 10% medical error rate. It is hoped that this study can inform efforts which seek to help Australia bridge the gap with these higher-performing countries, by laying bare and explaining the drivers of interprofessional referral behaviour and making sense of system and process gaps that GPs and specialists work with (or work around) on a daily basis.

2.8 Relationships and Service Orientation: Specialist Medical Provision

The issues associated with selecting an SMP are complex for a person who could be effectively placing their life in the hands of another. Patients trust that their medical specialist will perform actions that result in positive outcomes (Anderson & Narus 1990). Consequently, when trust is developed by the patient and their referring doctor, based on their experience with a particular specialist, they will most likely want to maintain that relationship because of the uncertainty and risk of going to another specialist (Berry 1995).

Reviewing research around service relationships, Tam and Wong (2001) highlighted the need for consumers to have access to information and knowledge to help make informed choices. They further proposed that if consumers can master such expertise, it will help them to engage in more meaningful relationships. Therefore, it follows that a specialist should properly manage the relationship with a patient and their referrer and view each encounter as an interactive process and an opportunity to reciprocate and enhance trust through superior quality service (Grönroos 2001; Solomon et al. 1985; Johnson & Grayson 2000).

The relationships between the participants in the patient–referrer–SMP relationship necessarily include the specialist's support staff. When patients access the service of an oncologist, for example, support staff usually play an integral part in the service delivery.

It has been found that staff attitudes, behaviours, service orientation level and, more recently, engagement level are likely to influence the customer satisfaction level (Grönroos 1990; Johnson & Grayson 2000; Kim, McCahon & Miller 2003; Kim, Leong & Lee 2005; Teng & Barrows 2009). Therefore, specialists seeking differentiation to surpass their competitors should create a service-oriented climate by selecting highly engaged employees (O'Connor & Shewchuk 1995) who strive to satisfy consumers (Grönroos 1990; Hennig-Thurau 2004; Heskett, Sasser & Schlesinger 1997). Specialists who pursue service-oriented business strategies are likely to build long-lasting relationships, enhance consumer commitment (Homburg, Hoyer & Fassnacht 2002) and create competitive advantage (Teng & Barrows 2009) and positively influence their financial performance (Homburg, Hoyer & Fassnacht 2002; Kohli & Jaworski 1990; Lytle & Timmerman 2006; Narver & Slater 1990). See Figure 2.1 for the four key elements of competitive advantage being explored.

Cost Leadership
A firm's ability to produce a good or service at a lower cost than its competitors, which gives the firm the ability to sell its goods or services at a lower price than its competition or to generate a larger margin on sales.

Differentiation
A firm's abiltiy to leapfrog other market players by the introduction of completely new or notably better products or services.D

Innovation
A firm's ability to leapfrog other market players by the introduction of completely new or notably better products or services.

Operational advantage
A firm's ability to perform internal business activities better than competitors. These include the actual functioning of the business as a whole, staff, policies, proecdures, work practices etc,

Figure 2.1: Primary Components of Competitive Advantage

Yet, like all measurable variables, competitive advantage is strictly contingent on the context within which it is applied. To date, there is a significant lack of research that seeks to identify contributing factors of competitive advantage within a service environment, such as specialist medical care. Perhaps this is due, in part, to the particular nature of the healthcare industry in which the usual marketing and business strategies are not applicable and the Australian legal restrictions on economic exchange mean that medical providers are unable to advertise their services and/or skill as superior to those of their competitors.[1] Further, owing to the Australian Department of Health mandate and the Australian Medicare guidelines, any potential for a significant cost variation is well contained. Owing to these sector-specific restrictions, most fundamental competitive advantages are exempt in a medical service environment, in particular, the conventional product-based measures of quality, quantity, differentiation, time to market and cost leadership. Consequently, other attributes must be identified and investigated to create differentiation.

The primary objective to creating this differentiation is to predict, obtain and sustain service loyalty. Service loyalty may be defined as 'the degree to which a customer exhibits repeat purchasing behaviour from a service provider, possesses a positive attitudinal disposition towards the provider, and considers using only this provider when a need for this service arises' (Gremler & Brown 1996, p. 173). Although loyalty is an important issue for all businesses, it is particularly salient for service firms for three reasons:

1. Loyalty is greater or more prevalent among services consumers than among goods consumers (Zeithaml 1987).
2. Services provide more opportunities for person-to-person interactions which, in turn, often provide opportunities for loyalty to develop (Parasuraman, Berry & Zeithaml 1985; Surprenant & Solomon 1987).
3. Perceived risk is often greater when purchasing services than goods (Murray 1991), providing an atmosphere more likely to lead to customer loyalty since loyalty is often used as a risk-reducing device (Ghotbabadi, Feiz & Baharun 2016; Gremler & Brown 1999; Zeithaml 1987).

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[1] This prohibition is imposed by regulations and legislation such as the *Health Act* 1954 and the *Health Administration Act* 1982 (NSW) as well as the specialists' respective accrediting college/body.

The positive relationship between patient loyalty and the frequency of patient visits (Choi et al. 2004) leads not only to profitability—since it propels patients to choose the same provider again (Ruyter, Wetzels & Bloemer 1998; Sardana 2003)—but also to the development of relationship engagement. The same can be said for referring provider relationships. In fact, the cultivation of customer loyalty is an important challenge facing most service providers in which the primary aim is to foster and maintain long-term relationships. In the service setting, friendships are a complex set of exchanges that are influenced by instrumentality, sociability, mutual assistance, trust and reciprocity (Price & Arnould 1999, pp. 41–2). In short, SMPs must strive for the development of relationships with loyal customers (patients and referring doctors). Yet, how are these relationships established? Thus far, only a relatively small body of research has addressed the formation and maintenance of these important relationships in task-oriented, commercial contexts.

The relationship between specialist, referring doctor and patient is a reciprocal mutually dependent relationship founded on trust, in which each participant values outcomes under the control of the other (Calnan & Rowe 2006). The patient requires the services of both specialist and referrer, the specialist cannot operate without referred patients and the referrer does not have the requisite skill to attend to specific ailments. Molm (1994) argued that such a structure 'of mutual or reciprocal dependence is a defining characteristic of all social relations based on exchange' and that 'in mutually dependent relations, each [participant] values some outcomes that are under the control of the interaction partner' (p. 165), providing the other participant with benefit through the exchange either directly or indirectly through the patient. Therefore, the roles of trust and reciprocity are brought to the foreground within these relationships; it is not a matter of simply cultivating consumer loyalty found in relational marketing techniques but rather an explicit involvement and development of a relationship of collaboration based on trust. This role of trust stimulates discussion about the nature of the relationships between specialist, referring doctor and patient. Indeed, it could be argued to be the central feature of an effective medical (social exchange) relationship.

These varied attributes that influence service loyalty, trusting behaviours and perceptions of trustworthiness are an essential component of stable, ongoing social exchange relationships, which are not solely reducible to one component (Price & Arnould 1999). Instead, these service-based relationships are associated with the quest for preferred

outcomes, which include commitment and are founded upon reputation, service quality, loyalty, trust and reciprocity. According to Sumaedi, Yarmen and Bhakti (2016), they provide a health service quality model, which comprises the outcome, interaction, and environment of healthcare service, as the major dimensions. The service outcome comprises three components: waiting time, mediation, and effectiveness. Service interactions encompass the nature of the initial interactions, professional expertise and hard (physical examination) interaction, all of which are essential domains of medical professionalism. The service environment includes the ambient condition and the nature of the medical equipment in use.

Although service and product providers both recognise service as an important source of competitive advantage (Olivia & Kallenberg 2003), if not the paramount contributing factor, service quality remains an elusive and abstract construct, subject to relative partisanship (Parasuraman, Berry & Zeithaml 1985; Tomiuk 2000). In fact, there appears to be no universal or well-accepted conceptual definition or model of service quality, nor an operational definition as to how service quality can be measured and assessed (Seth, Deshmukh & Vrat 2005, pp. 933–4). Thus, neither is its definition, be it conceptual or operational, made clear in the literature nor are its measurable qualities easily applied to different contexts.

Numerous studies have sought to define and measure service quality and analyse related customer perceptions using product-based criteria, but none have dealt with a pure service environment where all the participants are presumed equally qualified and following the same clinical protocols. In these unique circumstances, how can services be differentiated, and long-term relationships established for a competitive advantage? Despite the significance of these questions, this topic has received relatively little attention in the literature. Consequently, multidimensional research is required whose appropriateness is derived from the nature of the social phenomena being explored (Morgan & Smircich 1980; Easterby, Thorpe & Lowe 1991). The impact of perceived healthcare service quality on the provider's success or failure has been well established (Headley & Miller 1993; Reidenbach & Sandifer-Smallwood 1990). However, this significant relationship between service quality and success is largely imputed to patient satisfaction, which functions as a mediating variable between the two constructs. For healthcare providers, consumer satisfaction leads to favourable results, such as higher rates of patient retention, positive word of mouth and higher profits (Peyrot, Cooper &

Schnapf 1993; Zeithaml 2000). Patient satisfaction also influences the rate of patient compliance with physician advice and requests (Calnan 1988; Pascoe 1983). Put simply, patient satisfaction affects the outcome of medical practices, and it is for these reasons that patient satisfaction assessment has become an integral part of healthcare organisations' strategic processes (Choi et al. 2004, p. 914; Reidenbach & McClung 1999).

Satisfaction is crucial when consumers and purchasers of healthcare services decide on new enrolment and reenrolment (Mummalaneni & Gopalakrishna 1997; Woodside & Shinn 1988; Woodside, Frey & Daly 1989). Choi et al. (2004) asserted that to create or sustain competitive advantage, healthcare providers are compelled to integrate the traditional medical approach, which stresses the effectiveness and efficacy of health service outcomes, with a patient-centred principle that not only considers patients' concerns and interests, but their decision-making principles and the factors that influence these important decisions. Thus, medical specialists need to understand consumer (patient and referring doctor) behaviour and the reasons for that behaviour.

Therefore, this thesis aims to explore and understand factors influencing lasting professional exchange relationships between referring doctors; that is, between GPs and specialists, and from one specialist to another. This includes addressing the following lines of inquiry:

1. What factors contribute to the commencement of a relationship?
2. What factors contribute to the maintenance of this relationship?
3. What are the implications of such professional exchange relationships on referral and patient outcomes?
4. What are the implications for the provision of private healthcare for cancer patients in Australia?

Based on current literature, although the specialist–referrer relationship, which may span a working lifetime and incorporate their mutual patient to an unknown extent, is not specifically dealt with by the literature, the theory of social exchange could provide a theoretical lens to examine this relationship because SET argues for 'a study of the relations amongst participants resulting from benefits and costs they provide for one other' (Blau 1964; Emerson 1976; Homans 1974 [1961]) (cited in Molm, 1994, pp. 163–4), underlined by a 'structure of mutual dependence' (Molm, 1994, p. 163). A basic tenet

of social exchange relationships is that they have the potential to 'evolve over time into trusting, loyal, and mutual commitments' that deliver benefits to all involved in the social exchanges (Cropanzano & Mitchell 2005, p. 875).

This complex professional services relationship between specialist, referrer and patient is founded on a number of factors including reputation, service quality, trust and reciprocity. Thus, to identify and examine competitive advantage in the specialist healthcare environment, in which laws prohibit economic exchange such as a referral fee, new approaches must be adopted to create medical-specific competitive advantage factors. Research is required to expand this uncharted body of knowledge by exploring the creation of an enduring service differentiation model for a SMP. which defines reputation and the attributes that lead to lasting social exchange relationships, underwritten by loyalty, trust and reciprocity.

2.9 Provision of High-value Care

> Medicine exists in the service sector of the economy…. High quality service is critical
> to the current and future practice of medicine, and is a distinguisher in the market place.
> (Stewart 2011, p. 638)

HVC offers physicians a model for providing the best possible patient care, whilst simultaneously reducing unnecessary health costs to the healthcare system (American College of Physicians 2012). HVC has a 'triple aim': better care for individuals, better health for populations and a lower cost per capita (Martin, Berwick & Nolan 2013). To achieve this threefold aim, the strategies proposed are an amalgam of relationship approaches, professionalism and high-value service. These authors stipulate that all actors should have common goals of mutually agreed risks and benefits of cost-reduction, build trust through transparency about costs and outcomes and develop new business models, which allow everyone to succeed in a system that costs less, with increases in productivity through redesigning care, such that competition based on real value is encouraged. While cooperation should dominate in setting goals, administrative work, measurement, financial reporting and planning and innovations, when costs and outcomes become transparent, competition among specialists, chronic-disease managers and highly specialised services might be advantageous, caution is recommended to ensure patient outcomes remain the focus.

Research that focuses on the process through which consumers selectively identify and then utilise specialist advice is needed. Research also needs to explicitly connect the provider choices of individual consumers to established measures of provider quality. However, assessments of individual service provider quality are currently unestablished (Harris, & Buntin 2008). This gap is addressed in the current research through identifying and exploring three central concerns:

1. identifying professional-to-professional exchange behaviour between GPs and SMPs, and among SMPs, when seeking a specialist service, and subsequently understanding the reasons for that behaviour; A particular focus will be on the process that leads to the development of trust, and the factors that influence the initial choice to use particular specialist providers;

2. understanding the relationships that build around these circumstances and the factors that contribute to their sustainability; and

3. determining the implications on best patient outcomes through the provision of timely and correct referral.

2.10 Chapter Summary

This chapter scoped the related literature on the role and significance of referral in best patient outcomes. Of central importance to the mission of this thesis, cancer survival and referral timeliness/appropriateness, have been shown to be, and are widely held to be, positively correlated. The GP-to-SMP referral relationship has been subject to more study than the SMP–SMP referral relationship, and hence, relevant research findings are limited.

The likely role of professional exchange relationships as determinants of referral between GP and SMP, and from one specialist to another, was found to be supported by the literature, along with patient-related factors and pragmatic systemic factors. A 'within-doctor' explanation of interprofessional referral behaviour and practice is discussed in this literature, but no widely agreed constellation of determining factors has been established. The probable role of stronger understandings (contributing to better quality and sustainability) of these key inter-practitioner relationships (i.e. GP–SMP and SMP–SMP), as drivers of HVC and competitive advantage have been noted in the chapter. In the next chapter, SET, RMT and trust, which comprise the conceptual theoretical framework for the present research, are critically reviewed.

Chapter 3: Literature Review—Conceptual Bases of Theories

Exchange theory can account for almost all social phenomena. ... it is especially useful in pointing up relationships among highly diverse phenomena. When its implications are extended, the exchange formulation may have significant generative effects ... when properly elaborated ... it can serve humane ends. (Gergen 1980)

3.1 Overview

This study seeks to determine the dynamics and characteristics of social exchange and professional relationship drivers in GP and specialist referral practices, which operate in an ethically bound, high-value service environment in the oncology context. The drivers of relationships between GPs and SMPs and between SMPs in the field of oncology, are explored within a multidimensional theoretical framework that includes SET and RMT. In this chapter, both theories are reviewed and assessed via a medical professionalism lens.

Based on a theoretical model (see Figure 2.1) and a qualitative methods approach, the aim of this research is to identify and understand both the drivers and detractors of lasting professional exchange relationships and its impact on referral practices in the medical professional context. Of particular interest to this research is the role of professional exchange relationships as antecedents to referral. It is hypothesised that by understanding the drivers of interprofessional exchange, medical professional perspectives of the factors that facilitate timely provision of HVC through appropriate referral will be ascertained.

3.2 Social Exchange Theory: Historical Overview of Theory and Research

This development of social exchange theory (SET) is attributed to many theorists from the fields of anthropology and sociology. Ekeh (1974) credited the first body of literature on social exchange to Sir James Frazer (1854–1941), the father of modern anthropology. His theorising around social exchange could be classified as focused on individualistic orientation based on individual economic motives. In contrast, the French anthropologist and ethnologist Levi Strauss (1948) postulated a collectivistic theory of social exchange in the late 1940s, conceptualised on the notion of univocal reciprocity and generalised exchange that involves three or more parties in the exchange. Levi Strauss's works were

not translated into English until 1969. In the mid-1950s, Homans (1983), to whom SET is formally credited, conceptualised social exchange individualistically. In advancing theory, Homans proposed that exchanges tend towards equilibrium, whereby the amount given in an exchange would tend to be matched by an expectation of obtaining something similar in return; thus, a cost–reward operative would be at play.

Since the inception of SET as an explainer of social relationships, resource exchange has been considered a key determinant (Blau 1964; Cropanzano & Mitchell 2005; Dunford, Snell & Wright 2001; Foa & Foa 1980, 2012; Gouldner 1960; Kinchen et al. 2004; Molm 1994; Wernerfelt 1985, 1995).

3.2.1 Origins and Progressive Development of SET

The notion of exchange between social actors was first explored in depth by the social anthropologist Malinowski (1922) in the early 1920s in his seminal study of Trobriand Islanders' exchange practices. His theory of social exchange was predicated on social psychological needs, wherein individual psychological needs and societal needs were blended (Ekeh 1974). He did not address economic motives in social exchange processes.

Inspired by Malinowski's work, Mauss (1923) studied ancient cultural gifting and exchange practices in primitive societies, seeking holistic explanations for human exchange-related behaviour. Prefacing the deep concern with social exchange that ensued in sociology throughout the twentieth century, Mauss proposed that understanding human exchange scientifically might be central to the establishment of an enlightened political and social life for humanity:

> It is possible under certain circumstances to study total human behaviour; and how that concrete study leads not only to a science of manners, a partial social science, but even to ethical conclusions—'civility', or 'civics' as we say today. Through studies of this sort we can find, measure, and assess the various determinants, aesthetic, moral, religious and economic, and the material and demographic factors, whose sum is the basis of society and constitutes the common life, and whose conscious direction is the supreme art—politics in the Socratic sense of the word. (p. 81)

Mauss also emphasised the competitive and strategic aspects of gift giving and exchange, stating that by giving more than the competitors, a person lays claim to greater respect

and power than the receiver, and thus laid the foundation for a theoretical understanding of social exchange and relations.

It took more than half a century for social exchange to be studied in a modern context (Blau 1964; Emerson 1976; Homans 1983; Molm, Takahasi & Peterson 2000). Blau (1964) explicitly distinguished between negotiated and reciprocal transactions, stating that a negotiated exchange was characterised by cost–reward certainty whereas a reciprocal exchange entailed risk:

> Social exchange … involves favours that create diffuse future obligations not precisely specified ones, and the nature of the return cannot be bargained about but must be left to the discretion of the one who makes it (p. 93).

For Blau, whether an exchange was reciprocal or negotiated was a more fundamental question than how the exchange was carried out. The existence of reciprocity distinguished a social exchange from an economic one, which was likely to be negotiated, formal and involve exact quantities. From here, it became apparent for Blau, that social exchange requires trust: 'Since there is no way to assure an appropriate return for a favour, social exchange requires trusting others to discharge their obligations' (Blau 1964, p. 94). For both Homans and Blau, social exchange as economic exchange includes non-material goods that contribute to human happiness. (Ekeh 1974).

Similar to Mauss (1923), Blau (1964) viewed social exchange as vital to the fundamental componentry of the social force itself. For Blau, social relationships united not only individuals in groups, but also groups in communities and societies:

> The association between individuals tends to become organised into complex social structures, and they often become institutionalised far beyond the life span of human beings, while structures of social relations are, profoundly influenced by common values, these structures have a significance of their own. (1964, p. 13)

Viewing social exchange under a microeconomic theoretical perspective, exchanges are between people who do not know each other (Hall 2001). The original conceptualisation of SET did not consider information or knowledge as a resource. Social exchange was described in terms of obligations, expectations, giving, receiving, and repaying. An interpretation of social exchange, in terms of commitment mechanisms in social organisations, was proposed by Kanter (1968). Sourcing historical and contemporary

records of research on utopian communities, three core constructs of continuance, cohesion and control were identified as axes of commitment in social systems. Continuance (for Kanter) referred to cognitive commitment to fulfilling social roles with no evaluation or affect attached to the role and functioning, based on rewards/profits and punishment/costs. Cohesion reflected attachment to social relationships without internal moral imperatives, and control was the commitment to norms and values within the social group, which morally bound the individual.

In 1976, Emerson asserted that SET should be viewed, not so much as a theory, but as an umbrella or frame of reference for multiple micro and macro social exchange-related explanations. He advanced understandings of negotiated exchange by introducing and empirically testing a theory of power dependence relationships, whereby he proposed that the mutual dependence of exchange participants provides the structural basis for their relative power. From here, the benefits associated with exchanges were understood to relate to participants' relative dependence upon each other.

The research of Homans (1983), Blau (1964), Emerson (1976) and the originating anthropological theorists contributed to a modern sociological understanding of relationships as existing in a frame of complexity, in which the dimensions of communication, exchange, relationality, dependence, power, commitment, reciprocity and negotiation were all collectively at play. Clark and Mills (1979) conceptualised social exchange in terms of relationships, arguing that the term exchange relationship was more appropriate than economic exchange and that understanding exchange as a communal relationship was more apt than using the traditional construct of social exchange. Under Clark and Mills' frame, exchange relationships involved repayment within a specified period and involved exchange of economic or quasi-economic goods driven by personal interest. For Clark and Mills, communal relationships were open-ended, not necessarily time bound and involved the exchange of socio-emotional benefits.

The significance of communication, social exchange and interprofessional relationships in determining healthcare referral practices has been highlighted by a limited number of researchers (Delva et al. 2011; Harris, et al. 2016; Hespe 2010; Newton, Hayes & Hutchinson 1991). In this regard, O'Donnell (2000), McBride et al. (2010) and Harris et al. (2016) stated that it is necessary to facilitate a better understanding of interprofessional

relationships between medical professionals and its effects on referral practices and patient outcomes.

3.2.2 Social Exchange in the Professional Context

In management research, the application of social exchange-related theory to workplace relationships has been studied extensively (Brock 2006; Brunetto 2014; Cropanzano & Mitchell 2005). Blau's (1964) framework comparing economic and social exchanges stated that social exchange involved unspecified commitments and led to feelings of personal obligation, gratitude, and trust, unlike a pure economic exchange. This model postulated antecedents in the workplace as leading to interpersonal connections, which were referred to as social exchange relationships. For Blau, social exchange relationships occurred when employers took care of employees, leading to beneficial consequences in work behaviour and attitude terms. Blau referred to social and economic exchanges as varieties of transactions rather than as relationships.

The focus on relationship formation in social exchange was advanced by Organ (1994), who maintained that an exchange relationship could take on the quality of a covenant, binding an individual to a collective. Organ and Konovsky (1989) had earlier differentiated social and economic exchange relationships, rearticulating these concepts as more than a set of rules, but rather an interpersonal attachment between two or more individuals. This realisation led to the development of relational constructs in workplace social exchange.

From the 1990s, Molm reinvigorated social exchange theory-making by distinguishing the characteristics of reciprocal exchange from negotiated exchange and proposing a shift from a dichotomised view of exchange as either behaviourally or rationally framed, towards a more integrated cognitive–behavioural view (Molm 1994, 2003, 2010; Molm, Takahasi & Peterson 2000). This theory of social exchange has been used in cultural settings as well as in interprofessional relationships. Further to this, Shore et al (2009) provided a differentiation between social and economic components in social exchange relationships, and the moderating role of culture and individual differences in explaining outcomes.

Cropanzano and Mitchell reviewed SET and the related literature in 2005. They usefully sought an essentialist understanding of the work conducted until then and stated:

Although theorists diverge on particulars, they do converge on the central essence of SET: Social exchange comprises actions contingent on the rewarding reactions of others, which over time provided for mutually and rewarding transactions and relationships (p. 890).

They located SET as the most influential conceptual paradigm for understanding workplace behaviour and concurred with the established conceptualisation of social exchange as a series of interactions that lead to obligations. They also contended that interdependent transactions 'have the potential to generate high-quality relationships … under certain circumstances' (p. 875).

Brock (2006) proposed differentiating professional organisations based on archetypes, referring to a framework of structures and systems infused with meanings, intentions, preferences, and values that reflected a single interpretive scheme. Thus, an archetypal approach to a professional organisation 'involves taking a "holistic" perspective and looking not just at organisational structure and systems, but also at the beliefs, values and ideas they represent' (Brock 2006, pp. 158–9). Professional healthcare organisations have been subject to forces of change for several decades (Brock 2006; Brunetto 2014), with deregulation, competition, technology, and globalisation leading to radical changes in organisational fields. Brock asserted that 'Governments have frequently exerted pressure for change in governance and management that have undermined professional dominance. Increasingly competitive markets have induced professional bureaucracies to adopt more corporate and managerial modes of operation in search of increased efficiency' (p. 158). In such an environment, a singularised focus on cost containment at the management level may negatively affect workplace relationships in healthcare (Brunetto 2014). The strength and character of workplace relationships are thus increasingly important in healthcare. The findings of Brunetto et al. (2013) about nurses suggested that workplace relationship quality (in particular, as this relates to the manager – staff member dynamic) is a likely mediator of ultimate efficiency gain in healthcare.

The concepts of resource exchange, resource theory and relational theory are pertinent in the organisational context. Blau's (1964) framework comparing economic and social exchanges stated that social exchange involves unspecified obligations and leads to feelings of personal obligation, gratitude, and trust, and that a pure economic exchange does not. This model postulates antecedents in the workplace as leading to interpersonal

connections, which are referred to as social exchange relationships. For Blau, social exchange relationships occurred when employers took care of employees, leading to beneficial consequences in work behaviour and attitude terms. Blau referred to social and economic exchanges as varieties of transactions rather than as relationships. Clark and Mills (1979) also conceptualised social exchange in the workplace in terms of relationships.

As exemplified in Brock's (2006) perspective, Brunetto et al.'s (2013) research and Cropanzano and Mitchell's (2005) commentary, much of the social exchange-informed theory-making and research relating to the workplace has been concerned with employer–employee relationships, manager – staff member relationships or professional roles and relationships in the context of large and complex organisations. Theory-based understanding of professional-to-professional relationships, as it affects referral practices in the healthcare context, has not been advanced.

Although much has been explored in the wider field of social exchange, healthcare researchers, such as O'Donnell (2000), McBride et al. (2010) and Harris et al. (2016), who have taken an interest in professional relationships and referral practices have called for facilitating a better understanding of the impact of interprofessional relationships between medical professionals on referral practices and patient outcomes. Thus, this thesis seeks to address this gap by exploring the role of interprofessional relationships in determining referral patterns within the framework of SET and RMT.

The forthcoming sections of this chapter will present an in-depth review of literature on relational variables that underlie SET, with an emphasis on the role of trust in the provision of specialist medical care.

3.3 Relational Models Theory

Alan Fiske (1991, 1992, 2004) conceptualised RMT as a four-model construct that explained social life as a process, with people generally wanting to relate to each other and feel a sense of commitment and obligation to their relationships. This process entails seeking, making, sustaining, repairing, adjusting, judging, construing, and sanctioning relationships. Fiske (1992) stated that the RMT explained:

social life as a process of seeking, making, sustaining, repairing, adjusting, judging, construing, and sanctioning relationships. … people are oriented to relationships as such, … people generally want to relate to each other, feel committed to the basic types of relationships, regard themselves as obligated to abide by them, and impose them on other people. (p. 689)

He argued that all domains of social relationships, such as social norms, motives, social influence, social group structures, moral judgements, resource exchange, decision-making, sexual relationships, work organisation and cognitive foundations of religion, could be organised by combining four related elements:

1. Communal sharing: a relationship in which people treat some dyad or group as equal with respect to a particular social domain.
2. Authority ranking: where people are positioned in a linear hierarchy in which superiors take precedence and pastoral responsibility for subordinates, who in turn defer, respect and obey their superiors. These relationships are based on acceptance of legitimate asymmetries and involve power. They are not exploitative or coercive.
3. Equality matching: where people monitor, balance or address differences among participants and restore balance.
4. Market pricing: where relationships are oriented to socially meaningful ratios or rates.

Any of these four elements could exhibit features of the other. RMT as conceptualised by Fiske, shares significant commonalities with both SET and Resource Theory, in terms of the interplay of variables such as power, trust, communality, resource exchange and social solidarity in social interactions.

For Fiske, people attend to, and interact with, attributes of others that have relational features, which are meaningful in terms of their intentions, plans, expectations, social motivations, emotions, and evaluative judgement. All significant, intelligible relationships can be classified into one of the four elements, and analysis of the operations and relationships suggests that the four elements are operative when people undertake social exchange (i.e. bilateral exchange, contribution and distribution).

In any complex human interaction, such as professional exchange between doctors and between doctors and patients, all four of Fiske's elements might be at work, alternating and competing to facilitate relationships. In the words of relational theorist, Engestrom (2000):

> If medical practitioners are asked why they do what they do, the eventual answer almost invariably is because of the patients. This is not merely an idealist statement naively reproducing or advocating selfless devotion to a higher calling among healthcare employees. What … more than anything arouses involvement, effort, emotion, excitement, frustration, and stress among frontline primary care and hospital staff is daily encounters with real, live patients … where each patient gives actions their ultimate continuity, coherence and meaning. (p. 974)

The next section attempts to bring SET and RMT together by creating a new model to help us understand the constructs of both these theories, as determinants of significant variables, which might influence referral practices and patient outcomes.

3.4 Combined Perspective on Theory

This section analyses the commonalities of RMT and SET in the context of the provision of specialist medical care and how it impacts on interprofessional referral relationships. To obtain an understanding of how RMT and SET can be best utilised in the context of this thesis, an understanding of the combined perspectives on theory are critically reviewed. Many reviews of SET in the psychological and sociological context have been undertaken (Cook & Rice 2003; International Encyclopedia of the Social Sciences 2008; Sabatelli 2003), with social exchange relationships measured at the individual level and the relational level.

The main assumptions of SET from the individual viewpoint are that individuals seek rewards and avoid punishments; they interact in a considered manner with the expectation of maximising profit and minimising costs; each individual's evaluation of costs and rewards is unique. In any exchange relationship, there is interdependence between exchange partners, and these relationships are regulated by the norms of trust, commitment, reciprocity, justice, and fairness.

In social exchange, individuals assess satisfaction in terms of the outcomes of a relationship; it is contended that this same principle can be extended to the medical

oncology setting. This satisfaction achieved through exchange equates to rewards from the relationship and the experiences of outcomes compared with expectations, while accounting for the costs incurred. Thibaut (2017) and Kelley (1966) referred to this as Comparison Level, highlighting the role of previous experiences and personal expectations in the satisfaction level experienced in a social exchange relationship. When the outcomes derived from a relationship exceed this level, the relationship is rated as highly positive. They also developed the concept of Comparison Level of Alternatives that establishes the lowest outcome level acceptable to a person in a relationship, which determines whether the person will continue or leave to seek alternative relationships.

In some instances, unsatisfactory relationships might continue for want of better alternatives. There might also be a sense of dependence, which is a cost of a social exchange relationship and is usually acceptable in highly rewarding relationships. Dependence can also be caused by barriers in social exchange relationships, with internal barriers being a sense of obligation and indebtedness, and external barriers encompassing material considerations and legal and community pressures, which have high social and economic costs. There are also individual beliefs and the values of trust, social and cultural norms of reciprocity, justice and equity that determine acceptable behaviour and relationship continuity. In the research conducted for this thesis, it is beneficial to understand if the aforementioned barriers and drivers of exchange relationships are transferrable in the interprofessional relationships in the Australian oncology setting.

From an anthropological perspective, a significant characteristic of social exchange is that the sum of values of a relationship for the participants is greater afterwards than it was before; that is, each participant gives the other more than the participant had possessed. Simmel (1971 [1908]) describes this perspective:

> Exchange is not merely the addition of the two processes of giving and receiving. It is rather, something new. Exchange constitutes a third process, something that emerges when each of those two processes is simultaneously the cause and effect of the other. (p. 57)

From a psychological and sociological perspective, social exchange involves rewards and costs, and based on previous experience, people participate in an exchange to derive benefits while minimising costs. This was the major theoretical perspective of Homans (1974). His work, postulated in 1961, focused on social exchange as dyadic. He defined

social exchange 'as the exchange of activity, tangible or intangible, and more or less rewarding or costly, between at least two persons' (Homans 1983, p. 54). For Homans, cost was viewed primarily in terms of alternative activities or opportunities foregone by the actors involved, behaving as individuals in interactions, and the social behaviour that emerged as a result of the process of mutual reinforcement (or the lack of it).

Blau, who was a contemporary of Homans (1983) in the 1960s, conceptualised social exchange as a process of central significance in social life, underlying the relationships between groups as well as between individuals. While individuals can participate voluntarily in social exchange, they expect an outcome. However, the nature of obligations is unspecified. Reviewing the works of social exchange theorists, Homans cited Blau's theory, which proposed that inequalities result from exchange based on who controls more highly valued resources. As a result, these individuals incur social debts that they can most easily discharge through subordinating their social debtors. Such relationships of subjugation and domination took on a self-perpetuating character and formed the basis of power inequality.

Emerson's theory of social exchange in the 1970s and mid-1980s blended the theories of both Homans and Blaus. While his micro-level theory of social exchange is based on reinforcement principles, he also developed an analysis of social exchange in terms of network structures, with power as a dominant variable in exchange structures. This is further explained through the work of Coleman (1986):

> "The actions that purposive actors will engage in when this configuration of interests and resources exists is social exchange, and when a number of these exchange processes are interdependent, we describe the whole set as a market institution." (p. 1325)

For Emerson, the relationship between power and social structure was the central problem in SET. In a dyad of exchange partners, the power of one actor over the other is a function of the value one actor places on resources controlled by another, and the relative availability of alternative sources of supply of those resources. Cook and Emerson (1978) demonstrated that power is a function of relative dependence, as a feature of networks of exchange partners whose relative social power is the result of the shape of the social

network and the positions they occupy. This is also manifested in the unequal distribution of rewards across positions in the network.

Conversely, in the 1990s, Molm distinguished between negotiated and reciprocal exchange. While the former involved bargaining and negotiation, followed by agreement upon the terms of exchange, in reciprocal exchange, the individual acts for another or others without knowledge about future reciprocation. If costs and benefits are considered equal, reciprocal exchanges generate more trust. Thus, Molm's theoretical view was that under some conditions, risk generates trust.

Molm's research demonstrated the relationship between social exchange and power was conceptualised differently. The prevalent theoretical notions of power focused on its structural influence through the threat and/or practice of exclusion from exchange. She also believed that power is not tied solely to the legitimate use of authority. It could also take the form of coercion or punishment. Although punishment power is not used frequently, it is usually employed to influence the future actions of one's exchange partners. That is, power can have strategic motivations in exchange relationships.

In the present thesis research the roles of trust, reciprocity, clinical judgement and decision-making in determining lasting professional-to-professional relationships based on social exchange and their impact on referral practices and patient outcomes are considered. Another significant variable in the present research is the level of commitment between medical professionals in terms of referral of patients. Research on commitment and social exchange focused initially on the choice of an actor to form an exchange relationship with a partner relative to all available exchange opportunities with others. Power-use and commitment was found to be inversely related. In social exchange relationships, research has linked commitment to social uncertainty.

Based on their appraisal of theory up to the early 2000s, Cook and Rice (2003) asserted that social uncertainty is likely to promote commitment formation. Further, they supported the view that commitments to specific partners can function as a viable solution to the problem of uncertainty. Cook and Rice (2003) also noted that at the macro level of exchange, while commitments might increase the feelings of solidarity, and resources might be exchanged more equally, there may also be a consequent adverse effect, in terms of reduced aggregate levels of exchange productivity and efficiency. For them,

commitments can help reduce the use of power in imbalanced network structures, leading to a more egalitarian distribution of resources.

Where power between participants is unequal, power-advantaged participants have better opportunities for exchange. As uncertainty increases, if power-advantaged participants form commitments with power-disadvantaged partners, they erode their base of power (Cook & Rice 2003). Cook and Rice (2003) opined that status can be defined as a clear determinant of observable power and prestige within a group. The location of an individual in a network was viewed as the key determinant of power and influence (e.g. control over resources, such as knowledge, information and goods and services at their disposal). In the context of this thesis, one of the researcher's aims is to see if RMT and SET can develop an understanding if the notion of power in an exchange relationship outlined by Cook and Rice (2003), translates into the GP to SMP inter-professional referral relationship.

Research from Molm in the 1990s, and Cook and Rice (2003), attempted to develop a notion of composite power, which combined the power derived from both the location of an individual within a network and the power derived from status in a hierarchy of status relationships. Power can be conceptualised as a structural potential that enables some individuals to earn favourable resource distributions at the expense of others. The status of the individuals in the exchange influences the perceived value of the resources exchanged. Resources associated with high-status actors are perceived to be of higher value than those of lower-status actors. In exchange networks of equal power, there is a preference to interact with high-status individuals, and they are actively more sought after and receive more favourable exchange rates in both equal and unequal power networks.

Cook and Rice (2003) stated that while both economic sociology and social exchange have developed in isolation from one another, there are theoretical overlaps in the studies on 'embeddedness'. Research on embeddedness shares common ground with that on social exchange. The premise underpinning the theory is that exchanges are rarely purely economic and are often embedded in networks of social relations. This is the central claim of economic sociology. Embeddedness has profound behavioural consequences and affects the structure of exchange relationships and the success of economic ventures. Embeddedness helps social exchange move beyond narrow economic goals that originally constituted social exchange, and it generates outcomes that are independent of

them. Participants in social exchange develop feelings of relational cohesion directed to the ongoing exchange relationships. The feeling of cohesion leads to a wide variety of behaviours that go beyond economic interests, which may include gift giving, forming new joint ventures with old networks, and remaining in the exchange relationship, despite the presence of new potentially profitable partnerships.

In the context of this thesis, exchange relationships and the role of power within them is an important to understanding GP to SMP, and SMP to SMP inter-professional referral relationships. Using the theoretical informants of SET and RMT the researcher hoped to develop an understanding if relationships are mutually beneficial, and how the dynamic of power influences the formation and maintenance of interprofessional relationships; how this contributes to the decision-making process in referrals, and if this influences patient outcomes. In addition to this, this thesis sought to understand if power held influence in the doctor-patient-relationship, and how this impacted communication.

3.4.1 Doctor–Patient Communication

A good interpersonal relationship is likely to have some social characteristics and to include clinical and therapeutic aspects as well as address the development of mutual trust based on empathy, respect, genuineness, unconditional acceptance, and warmth. Crucial to this process are the listening skills whereby the doctor elicits feelings and promotes reflection through empathetic paraphrasing, using silence and encouragement. A 'patient-centred' approach requires that the patient and doctor be equal partners in the relationship (Ong et al. 1995).

Doctor–patient communication is widely viewed as a significant aspect of medical professionalism, which affects the patient's wellbeing and behaviour. It has an overarching effect on the patient's sense of satisfaction, adherence to treatment, understanding of information shared, coping, quality of life and state of health. Interaction and communication are especially important in the case of life-threatening diseases, such as cancer (Ong et al. 1995, p. 903), which has a component of 'bad news consultation' (authors' quotation marks). Multifaceted and multidimensional, it is a significant modality for educating patients about disease evaluation, diagnosis, prognosis and care (Teutsch 2003, p. 1115). Teutsch raised a concern that under an overtly business-based

model of medical practice, patient–doctor communication may be sacrificed because of limited time and a culture of overt medical authority, which induces compliance.

Ong et al. (1995) discussed communication in the context of the psychosocial components of cancer. Based on studies from psychosocial oncology, they scoped doctor–patient communication from four different dimensions:

1. the purpose of communication;
2. the analysis of doctor–patient communication;
3. specific behaviours during consultations; and
4. the effect of communicative behaviour on patient outcomes.

Regarding the first dimension, the purpose of communication, the review authors posited three different purposes of doctor–patient communication: those based on a distinct purpose (such as creating a good interpersonal relationship); exchanging information; and deciding on treatment. The purpose of communication is the exchange of information in medical communication.

For the patient, two needs have to be met, the need to know and understand, and the need to feel known and understood. Following diagnosis and deciding on a treatment plan, doctors must impart information skilfully to the patient. In the case of cancer, the patient's desire for information is high. Patient dissatisfaction can be caused by an absence of personal relevance in the communication of information about the illness at hand. While physicians might believe that they have a given objective and precise information, the patient might feel that there was nothing new. It then follows that an SMP also needs to provide this same level of accurate timely detail of diagnosis and treatment plan to the GP to ensure the patient's need for information is met, enabling the GP to manage and coordinate the patient's care in an optimal manner (Ong et al. 1995).

Regarding the second dimension (the analysis of doctor–patient communication), research-based communication analysis has identified a binary behaviour categorisation as either socio-emotional or instrumental behaviour. In the third dimension of doctor–patient communication (specific behaviours during consultation), communicative behaviours identified include instrumental and affective communication encompassing both verbal and non-verbal channels. While instrumental or cure-oriented communication is in the cognitive domain, socio-emotional behaviour or care-oriented behaviour is in the

emotional domain. Both types of behaviours are integrated in the physician's functioning. Instrumental behaviour includes giving and seeking information, counselling, giving directions, identifying future treatment plans, discussing side effects and test results, discussing details such as tumour size, explaining reasons for treatment or non-treatment and explaining concepts. Affective behaviour consists of behaviour patterns that are encouraging, relaxed, friendly, open, honest, and empathetic (Ong et al. 1995).

Reviewing literature on the quantum of information given by physicians, Ong et al. (1995) reported divergent findings. While some researchers found high proportions of time dedicated to information giving, some reported a little more than one minute devoted to the process in a 20-minute consultation. Further, they reported that oncologists are known to have deliberately withheld information from patients because of the view that total disclosure may lead to strong negative emotional reactions from the patient. It remains the case also that doctors themselves have to cope with their emotions in this communicative process (Ong et al, 1995).

In relation to the fourth dimension of doctor–patient communication (the effect of communicative behaviour on patient outcomes), Ong et al. (1995) asserted that physicians' communication behaviours do affect patient outcomes. Some of the outcomes studied in the past cover the areas of patient satisfaction, patient compliance/adherence to treatment, patient understanding of information, disease-specific health outcome measures and psychiatric morbidity. Doctors' instrumental behaviours have been highly correlated with patient satisfaction, although there have been contradictory findings pertaining to the relationship between physicians' affective behaviour and patient satisfaction. In terms of compliance with treatment advice, cancer patients have generally been shown to be compliant with oncologists' recommendations. Compliance has been positively correlated with more information giving and positive talk by the doctor. Patient satisfaction would likely lead to positive feedback about the SMP to the GP and thus encourages the process to be repeated (Ong et al. 1995). This is one form of reciprocity between doctors because patients would feel obligated to, and happy with, their GP because they had made a good referral.

Fallowfield et al. (1990) have raised the need for assessing the effectiveness of the doctor–patient relationship in the name of promoting better health outcomes for patients. More patient, and less physician controlling behaviours (questioning, interruptions), more

affect and more information giving by the physician have been shown to lead to a better patient health status. In psychosocial oncology studies, the lack of information has repeatedly been related to psychological difficulties during the diagnosis and treatment phases of cancer. Breast cancer patients who felt they did not receive adequate information were twice as likely to show signs of psychiatric morbidity (depression and anxiety) a year after surgery compared with those patients who were satisfied with the information given (Fallowfield et al. 1990).

The quality of information extended by the referring physician as a determinant of the quality of the referral process was examined in the US chronic healthcare context (Ireson et al. 2009). Exploring the patient's perspective of the information transfer, from referring to the specialist physician and consequent impact on trust in the physician, Ireson et al. (2009) undertook a cross-sectional study of 250 representatively selected patients suffering from chronic disease. Trust was found to correlate highly with the provision of good explanations regarding diagnosis, treatment and self-management procedures given by the specialist. Among patients, 74% received good explanations from SMPs, but notably, 20% received conflicting information from the SMPs compared with information provided by the referring physician. Most patients (85%) reported receiving good explanations from the referring doctor regarding the reason for the SMP visit. However, 26% reported feeling unprepared about what to expect next, and 8% received no information. Overall, patients felt the amount of preparatory information was adequate, but found that specific information lacking.

Patients in the Ireson et al. (2009) study reported feeling involved in the decision-making process, but more than 25% felt unprepared about what to expect at the specialist visit, and what to ask or tell the specialist. While the referring doctor sent information to about 50% of the patients, almost 25% had to take some or all of the information to the specialist themselves and more than 25% of the patients reported that their referring physician did not give them anything to take and/or send anything to the specialist's office. This last group felt significantly less satisfied with the level of preparation from the referring physician, their experience with the specialist and the self-management information provided. While most patients continued to see their referring physician following the specialist visit, about 9% opted for another and 12% were managed by the specialist directly (Ireson et al. 2009).

The level of satisfaction with the preparatory information emerged as the most significant variable determining the patient's decision to continue seeing the referring physician or choosing another PCP. In particular, the satisfaction with the way the referring doctor and specialist coordinated the care was highly correlated with the patient-centred preparatory information from the referring physician, with patient-centred information from the specialist physician and with patient-centred information given to the patient about self-management (Ireson et al. 2009, p. 8). Patient satisfaction was highest with the coordination of care by the specialist when the specialist sent information back to the referring physician, and those who reported that the specialist coordinated their care well were likely to have been informed regarding follow-up care by the specialist. This perception was also strengthened based on how well the referring physician explained the follow-up after the specialist visit and prepared the patient regarding the specialist visit.

While 76% of patients reported feelings of being cared about, by both the referring physician and the specialist, 20% did not trust their referring physician to manage their care. There was a direct positive association between a patient's reported satisfaction with the preparatory information for self-management and trust in the referring doctor (Ireson et al. 2009). High levels of trust in SMPs were also associated with patients receiving good information, the SMP understanding of why they were referred, and the information provided by the SMP regarding diagnosis, prognosis and how to care for themselves at home. Trust in the SMP was also related to SMP patient-centeredness.

Against this backdrop, the present research seeks to contribute to understandings of the role and impact of relationships on patient outcomes. With GPs being directly involved in over 85% of all cancer diagnosis, it is important that they provide relevant, timely and correct clinical judgement and decision-making in terms of both the diagnosis and the referral, as highlighted by Vedsted and Olesen (2009), who submitted that in the case of diagnostic knowledge, and when and where to refer patients, there are shortcomings in both documentation and information, calling for more effective strategies.

To summarise, based on a social exchange/relational theoretical framework, it could be advanced that medical professional-to-professional relationships are likely:

1. to be determined by the professional exchange variables of trust, reciprocity, commitment and loyalty;
2. to determine motivation, judgement and decision-making;

3. to have a significant emotional component and involve risk and uncertainty;
4. to likely use the four relational models of communal sharing, authority ranking, equality matching and market pricing;
5. to affect referral patterns; and
6. to influence patient outcomes and survival.

3.5 Trust

Trust has been raised in both exchange and relationship contexts so far in the discussion. The section that follows provides a comprehensive review of the literature on trust, in the context of professional-to-professional relationships in the healthcare setting. As Mollering (2001) stated, 'Trust is a foundational orientation between self and other, which encompasses all three modes of human experience – emotion, cognition and behavior – standing in systemic and reciprocal reflexive relationships.'

Trust is a topic that has provoked considerable interest and often heated debate within psychology, political science, economics, anthropology, history, and socio-biology (Ruotsalainen 2003). Ruotsalainen (2003) considered trust as a dynamic phenomenon that takes on different characteristics in the early, developing, and mature stages of relationships. Simpson (2007) referred to trust as a cardinal construct that transforms the meaning of other attributes and descriptors of a relationship. Considering the limited focus on interpersonal trust in research owing to a variety of reasons, Simpson called for a deeper, more sophisticated understanding of how trust emerges, operates, changes, and declines within close relationships. He stated that trust is social capital, and given the current pattern of declining trust in the world, it is necessary to establish deeper levels of trust:

> since there are few constructs in the field of interpersonal relationships that are more central or important to relationship functioning and outcomes than trust. Without trust, voluntary relationships are not likely to develop, let alone grow or be maintained. (p. 604)

Morrone, Tontoranelli and Ranuzzi (2009), in their Organisation for Economic Co-operation and Development (OECD) research on measuring trust and its role for progress of societies, stated that trust is the foundation of interpersonal relationships, which in turn are key determinants of human wellbeing and economic development (p. 5). Citing

research by Helliwell (2001, p. 43), the authors assert that trust is matched by trustworthy behaviour with a commensurate reduction in risk and uncertainty. An application of the Morrone et al (2009) stance here, when applied to interprofessional referral relationships, has significant implications for the provision of healthcare and best patient outcomes, as well as enabling a reduction in medical error.

Frederiksen (2012) defined trust as a social form, a highly variable, relational process that may appear in very different ways depending on circumstances. Further:

> Trust is relational. That is to say, my trust of you depends on our relationship, either directly through our own ongoing interaction or indirectly through intermediaries and reputational effects. If we have no or only a passing relationship, we are not in a trusting relationship. (Robbins 2016, p. 2)

Relational trust entails not only beliefs in the positive intentions of the trustee but also in the absence of negative intentions, giving rise to the condition of high trust/low distrust. Unmet expectations can be survived in relational trust if good faith is restored, and interactions are fair. In a broad sense, relational trust becomes identity-based trust, when employees characterise themselves in relationship to their teammates as 'we', deriving psychological benefits as part of a successful enterprise. According to Rousseau, Sitkin and Camerer (1998):

> Trust takes different forms in different relationships – from a calculated weighing of perceived gains and losses to an emotional response based on interpersonal attachment and identification. Market-based exchanges may emphasise calculus more, whereas communal relationships might emphasise identification. The scope of trust may vary, based on the relationship's history, stage of development, and cues in the immediate setting. (p. 398)

According to Whitener et al. (1998), trust has three facets:

1. Trust in another party reflects an expectation or belief that the other party will act benevolently.
2. Trust involves a willingness to be vulnerable and risk that the other party may not fulfil one's expectations.
3. Trust involves some level of dependency on the other party such that the outcomes of one individual are influenced by the actions of another.

Implicit in all the definitions of trust is the dimension of reciprocity. Reciprocal trust is the trust that results when a party observes the actions of another and reconsiders own attitude and subsequent behaviour based on those observations, and a relational trust develops when this is applied to a group setting (Serva, Fuller & Mayer 2005). There is a strong element of reciprocal confidence; thus, trust has both a reciprocal and relational quality, and a high moral value, and thereby becomes a special medium of social exchange. Mollering (2001) stated that Simmel's (1950) conceptualisation of trust is based on the ideas of weak inductive knowledge, faith, reciprocity, and moral obligation. Trust without the expectation of reciprocity is self-destructive (Evans & Krueger 2009). When we trust a stranger, we need to justify accepting the risk that our trust could be violated.

3.5.1 Trustor and Trustee Characteristics

Trustor and trustee characteristics are important to define within the realm of trust. The attributes of trust such as propensity to trust, perceived risk of trust, leadership prototypes, prior history, and trustee characteristics are all important building blocks that form the trust relationship. As such, the trust attributes referred to hereinbefore, warrant a clear description.

Propensity to trust: This refers to the general willingness to place faith in others' reciprocity and good intentions. Propensity to trust affects the information that is salient (i.e. strengthens one's belief in the trustworthiness of others) and how the information is processed when deciding to trust (Burke et al., 2007).

Perceived risk: As more risk is experienced within a team (e.g. task ambiguity, task importance), trust in the team leader will become increasingly important in reaching the desired outcomes (e.g. reduced turnover, increased communication; Burke et al. 2007).

Leadership prototypes: The leadership prototype that one holds will moderate the relationship between ability/competence and the decision to trust.

Prior history: The degree to which one has a prior history with the leader will affect the decision to trust. Prior interaction and its outcomes (e.g. positive or negative) will be integrated into an individual's mental model pertaining to that leader. Like reputation,

prior history with a leader will colour how present interactions are viewed (Burke et al. 2007).

Trustee (leader) characteristics: Although many leader characteristics were identified as the antecedents of trust, Mayer, Davis and Schoorman (1995) argued that leader reputation acts primarily in a moderating role. Reputation reveals information about a leader's ability and morals. Reputation will influence the degree of trust, monitoring and accountability standards. Possessing a high reputation facilitates trust among followers and leaders and is associated with a greater degree of autonomy and discretion. In addition, a positive reputation will influence the likelihood that followers will perceive leader intentions in a positive light and serves as a heuristic to guide decision-making. Leaders with credible reputations will often receive some latitude on their decision-making even without personal interactions or direct observations (Mayer, Davis & Schoorman 1995).

Leaders' reputation will depend on the context and will be defined based on their social network. In turn, it will affect self-esteem, social identity, individual behaviour, and social interactions. Reputation will be strengthened as more interactions occur and behaviour reinforces reputation; however, if behaviour is inconsistent with reputation, it will become redefined, and expectations will diminish. Because reputation is considered a valuable asset, people are not necessarily willing to behave inappropriately at the risk of damaging it, especially if developing it was a lengthy process (Mayer, Davis & Schoorman 1995).

The above rationale could be applied in the healthcare context by replacing the term 'leader' with SMP and the term 'follower' with GP, though with the qualification that the GP is not economically dependent on the SMP. Based on such a modification, it might be reasonable to postulate that GPs have a propensity to trust SMPs, just as they expect patients to trust them; and only when trust is betrayed and/or expectations are not met, will the GP look for workarounds and alternative SMPs to refer their patients to as seen in Hespe, (2010).

3.6 Trust and Professional-to-Professional Relationships

Schoorman, Mayer and Davis (2007) drew attention to the paucity of research on trust in management literature, stating that they were struck by the relative scarcity of research

on the topic during the mid-1990s. Although scholars from different disciplines, such as management, psychology, philosophy, and economics, presented insightful views and perspectives on trust, many of them seemed to talk past one another. Thus, Schoorman, Mayer and Davis aimed to integrate these perspectives into a single model of trust as an aspect of relationships.

Schoorman, Mayer and Davis (2007) clarified their approach to conceptualising trust by acknowledging the difficult decision that they had to make when defining trust in a way that departed from the widely accepted approach of trust as a dispositional trait-like concept, to an aspect of relationships. Rotter's (1967) definition of trust was the dominant view in literature, because the author(s) also included ability as an antecedent to trust, which allowed trust to vary within a given trustee across domains. The literature that followed has continued to accept the view that trust is based in relationships.

The perceptions of an individual's ability, benevolence and integrity will influence the degree of trust the individual can garner; such perceptions also affect the extent to which an organisation can be trusted. While at higher levels of analysis, viewing the trustee in terms of ability and integrity is well accepted, when assessed between organisations, benevolence has received little attention. Benevolence was defined 'as the extent to which a party is believed to want to do good for the trusting party, aside from an egocentric profit motive' (Schoorman, Mayer and Davis, 2007, p. 345). However, much of the research on trust is limited to relationships at a single analysis level—either dyadic trust relationships within organisations or trust between organisations.

Schoorman's earlier research in 2002 suggested that future research should consider the process and timeframes in which each of the variables, such as integrity and benevolence, contributes to trust. While high correlations were noted between integrity and benevolence in laboratory settings, this finding is ascribed to the lack of time to develop real data about benevolence. In field-based research, while judgements on ability and integrity will form quickly, benevolence judgements will take more time, and the effect of perceived benevolence on trust will increase over time as the relationship develops. Moreover, Schoorman, Mayer and Davis (2007) noted that in the absence of a clear multilevel conceptualisation of trust, methodological difficulties can arise. Thus, in the present research, the trust attributes of ability, benevolence and integrity, and their impact on professional exchange relationships, are analysed and considered.

3.7 Trust in the Healthcare Context

The concept of trust in health care refers to confidence in competence (skills and knowledge), as well as ascertaining whether the trustee is working in the best interests of the trustor as evidenced by the honesty, confidentiality, care and respect shown (Rowe & Calnan 2006, p. 377). The trustor has positive expectations regarding the competence of the trustee and the feeling that one will not be taken advantage of by others.

At the macro level, this would include the trust of patients and public in clinicians and managers and in the healthcare organisation and system. For instance, using a relational view of competitive advantage theory, Chen, Preston and Xia (2013) examined the factors that influence hospital supply chain performance: trust, knowledge exchange, information technology (IT) integration between the hospital and its suppliers and hospital–supplier integration. They found that IT integration and trust are both essential for effective knowledge exchange between a hospital and its key suppliers, and consequently, enabling the achievement of hospital–supplier integration and the improvement of hospital supply chain performance. They also noted that interorganisational process capabilities, such as hospital–supplier knowledge exchange and integration, mediate the effects of IT capabilities and trust on supply chain performance. Trust is a useful governance mechanism that safeguards the relationship between trading partners, reduces transactional costs (Dyer & Chu 2003) and operational risk (Tazelaar & Snijders 2013) and facilitates complex exchange (Uzzi 1997).

At the micro level, trust relationships in health care are between the individual patient and clinician or between one clinician and another, or between a clinician and a manager. The role of trust appears central to the nature of the relationships between specialists, referring doctors and patients. This may be a key feature of an effective medical professional exchange relationship. Calnan and Rowe (2006) undertook a comprehensive review as well as primary research on trust relationships in health care in the UK. On the salience of trust in health care, they emphasised that trust is necessary where there is uncertainty regarding the motives, intentions, and future actions of those on whom one is reliant, and thereby entails a level of risk. A limitation of this study is that although it is healthcare focussed, it is not directly related to the oncology referral relationship; notwithstanding this, critical examination indicates that this research may be adapted to the specialised field of oncology.

Calnan and Rowe (2006) noted that this element of risk and uncertainty at the micro level is potentially related to the patient perceptions of the competence and intentions of the practitioners on whom they are dependent. They are in a position of vulnerability, being ill and in a situation of unequal relationships between themselves as a lay person and a health professional. It is the medical expertise of the professional, which is the basic condition for generating trust, together with the affective aspects.

According to Calnan and Rowe (2006), 'Trust has traditionally played an important part in the relationship between its three key actors: the state, healthcare practitioners, and patients and the public' (p. 350). They concluded that studies in organisational literature have suggested that trust relationships between providers and managers influence patient–provider relationships and levels of trust. This suggests that trust is neither a dispositional nor an individual attribute but constructed from a set of interpersonal behaviours or from a shared identity. In contrast to the volume of literature that has assessed trust from the patient perspective, research examining the value and impact of trust from a managerial or organisational perspective is limited. Figures 3.1 and 3.2 highlight this discrepancy in research graphically.
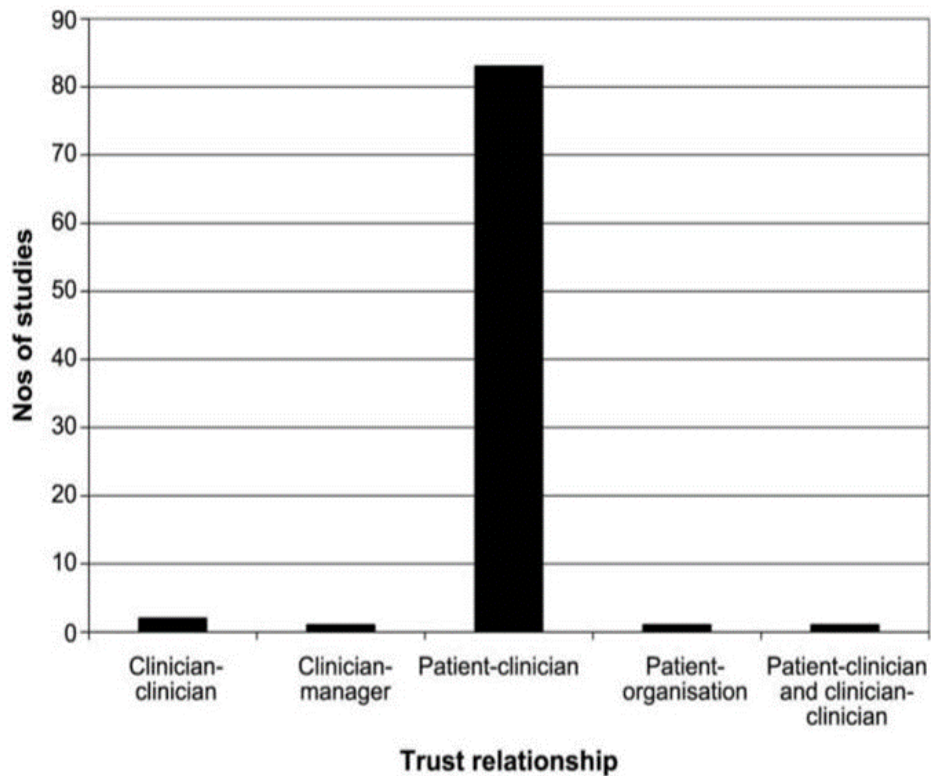
Figure 3.1 Trust Relationship (a)
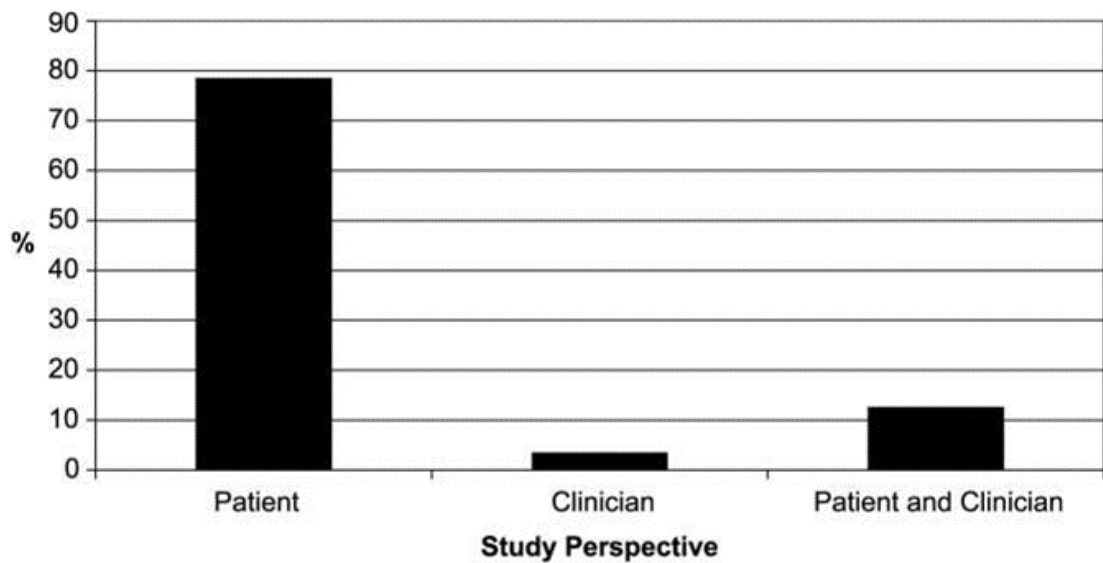
Figure 3.2 Trust Relationship (b)

(Calnan & Rowe 2006, p352)

Further, Calnan and Rowe (2006) stated:

> From an organisational perspective trust is believed to be important in its own right in
> that it is intrinsically important for the provision of effective health care and has even
> been described as a collective good, like social trust or social capital. (p. 352)

In addition, '[T]rust is important to health systems because it underpins the co-operation
throughout the system that is required for health production' (Gilson 2003, p. 1461).
Gilson (2003) considered health systems part of the social fabric, which functions as a
facilitator between citizens and the system to construct broader social value by allowing
citizens to attain optimal health, participate in decision-making, be treated respectfully,
develop a sense of personal worth and contribute to the social good.

In a survey of 417 patients who were referred to specialist physicians (Keating et al.
2004), the correlates of trust identified included the listening skills of the specialist, the
provision of increased amounts of information, proactive guidance if health issues
change, the likely course of action to be taken and the involvement of the patient in
decision-making. Thus, relational factors based on social exchange play a significant role
in determining trust between medical professionals.

In this regard, reputation, trust and reciprocity seem likely to affect the complex
professional services relationship between specialist, referrer and patient (Bakker et al.

2000; Diekmann 2004; Gobel, Vogel & Weber 2013; Molm 2010; Thorne & Robinson 1988; Uhl-Bien 2003; Yilmaz, Sezen & Ozdemir 2005). According to Axelrod and Goold (2000), the relationship between a specialist and a referring doctor is a reciprocal mutually dependent relationship founded on trust, in which each party values outcomes under the control of the other:

> Interpersonal trust relationships are typically found where there are risks and uncertainty … The trusting patient is placed, sometimes unwillingly, in a position of vulnerability to the surgeon. … trust develops through a prolonged continuous process of care in which the patient and physician together reach a diagnosis and implement a care plan. (p. 59)

The specialist cannot operate without referred patients, and the referrer does not have the requisite skill to attend to certain ailments. To achieve positive outcomes, communication is an essential exchange variable. Studies have highlighted the role of compassion, professional competencies, communication patterns, openness to seek second opinions and strong ethical judgements as factors that strengthen the physician–patient bond, with trust being the cornerstone of all communication among participants. Axelrod and Goold (2000) noted that patient trust is an essential component of the specialist referral processes. Consequently, for ideal health outcomes to be achieved, it is imperative that physicians elicit rapidly the trust of new patients who know virtually nothing about them (Axelrod & Goold 2000; Hall, M. et al. 2002).

The ability to elicit this trust in a stranger primarily depends on information gained by the patient from referring doctors. To illustrate, a referring physician's recommendation of a particular specialist instigates a transfer of trust from the referring physician to the patient through which the physician's assessment of a specialist's inherent trustworthiness is passed on to the patient. In short, a patient trusts that the referring physician has measured the skills and qualifications of all relevant specialists and has come to a well-informed decision of the best specialist for their patient's specific needs. Based on this assumption, the patient is enabled to trust the specialist, even when there has never been any contact between them previously (Newman 1998; Offe 1999; Patterson 1999). Such surrogate trust provides the basis for a patient's judgement that healthcare providers will act in their best interests. The more extensive the discretionary powers of the trusted, the less clear-cut will be the answer to the question of when trust is lost. If a trust relationship is to

continue, some tact and willingness to forgive on the part of the truster and some willingness on the part of the trusted, both to be forgiven and to forgive unfair criticisms, seem essential (Baier 1986, p. 238).

Although a patient may believe their referring physician has measured and assessed all SMPs in a particular field, this may not be so. This thesis identifies and assess the process by which a PCP/referrer comes to know of an SMP in a particular field and what likely factors induce that referrer to undertake the initial contact/referral. Although the literature does not expressly address this issue, preliminary evidence by exception, indicates that they may have studied together; a colleague may have told them about that SMP; the SMP may have approached the referrer; or they may have met in the context of continuing education, whereby the SMP was a presenter and/or working in the same geographical environment, such as the same building/clinic/hospital (Shortell & Anderson 1971; Vahidi et al. 2013; Walshe 2008).

Since trust arises from patients' need for physicians, it is likely that the greater the sense of vulnerability, the higher the potential for trust. This relationship of dependence highlights the role that trust inevitably and unavoidably plays in treatment relationships (Pellegrino & Thomasma 1993). Social exchange research has suggested that from the client's perspective, loyalty, intention to recommend and feelings of friendship closely interrelate. Other findings have indicated that although trust is correlated highly with friendship, it is a separate and distinct construct (Price & Arnould 1999).

While medical professionalism is avowed as medicine's contract with society (ABIM 2004), an imperative to fulfil this contract is public trust in physicians and specialists, and allied health practitioners, which depends on the integrity of the whole profession. Madubata (2016) writing for the ABIM Foundation, on the role of between medical professionals and the shared honour code, stated that when a lack of trust occurs, it affects the ability of doctors to work together:

> At the end of our day, our patients are ultimately the ones who benefit from our professionalism. They depend on us to show up when necessary to offer our specialised skills to help them to get better, but they also expect us to use our judgment to act in ways that would allow us to treat them as effectively as possible. (pp. 1, 2).

Kaiser et al. (2010) explored the role of interpersonal trust in patients with their regular providers and cancer physicians. They interviewed 704 breast cancer patients regarding trust in their regular provider, diagnosing doctor and cancer treatment team. Women who reported high levels of interpersonal trust in their regular providers were significantly more likely to be trusting of their diagnosing doctor and cancer treatment team.

In the Australian healthcare context, Ward et al. (2015) explored the nature of patient trust and their reasoning about trust and distrust in public and private hospitals in South Australia. They stated, 'The issue of "choice" is central to the issue of trust in public and private healthcare and hospitals, since choice is an underpinning ideology in the private setting although it is largely absent in the public setting' (p. 2). In the modern age, making choices is considered a hallmark of 'good citizenship' notwithstanding dealing with the potential risks. Ward et al. defined trust as a patient's optimistic acceptance of a vulnerable situation, believing that the trustee will care for the patient's interests, with the patient required to accept all types of risks associated, as would be in any given relationship.

Placing trust in doctors and nurses and/or the system helps reduce complexity and simplifies decision-making. Ward et al. (2015) stated that patients depend on doctors to show up when necessary, to offer their specialised skills to help them recover, but they also expect doctors to use their judgement. They highlighted that the difficulty in understanding and explaining the rationality of patient trust in public and private hospitals may be partly related to difficulties in defining, conceptualising, and thus empirically researching trust. For the purposes of their research, the authors adopted the often-used definition of trust from sociological literature:

> the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests, with the truster being required to accept the risks associated with the type and depth of the interdependence inherent in a given relationship. (p. 3)

They stated that trust functions in a way to reduce the complexity in society, because 'placing trust in individuals and systems simplifies our decisions to act in ways that would allow us to treat them as effectively as possible' (p. 3).

The construct of trust explored in the thesis research includes the ethical, collegial, agentic, reciprocal and communitarian dimensions underpinning stable and ongoing social exchange and referral relationships between GPs and SMPs, and between SMPs.

Luhmann (2000) argued that trust develops with familiarity and that individuals base their decisions to place (mis)trust in an individual or system on both familiarity and risks associated with decisions made for the future. In the healthcare context, individuals are likely to establish trust with known health professionals or hospitals as their familiarity increases. Trust is likely to be enhanced in established systems known to an individual, where their experiences have been positive. The patient's 'choice' in private healthcare would lead to the development develop a relationship with particular doctors, and thereby, familiarity and trust. In the context of the lack of familiarity, Luhmann argued that 'confidence' is required, which differs semantically from 'trust'. Trust, for Luhmann, is an active process of choosing between options on the basis of the option to trust. However, when there are no options, it is something other than trust, namely, confidence, dependence, obligation and blind or assumed trust.

In their research on trust, Ward et al. (2015) interviewed participants to explore their experiences, perceptions and observations as patients who had been treated recently in either public or private hospitals. The aim was to understand patient trust in the hospitals, and the various elements of the hospital system, such as doctors, nurses, cleanliness, anticipated benefits/barriers, and choice, stemming from the conceptual importance of both interpersonal and institutional trust. Purposeful sampling was used to select participants, with importance given to include patients who had experienced various levels of risk during treatment. Further, patients who were undergoing urgent, semi-urgent and non-urgent procedures in the hospitals were also included. Participants were asked to describe their actual experiences of being in hospitals, both as patients and as carers/family members, seeking their perceptions about the care they received, their expectations of care and whether these were met. Most participants had experiences of both, either as patients or carers, and could thus make comparisons based on experiential knowledge rather than conjecture.

Results were categorised within the overarching theme, trust consideration, into subthemes such as sustained optimism, choice and reputation, and personal responsibility resulting from the choice. The responses of patients in public and private hospitals were

treated separately. In the theme, 'Trust consideration in public hospitals', public hospital patients perceived themselves as having no choice in which doctors they consulted. The emerging subtheme was entitled 'blind faith in experts'. However, this was not seen in negative terms. They had an innate trust and faith in the expertise of the doctors and contrasted it with their own relative lack of knowledge. Ward et al. (2015) highlighted the difficulty for participants to differentiate between trust in doctors and trust in the hospitals since the doctor was the human element, representing the hospital.

'Pragmatic acceptance' was the second subtheme. The participants seemed to show their knowledge of the health system and its failings, and simultaneously, they recognised that human resources in the system (e.g. doctors and nurses) were doing their best. Ward et al. (2015) found that 'There was a palpable sense with all public patients of both respect and sympathy for healthcare professionals working in public hospitals, which led them to fervently defend the public system' (p. 297). The base level trust seems to be in the medical/hospital system, which according to Ward et al. translates to trust in hospital bureaucracy, doctor registration, medical training, quality, and safety systems.

'Sustained optimism' was the third subtheme in the category trust considerations in public hospitals. Participants justified potentially negative elements of the public hospital system with a sustained optimism; for example, by stating that individual doctors were trying to do their best under difficult circumstances. Thus, public patients seemed to find ways to maintain trust in the medical health system. If optimism is removed, then patients may be left with negative feelings, which could lead to distrust. Distrust may be too unsettling when a person is in a vulnerable position and considering that there are no alternatives in healthcare. The authors concluded that owing to the lack of competition in and between public hospitals, doctors are not forced to constantly assess and improve their quality, since patients find ways to trust and reinforce and/or maintain their trust.

Another subtheme was personal responsibility resulting from the patient's choice. This is a notion among private patients, the perception that they have to take responsibility for their own health and their own decisions, a form of shared care and patient-centred-care. They cited research on trust, where trust meant choosing one action (consent to surgery) in preference to another (having a second opinion or choosing another doctor), despite the possibility of being disappointed by the actions of the trusted person. This means the patient expresses a need to take on the responsibility of choosing which doctors to consult,

and in so doing, taking on the blame if their trust is misplaced. The authors discussed blind or assumed trust and critical, conditional trust that the patient has in order to make a decision; and the merger of the major social exchange variables of trust, clinical judgement and decision-making emerged as significant factors in patient trust and patient outcomes.

Recommended research from Ward et al (2015) is from the supply side of the medical equations, with health professionals, managers, and policymakers in public and private healthcare organisations in order to understand how they attempt to develop, maintain and extend trust with patients. Participants did not recognise that a large proportion of Australian doctors work in both public and private hospitals/facilities and hence are likely to do their best across both sectors (Ward et al, 2015).

In the words of Todd (1989, p. 16), the patient is a stranger in a strange land, 'where only a small minority understands the gadgets, procedures, and options; for doctors the territory is familiar'. In addition, seeing a specialist or undergoing a particular procedure, particularly for cancer care, is often associated with a higher degree of seriousness and vulnerability in so far as these are likely to be life or death situations. According to S. Pearson and Raeke (2000) this may be a key reason that consumers are inclined to trust the professional expertise of a medical practitioner. Indeed, trust has long been recognised to play the central role in any interpersonal medical relationship (Pearson, S. & Raeke 2000). It is a concept that resonates strongly with doctors as well as patients, for the degree of trust in healthcare relationships can have life-changing consequences (Thom, Hall & Pawlson 2004). This is particularly so in relation to high-value professions, such as clinical medicine, where the professional domain is ethically bound but inherently relational, in the sense that the activity of one medical professional is often ignited by the referral of another. Although both medical professionals work for best patient outcomes, studies have highlighted the significance of interprofessional relationships and trust on referral practices (Delva et al. 2011; Harris, et al. 2016; Hespe 2010; McBride et al. 2010) and patient survival (O'Donnell 2000). These studies emphasised the need to explore interprofessional relationships between medical professionals in depth because these influence referral practices and patient outcomes. The present research will be pathbreaking in this context, since it attempts to address this gap by exploring interprofessional relationships in determining referral patterns within the framework of SET and RMT.

Health care in Australia is universal, and private health care is available for purchase and encouraged by government policy and financial incentives/penalties. Consumer-directed health care is premised on the notion that consumers are motivated and knowledgeable enough to choose the best value in health care, taking both price and quality into account (Tu & Lauer 2008). In fact, research on decision-making shows that when asked to make decisions about complex matters, individuals adopt simplified cognitive strategies, such as comparing alternatives based on single important dimensions and leaving out other important dimensions (Hibbard, Slovic & Jewett 1997). In the case of health care, many prefer to have someone tell them what action they must take (Jewett & Hibbard 1996).

The determinants of patient choice in health care are further examined by Brown and Meyer (2015), who discussed the psychosocial and philosophical correlates of trust based on an analysis of how the features of vulnerability, time, and consciousness function in bounding the patient's choices and trust. Multiple structural processes of choosing and trusting, alongside continuing agency, help further illuminate various power dimensions within clinical encounters. Trust is understood as seemingly a sufficient but not necessary proxy for choosing healthcare options, forming one important mechanism among others that acted to bound reflection upon pursuing particular healthcare paths. There were other factors, including understanding of the system, socioeconomic structures, illness vulnerabilities and chronology, that interacted to constrain, but not annihilate, choices to trust, with trust understood as an emergent enactment of structure from the (near or distant) past, and which, in turn, structures, but does not determine, 'choice' in the present. The role of power, prior experiences and emotions are considerations that govern trust in all exchange-based relationships, whether professional-to-professional or social exchanges.

Brown and Meyer (2015) stated that the influence of power in constraining 'choices' to trust, via wider socio-structural and chronological processes, are regularly overlooked within the social-scientific literature, because of a focus on the distinctive features of trustees and systems and how these are appraised by the truster. A person's history or habitus, emotional state, and decision-making ability are inherent to trust, constituting further dimensions by which healthcare decisions are embedded within socio-historical contexts and the power relations pervading therein. The history of previous social experiences can be seen as endowing the potential truster with a stock of knowledge, interpretative inclinations, and basic starting assumptions, it is important in the context

of this research on how/if this influences interprofessional exchange relationships. The emotion of self-confidence, as integrated with the emotions generated in the interactions with the potential trustee, have been emphasised as effective ways of knowing and trusting. These emotional reactions, as with (and as part of) habitus, are learned via a complex history of prior social interactions across social contexts/fields. Both habitus and affect help cut through complexity and represent two formats by which rationality is bounded in everyday life. If this theory is placed in the referral process of oncology: Will a referrer only refer to an oncologist they share history with, and has provided positive outcomes in the past; hence, diminishing the other patient-centric aspects of accessible and affordable treatment options in a geographical friendly location?

Based on their research on variables determining patient choice to receive treatment in the British and the Australian healthcare contexts, Brown and Meyer (2015) concluded that culture also has profound bearing on healthcare decisions, and the power dynamics of inequality and of representation that cut across sociocultural fields, shaping past experiences and assumptions, and thereby influencing trust and choice.

In this study, the role of trust in determining professional-to-professional relationships and referral practices will be ascertained. Feedback from the patient to the GP and SMP will be critical components in affirming or deterring trust-based professional exchange relationships and referral decisions; and understanding the background analytical approaches to the research on trust with heed this process. Simpson stated that 'Outside the realm of relationships, trust acts as a social lubricant that promotes cooperation between group members, sustains social order and permits beneficial long-term exchanges that otherwise might never occur' (2007, p. 587).

3.8 Approaches to Research on Trust

A sociological conception of trust emphasises the need to distinguish between the levels and dimensions of trust, according to Lewis and Washington (2012). Based on a meta-analysis, they concluded that the cognitive and emotional dimensions of trust are strong, independent, and interconnected in the process of forming trusting relationships within formal organisations (Lewis & Washington 2012; McAllister 1995). The roles of fairness, consistency and promise fulfilment were found to be more salient in relationships with an obvious power differential.

Ability, benevolence and integrity, as well as trust and trust propensity, had significant unique relationships with behavioural outcomes. Ability had incremental effects on both risk taking and citizenship behaviours, and trust propensity had incremental effects on both citizenship behaviour and counterproductive behaviour (Schoorman, Mayer and Davis 2007). Ability, benevolence and integrity were significant predictors of affective commitment and not just trust. Affective commitment was found to be a significant predictor of citizenship behaviour when controlling for trust. From this perspective, trustworthiness may have dual importance, predicting behaviours through the mechanisms of both trust and affective commitment.

Although affective commitment provided an additional mediator for the effects of trustworthiness and trust propensity, the antecedents of trust had incremental effects on the outcomes even when the mediators were controlled. Lewis and Washington (2012) stated that this result points to the importance of yet other social exchange indicators, such as felt obligation and psychological contract fulfilment. Both offer useful directions for future research.

Alternatively, it may be that showing the completed mediation of trustworthiness and trust propensity requires a more comprehensive or direct approach to operationalising the social exchange phenomenon. The example cited by Lewis and Washington (2012) is of Shore et al.'s (2009) validated scale that reflects multiple facets for social exchange relationships, including the trust within the relationship, the investment between the two parties and the socio-emotional (as opposed to the financial) focus of the exchange. This may be evident in the exchange between a GP and an SMP in the referral process, the GP shall receive no financial reward for the referral, but instead may receive favour in accessibility or improved communication.   It may be that this sort of measure would fully mediate trustworthiness and trust propensity effects because the full spectrum of exchange concepts is being considered.

 Lewis and Washington also cited Seligman (1997), who stated the role of trust in social relationships is becoming more essential in the modern world of increased freedom and role ambiguity, and Weigert (2012), who contended that in the context of cosmopolitan interactions, the demonstration of behavioural trust can be a pragmatic tool for creating an atmosphere that may elicit cognitive and emotional trust. This is exactly the *reverse* of the 'causal direction' presumed by most trust research. Yet, in some instances, it may be

the most effective way to bridge a wide gap in trust expectations when the pillars of system trust are deteriorating.

In seminal research on trust, Deutsch (1958) considered the following factors in framing hypotheses:

1. the nature of the intentions that the individual perceives the potential object of trust to have;
2. the perceived power of the object of trust to cause the desired events;
3. the power relationship between the individual and the object of trust;
4. the influence of communication on the development of trust between two people; and
5. the individual's self-esteem since it affects readiness to trust.

The major findings from this study were:

1. There are social situations which, in a sense, do not allow the possibility of rational individual behaviour as long as the conditions for mutual trust do not exist.
2. Mutual trust is most likely to occur when people are positively oriented to each other's welfare.
3. Mutual trust can occur even under circumstances in which the people involved are overtly unconcerned with each other's welfare, provided that the characteristics of the situation are such as to lead one to expect one's trust to be fulfilled.
4. Some of the situational characteristics that may facilitate the development of trust appear to be:
   i) the opportunity for each person to know what the other will do before the person commits irreversibly to a trusting choice;
   ii) the opportunity and ability to communicate fully within a system of cooperation that defines mutual responsibilities and also specifies a procedure for handling violations and returning to a state of equilibrium with minimum disadvantage if a violation occurs;
   iii) the power to influence the other person's outcome; and
   iv) the presence of a third party whose relationship to the two participants in a game is such that each perceives that a loss to the other is detrimental to own interest vis-à-vis the third person.

Trust remains theoretically fecund and empirically cumulative. During the 1990s–2010, Hardin (1996, 2002) began to challenge the utility of social trust as a theoretical concept. They argued that the concepts and measures centred on generalised trustees and unspecified matters for which trust is placed yield few analytical insights into the dynamics of trust. Their recommendation was that conceptualisations of trust should move away from trust as a two-part relationship where actor A trusts persons or organisations of general type B without any constraint on the scope of trust. The shift was to a form of relational trust consisting of three parts: actor A's beliefs (the truster), specific actor B's perceived trustworthiness (the trustee) and particular matter Y of concern to actor A (Hardin 1996, 2002). In the case of oncology, an example of this would be Actor A (GP) has a perceived trust in Actor B (SMP) so will refer a patient based on clinical need (Y).

Throughout the study of trust and related constructs, researchers have overwhelmingly relied on traditional surveys to gather evidence to support or refute the importance of trust. By measuring trust through traditional surveys, researchers are only gathering a snapshot of trust at the time of data collection and have no scope to add follow-up questions should a tangent emerge from the typical responses. More emphasis should be placed on the dynamic nature of trust and the conditions under which the research findings presented will hold true. This need to account for dynamics over time underscores the need for more longitudinal research wherever feasible, in this domain of inquiry.

A second reason that traditional surveys may be problematic is that the trustor and the trustee may not share trust perceptions owing to their varying interpretations of context and experiences, which may require additional questioning beyond the preconstructed survey. The third reason that traditional surveys may be faulty in measuring trust is because humans appear to have poor insight into their decisions to trust co-workers and assume rational decision-making processes are involved. Thus, measuring trust through surveys makes it difficult to make sense of, and gain a deeper understanding of, the trusting relationship that exists within a team or department.

According to Mollering (2001), the Simmelian idea emerging strongest across researchers is that trust performs a crucial function in modern societies while the bases for trust are actually rather weak. The 'leap' is far from rational. For Simmel, trust combines good reasons with faith. Mollering believed that both notions as proposed by Simmel, the weak

inductive element and the faith element, are needed to understand trust as a state of favourable expectation regarding other people's actions and intentions. Trust can be imagined as the mental process of leaping, enabled by suspension, across the gorge of the unknowable from the land of interpretation into the land of expectation. (Mollering 2001, p. 412).

Butler (1991) stated:

1. Trust is an important aspect of interpersonal relationships.
2. Trust is essential to the development of managerial careers.
3. Trust in a specific person is more relevant in terms of predicting outcomes than is the global attitude of trust in generalised others.
4. A useful approach to studying trust consists of defining and investigating numerous conditions (determinants) of trust.

Mollering (2001) asserts that no major further contribution has been made to social theory from any of the studies on trust post Simmel's (1950) research, and further research in this area will help restore a richer understanding of the nature of trust as outlined by Simmel (Mollering 2001).

As framed by Calnan and Rowe (2006), trust relationships can be differentiated between the patient and the clinician, between clinicians, between clinicians and a manager, and between the patient–public trust in clinicians and managers in general, in a healthcare organisation, and in the healthcare system. See Figure 3.3
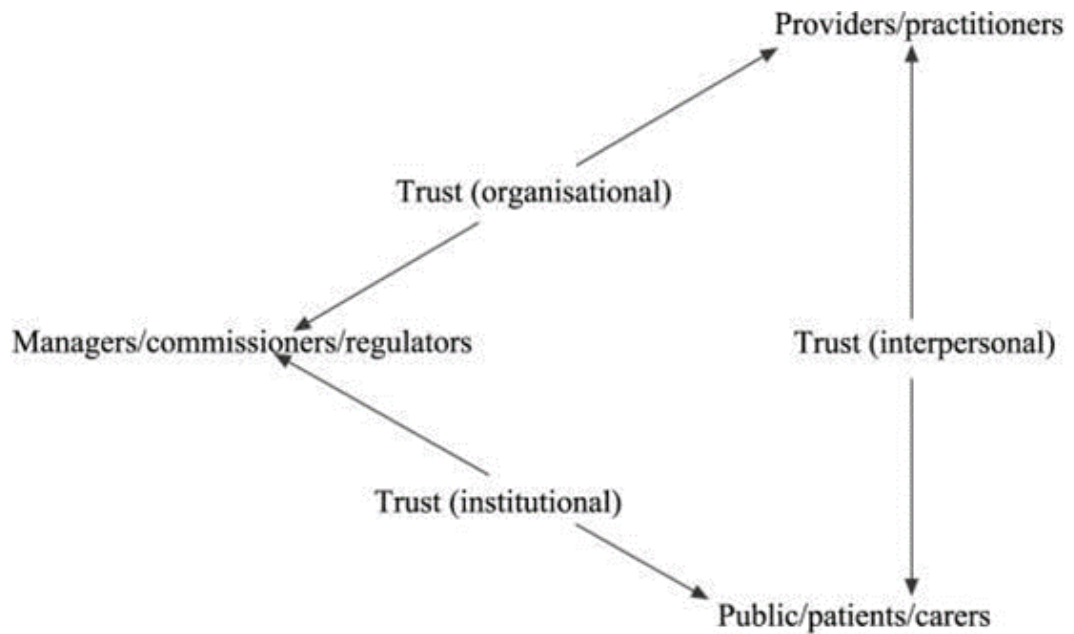
Figure 3.3: Framing Trust Relationships in Health Care

(Rowe & Calnan 2006, p. 350)

Simkovits (2015) highlighted 11 determinants for building and sustaining trust in the business context: rapport, honesty, sincerity, respect for self and others, openness, competency, mutuality, integrity, reliability, acknowledgement of errors, and recovery to help make up the loss and fulfil the promise. As is evident, the subvariables are innumerable, and although studies relating to trust are numerous, research that focuses on the nature and role of trust and reciprocity as determinants of referral behaviour, in the professional service environment of oncology, is relatively scant.

Calnan and Rowe (2006), researching trust relationships in health care, cited Quick and Entwistle (2006), who highlighted the significance of developing trust in relationships between patients and clinicians, between healthcare providers and patients and between practitioners to help reduce medical errors and enhance patient safety. Whilst the data from Calnan and Rowe may seem dated at 15 years old, it is affirmed by a more recent American study by Makary & Daniel (2016) where they found that medical error is a major cause for concern in the provision of quality health care; in fact, it is the third leading cause of death in the US.

Research on medical error in the Australian setting is under-represented; with the highest quality paper dating back to 1995, where Wilson et al. (1995) undertook a review of the medical records of over 14,000 admissions to 28 hospitals in NSW and South Australia.

The results from this 1995 study revealed that 16.6% of these admissions were associated with an 'adverse event' that resulted in disability or a longer hospital stay for the patient and was caused by healthcare management; 51% of the adverse events were considered preventable. In 77% of the cases, the disability had resolved within 12 months, but in 13.7% the disability was permanent and in 4.9% the patient died. A Harvard study undertaken in 1991 found that patients were unintentionally harmed by treatment in almost 4% of hospital admissions in New York State, with 70% of these patients suffering slight or temporary disability, and 7% with permanent disability. Further, 14% of the patients died, partly because of their treatment (World Health Organization 2005). In the UK, a review of patient records showed a 10.8% adverse event rate, about half of these being preventable (Neale et al. 2001). Adverse events at around 10% were reported in Denmark, New Zealand and Canada, which is indicative of a relatively high rate of medical error.

Seeing a specialist, particularly for cancer, is often associated with a higher degree of seriousness and vulnerability because these are likely to be life or death situations. Professional-to-professional relationships between family physicians and hospital specialists in the UK were qualitatively explored by Marshall and Phillips (1999). They sought to understand the nature of the relationship, rather than its impact on referral practices. The results highlighted a number of factors likely to influence the provision and utilisation of healthcare services that are dependent on the relationships between medical professionals, as key decision-makers of referrals. Marshall and Phillips said, 'For example, this research suggests that any hospital capacity planning that is based on the assumption that GPs refer to the nearest or cheapest hospital providing the required specialism is likely to be fundamentally flawed' (p. 281). They stated that the quality of patient care might be influenced in part by the interprofessional relationships among the physicians involved. However, this research was not based on a theoretical understanding of the drivers of professional-to-professional relationships.

This doctoral research study seeks to understand the role of trust, reciprocity, reputation and agency in professional-to-professional relationships, and its impact on referral and patient outcomes within the framework of SET and RMT, for improved understanding about why some specialists are trusted by doctors and others ignored. It is important to gain theoretical understanding of this complex issue if lasting changes have to be affected at the interpersonal and institutional level. This study will contribute to the development

of a new evidence base in relation to this fundamentally important dynamic underpinning so much of the cancer care diagnosis and treatment process —the GP-to-SMP as well as the SMP-to-SMP relationship, and the role of trust in determining referral practices. Further, the findings of this research may help re-examine and ultimately transform clinical referral pathways, enhance timely patient access to specialists and optimise patient referral to qualified specialists, thereby improving treatment and survival outcomes.

Figure 3.4 displays a multidisciplinary framework that draws together the two theoretical relational frameworks of SET and RMT. Developing a conceptual framework to explore factors determining referral practices, and doctor (GP–SMP and SMP–SMP) relationships, has not been attempted before. The factors of relevance for the present study include reciprocity, trust, cohesion, commitment, risk-uncertainty, dependence, resources and related concepts of shared values, judgement and decision-making.
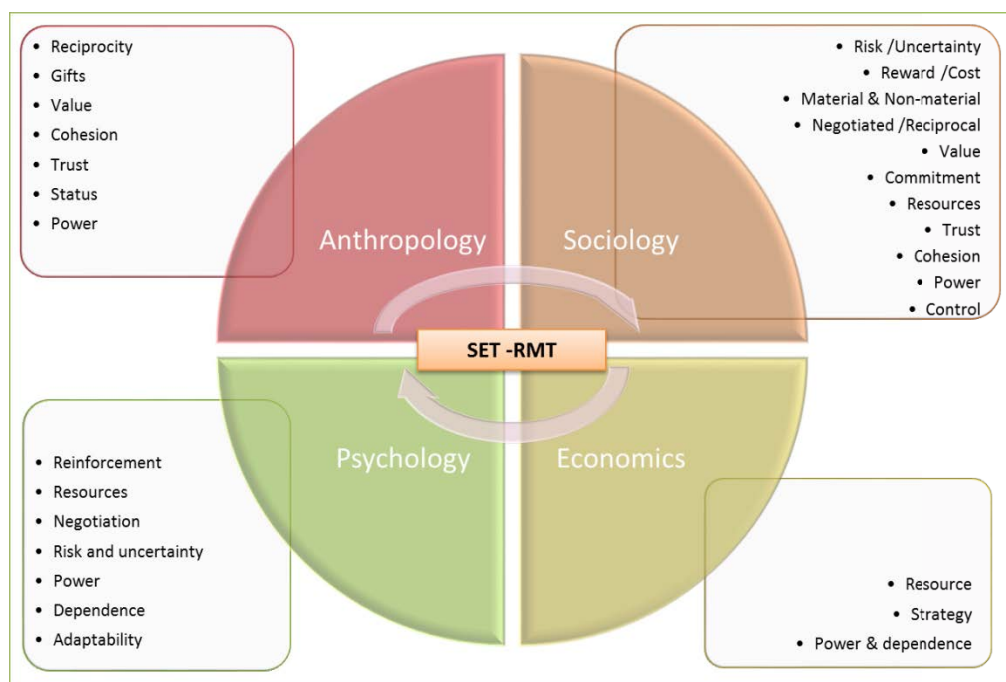
Figure 3.4: Social Exchange Theory and Relational Models Theory - A Multidisciplinary Framework

The proposed theoretical framework is positioned in the context of medical professionalism.

3.9 Professional Exchange Relationship: Primary Care Physician and Specialist Medical Provider

The interface of consultation between generalist and specialist has been a concern for the medical profession for some decades. D. Pearson (1999) offered some guiding principles for generalist–specialist relationships based on an appraisal of the American Physicians Ethics Manual literature on ideal consultation processes, and subjective experiences:

1. The patient's welfare and best interest must be the main concern of all physicians.
2. All physicians, as members of a common profession, have a duty to treat each other with integrity and respect.
3. All physicians have an obligation to use health resources appropriately and prudently.
4. Physicians should obtain consultation when they feel they need assistance in caring for the patient.
5. Unless authority has been formally transferred, the ultimate responsibility and corresponding authority for a patient's care lies with the referring physician.
6. Both physicians share the responsibility for establishing in partnership with the patient the goals of evaluation and treatment.
7. Both physicians should communicate patient information between themselves in a timely and complete manner.
8. Both physicians should demonstrate respect for the relationship the patient has with the other physician.
9. Both physicians share an obligation to resolve all conflicts between them in favour of the patient's best interests.
10. If the referring physician refers a patient to a specialist without prior consultation with the specialist, the referring physician should state in writing the desired level of consultation and the mechanisms of future communication.
11. Consulting physicians should respect care plans established jointly with referring physicians and carefully and respectfully explain recommendations for change/major procedures/additional consultants.

All of the principles, as outlined by the American Physicians Ethics Manual, have parallels in SET and RMT, when reviewed via the lens of medical professionalism. However, literature on referral practices in the UK, the USA, Germany, the Netherlands

and Australia indicates that there is a gap between guidelines as outlined and guidelines as practised (Hespe 2010; Manca, Breault & Wishart 2011; Manca et al. 2008; Marshall & Phillips 1999; Probst et al. 2013). For instance, there is no clarity on who has primary responsibility once the patient is referred. GPs cite instances of patients not being referred back to them by the specialist, or in some instances, cross-referred to other specialists without further communication to the referrer. The Australian Medical Association (1964) Code of Ethics has been derived from ethical codes dating back to the Hippocratic Oath and parallels the US code.

Codes of medical ethics become relevant here. D. Pearson (1999) cited the Code of Medical Ethics of the American Medical Association, which has continued mostly unchanged since 1847. Regarding the role of the physician, among others, it states: A physician who is called upon to consult should observe the most honourable and scrupulous regard for the character and standing of the practitioner in attendance: The practice of the latter, if necessary, should be justified as far as it can be, consistently with a conscientious regard for truth, and no hint or insinuation should be thrown out, which could impair the confidence reposed in him, or affect his reputation.

According to Pearson (1999), much has changed since then. Our health systems are and have been in a state of rapid change for at least the past three decades. The healthcare environment since 2000 has been described as consumer-driven, multigenerational, and multicultural, with a care environment characterised by integrated systems, IT adoption, specialisation and inter/trans-disciplinary practice. With the capping of the government-sourced health dollar during the 1990s as a proportion of gross domestic product in most industrialised countries, an environment increasingly characterised by competition has prevailed in many parts of the world and continues today. At present, service providers continue to be pressured to provide more efficient services and better patient outcomes. Both generalist and specialist medical practice have not been immune to this scenario:

> The new organisational and financial realities of American medicine are dramatically changing the rules by which physicians interact with each other …new or reinforced tensions have seriously strained many aspects of patient-physician relationships. Patients, money, prestige, autonomy, power – the state of all these and more seems uncertain as the old patterns of a profession organised largely as a cottage industry are swept away. (Pearson, D. 1999, p. S13)

Some of the ethical challenges facing physicians and specialists in the referral and care process have been explored in recent literature. One such US longitudinal study showed a marked increase in referral rates to specialist physicians across primary care, office-based and outpatient-department based settings in 1999–2009, with ambulatory visits resulting in a referral more than doubling during this period (Barnett, Song & Landon 2012). The authors cited the increasing complexity associated with providing quality care, which necessitates intervention by specialist physicians, as a causal factor. Currently, patients more frequently present with multiple conditions, and screening and preventive recommendations have increased considerably over the decade. This study found that physicians have to do more during a visit, resulting in less time to devote to each patient. Another finding from this study was that physicians with an ownership stake in the practice, and physicians receiving greater than 50% of their income from managed care contracts, provided fewer referrals compared with non-owner physicians, reflecting the prevailing financial drivers in the US to contain patients within their own practice.

Kinchen et al. (2004) assessed the factors determining a GP's choice of specialist when referring patients. The factors identified as significant determinants of choice included medical skill, appointment timeliness, insurance coverage, previous experience with the specialist, quality of communication, efforts by the specialist to return the patient to the GP and the likelihood of good patient–specialist rapport. The medical skill of the specialist was the most highly valued factor by all primary GPs. Descriptive research focusing on relationships between GPs and SMPs has identified disparities in power and prestige (Manca et al. 2008).

Suggestions regarding ameliorating this 'status gap' included the provision of incentives for GPs to be involved in academic/hospital teaching practices, developing learning environments in which GPs and SMPs interact, involving more GPs as positive role models in teaching and decentralising medical education so that specialists obtain more experience in community settings. According to Jecker (2004), medical professionalism serves important functions, such as resolving ethical issues, exposing individual bias and gaining a broader perspective (p. 47). Medical students are taught professionalism as comprising attributes such as being knowledgeable, altruistic, compassionate; committed to excellence and ongoing professional development; and responsive to the needs of patients and society, which supersedes self-interest. Probably it is the virtues associated with medical practice that are critical, and professional theory on integrity helps identify

these. Via self-reflection, students or clinicians might realise that they lack strong first-order principles and dispositions, such as compassion, which compel a professional towards competent clinical care.

Medical professionalism can help to uncover insidious bias by highlighting its shaky foundations. Jecker (2004) cited the example of racial and ethnic stereotypes, which might lead the health professional to internalise a simplistic formula for managing patients from diverse cultural backgrounds. Such bias precludes the professional from seeing all patients as unique individuals, which could limit the individual's chance of quality treatment.

Theories of professionalism serve the purpose of drawing attention to morally inappropriate behaviour when applying simplified sociocultural formulae to the care of patients:

> By distinguishing theory from practice, we can begin to see the complementary and distinct roles each plays in a moral life. Theory contributes to settling disputes by identifying the basic values at stake and by helping us see our situation in less specific terms. We can discern the abstract and general features of persons and relationships most perspicuously when we view them through the lens of theory. Theory also helps us to see more clearly the basis for our action and to lay bare the fact that our action might have little basis. (Jecker 2004, p. 48)

Aitini, Martignoni and Labianca (2014) recommended the doctor's consideration of the cultural context as significant, particularly with the advances in technology facilitating communication through use of electronic devices: 'where people have forgotten how to write a letter and where suffering and death have become all too common to attract attention beyond the initial moment' (p. 212).

Extending this research on understanding relationships between specialists and generalists in the Canadian context, Manca, Breault and Wishart (2011) conceptualised the main concern(s) surrounding the working relationship between general and specialist physicians, and model concern resolution. This modelling suggested that the specialised medical culture determined the areas of focus and expertise through setting boundaries, socialising based on expertise and gatekeeping access to valued resources to maintain a valued position in the medical hierarchy. For generalists, the focus was on service and

comprehensive culture, treating all illnesses with 'a focus on the patient and not on the disease' (p. 580); the specialists focused on specific details of the diseases, organs, technology and the like. This research although focused on Canadian health care is interesting to the Australian context as they apply a similar gate keeper system of referral for specialist care.

Although specialists lack the skills to manage general medical and non-medical issues, generalists were overwhelmed with work and lacked the necessary resources to deal with high patient volumes. Three themes emerged from Manca, Breault and Wishart (2011) research as key to developing better relationships:

1. Increasing accessibility: Appropriate accessibility involved deciding with colleagues when to consult, and the process leading to consultation, and consequently, sharing of resources.
2. Negotiating boundaries: Appropriate boundaries related to mutual empowerment, attention to fairness and justice, shared power relations and a sense of valuing one another.
3. Socialising learners and others: Socialising learners in a comprehensive culture involved facilitating understanding and experiencing one another's roles, which led to valuing the contributions of colleagues.

A similar finding was reported in a qualitative study on family doctors as seen through the eyes of specialists in the German healthcare context (Probst et al. 2013). Faced with a shortage of family doctors, and to understand possible reasons for this shortfall, 16 medical specialists from different health provision settings were interviewed. While the participants reported that family doctors enjoyed a high public status, family doctors themselves had a negative image of their standing. The authors recommended desisting from depreciating or up-valuing particular medical disciplines and taking new approaches to professional training. Image-enhancing measures to transform the 'traditional family doctor' image to that of a 'modern family doctor' were also recommended.

Marshall and Phillips (1999) examined the role of relative power and influence within the UK medical provider sector and the ways in which this is likely to affect patient referrals. The purpose of the study was to describe the GP–SMP relationship, to identify strengths and possible problems and to consider ways of improving professional interaction in the

healthcare system. They postulated that the interaction would have significant implications for any healthcare system in which the family physician is the first point of contact for patients and of access to relatively scarce and expensive specialist services. In the UK, the role of the GP in the NHS is well established—90% of NHS contacts are made in primary care, either directly or indirectly through the GP, who also acts as the gateway to specialist services via the referral system. The Australian healthcare system is not substantially different since all patients are referral dependent for access to specialist services.

The assumption underlying the Marshall and Phillips (1999) research was that interprofessional relationships may be a factor influencing referral behaviour and resource allocation. Further, since the GP initiates the referral, the professional-to-professional relationship will be a very important determinant. Apart from regulating patient flow, it also influences income streams in the health sector. Historically, in the UK, the relationship between GPs and specialists has not always been good, mainly because of the relatively low status of GPs.

Marshall and Phillips (1999) described GPs as being jealous of the status, facilities, and income of their specialist colleagues and resentful that at the time they commenced as GPs there was no special training for their role [In Australia GP became a specialty in 1996 (Bollum et al, 200)]. Reviewing studies during the 1960s and 1970s, they noted that there were difficulties with the way that GPs and specialists related to each other. Specialists complained about inadequate information and unnecessary referrals, and GPs expressed dissatisfaction with a lack of information, the failure to take account of important psychosocial information and delays in communication. The present context resonates with similar problems. Since then, there have been systemic changes in providing specialists with greater autonomy and power. In addition, the GP's role as patient advocate has been enshrined in (1989), and the increased influence this brought them regarding purchasing UK hospital services has led to a power shift in their favour.

Marshall and Phillips (1999) used a qualitative methodology which relied on thematic analysis, to explore the state of GP–specialist relationships. Interviews were conducted with samples of informants from the Royal Medical Colleges, the General Medical Council, the National Health Service, the British Medical Association and practising GPs and SMPs. The major themes that emerged included career choice, clinical interaction,

educational interaction and future models of working together, and four categories relating to the process of the interaction, which were cooperation, conflict, power and status. In terms of career choice, GPs were driven by their desire for patient-centred, long-term care, whereas specialists were more disease or technically oriented. In clinical terms, all regarded the GP role as fundamental and pivotal. Educational interaction was largely regarded by SMPs as a one-way activity driven by them. They believed that they had much to teach GPs but little to learn from them. GPs regarded the style and content of SMP-driven education as inappropriate; many preferred practically useful information relevant to their daily practice, delivered in an interactive environment. They also wanted rapid access to specialist advice, preferably on the telephone, and constructive critical feedback about the quality of their written referrals.

All participants felt that the current working relationship was unlikely to change significantly and would be influenced by political restructuring, patient demands and advances in medical knowledge. The opposing themes of cooperation and conflict were analysed in detail as they appeared to be central influencers of referral patterns. The desire to work well together seemed to be based on a wish to preserve potentially long-term relationships and the benefits for the patient of a relationship based on trust and mutual respect. Most clinicians seemed to work hard at developing good personal relationships with their colleagues. The development of the GP–SMP relationship was described as occurring over many years, first contacting, testing and judging each other on the basis of written and personal contact and then building on the relationship. There were examples of SMPs tailoring their advice to individual GPs, based on their in-depth knowledge of that GP, and of GPs sending certain types of patients to certain SMPs.

While the traditional view was that SMPs have a higher status, both within and outside the profession, and are more powerful and influential than their GP colleagues, there seemed to be a rebalancing in favour of GPs with GPs regarding themselves as having improved status and influence within the profession Marshall and Phillips (1999). The reasons ascribed to this shift were better training for GPs and improved facilities in the community. It should be noted that in the Australian context, general practice is now considered a speciality that requires a comparable study plan to that of a specialist (Bollen et al, 2000). Little is known about the relative power changes that may have occurred as this has transpired.

Public trust and confidence in the medical profession is essential for ensuring access to medical care. If people do not trust doctors, they will seek care elsewhere, or not seek care at all. A question arises: Why are some medical professionals trusted, while others not? Further, is there a trust continuum at play? This thesis seeks an understanding of the drivers of interprofessional exchange. This investigation may offer greater awareness of the impact of social exchange and professional relationships on referral practices, and oncology service provision. Such awareness may contribute to improved conduct of high-value service provision and better patient outcomes.

Bringing together the theories of social exchange and relationships within the broad canvass of medical professionalism, a socio-medical model conceptual framework has been developed, which incorporates the major domains and dimensions of both SET and RMT. See Figure 3.5.
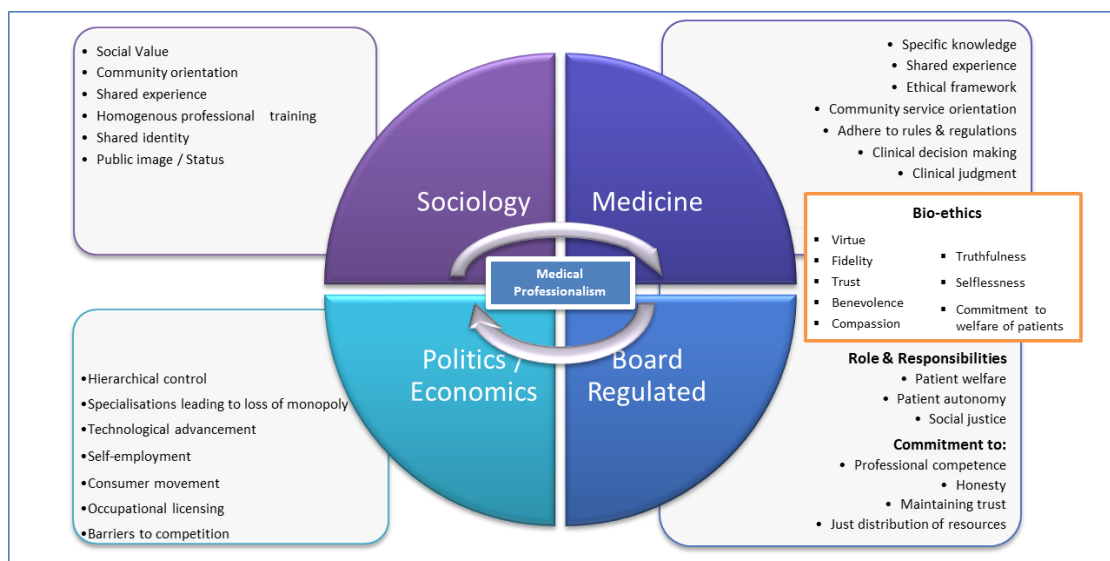
Figure 3.5: Social Exchange Theory and Relational Models Theory - Theoretical Lens Perspective; Major Variables in Medical Professionalism

3.10 Chapter Summary

This chapter explored SET, RMT and, to a lesser extent, the resource-based view as theoretical frameworks that might underpin professional-to-professional exchange relationships. These theoretical frames have informed multiple complementary and conflicting research agendas throughout the second half of the twentieth century and into the present time. Much of the research informed by SET and RMT has been unconcerned with healthcare; instead, its focus has been more generally organisational. That which has

been healthcare specific has yielded few enduring findings that shed light on the motivations and perceptions that seed and sustain relationships between GPs and SMPs and guide the actions of these professional actors. Possibly, trust and reciprocity are key to unmasking the core drivers of these relationships, in particular, as they are expressed in terms of referral decisions and behaviours. The goal of this thesis is to explore this fundamentally important area. As was established in Chapter 2, referral practice is key to patient outcome and mortality in the context of oncology. Without a strong theory-informed grasp of the exchange-related and relational factors at play between these two distinct groupings of medical professionals, we will forever remain in an incompletely informed position from which to drive positive change and development in the name of patient outcome. The next chapter reviews the methodological design and the methods to progress the empirical component of the present study.

Chapter 4: Methods

Methodologies are not neutral players in the work of social scientists, but rather active conveyers of stance, perspective, privilege, and values. (Greene 2015).

4.1 Overview

Methodology and methods are two terms treated as synonyms (Neuman 2006). 'Methodology is broader than methods and envelops methods' (p. 2). Neuman stated that it encompasses the social-organisational context, philosophical assumptions, ethical principles, and political issues of the topic researched. Methods are techniques for observing, measuring, and analysing data and reporting results.

In developing the framework (see Figure 4.1) of the research design for this thesis research, factors considered include the epistemology informing the research, the theoretical and philosophical perspectives underlying methodologies as a whole, the methodologies appropriate for the research and the techniques or methods for data analysis, all of which help further the process of seeking answers to the research questions (Creswell 2003). Davidson and Tolich (2001) stated that there is no research method that is intrinsically better than another and recommended that research should always be tailor-made, with the method determined by the research questions, the theory, the stakeholders and the reality factor of purpose, time, and the resources at disposal to accomplish the research.

In the present research, the methodological approach was informed by two major socio-psychological theories—SET and RMT. These theories have informed a methodological approach which relies on a qualitative method. The conceptual framework of medical professionalism overlays the theory-informed analysis, in order to yield both a theory-driven picture of the topic and an operational context for the findings. Medical professionalism is understood to represent the extant contract between the medical profession and society as a whole. This methodological approach seeks to frame an inquiry method that is well-positioned to describe the real-world drivers of professional-to-professional relationships that influence referral patterns.

Theoretical Framework	Variables	Methodology

Professional Exchange

Trust

Referral Decision

Theoretical Foundations

Social Exchange Theory

Relational Models Theory

Trust

Referral Decision

- Reciprocity ~ Relationship Engagement & Motivations:
  - Altruism
  - Positive Emotions
  - Relationship Dependence (mutual & reciprocal)
  - Group Gain
  - Loyalty
  - Status

- Reputation:
  - Excellence
  - Service Quality
  - High-value Care
  - Competitive Advantage

Qualitative Methods

Interpretive approach

Data analysis

Memoing;

Substantive coding;

Thematic coding;

Theoretical coding; and

Computer-aided qualitative data analysis: NVivo

Figure 4.1: Conceptual Framework for the Research

4.2 Major Methodologies/Approaches in Social Science Research

Neuman (2006) classified three approaches to social science research: positivist social science, interpretive social science, and critical social science. These approaches encompass both quantitative and qualitative research paradigms. Positivists generally take the position that inquiry in social sciences should be objective, allowing for time and context-free generalisations. Qualitative researchers take a subjective stance, informed by philosophical standpoints that colour their research approach. Constructivism, idealism, relativism, humanism, hermeneutics, and postmodernism are examples of such precognitive positions taken in the researching process (Johnson, R. & Onwuegbuzie 2004).

Under a modernist paradigm, the researcher's intent is to provide explanations for how the world works and to discover universal laws of cause and effect, which could later help in prediction. That is, the world is considered an objective, observable reality, independent of the observer, and is investigated through deductive methods, with hypothesis generation followed by testing against existing theories. Knowledge generated becomes accepted as facts or laws, which are verifiable against reality. Data collection and analysis can include conducting fieldwork, developing conceptual categories, coding, searching for patterns, testing, and building theory. To contribute to theory development, the research must meet the criteria of internal validity, generalisability, and freedom from bias in design, analysis, and reporting.

In the postmodern paradigm, knowledge is viewed as fundamentally fragmented and reality as unstable. In this sense, reality can be 'interpreted' rather than 'known'. Knowledge is considered a discourse at best, and postmodern theory-making highlights the need for deconstructing existing knowledge that has been conceptualised as truth and scientifically authoritative. Studies that use the postmodernist paradigm are based on analyses that seek to locate the ideological position of the study participants, as revealed by the analysis of discourses that they reproduce in their talk.

There is a clear distinction between quantitative (modernist paradigm) and qualitative (post-modernist paradigm) methods in research, with the primary goal in quantitative research of producing generalisable knowledge, which may be abstract and disconnected from the community of participants. In contrast, qualitative research can be viewed as a

process of understanding-seeking in relation to particular people and cultures in context (Onwuegbuzie, Johnson & Collins 2009).

4.3 Overview of Methodological Approach Taken in This Thesis

Framed by an interpretive methodological approach, the present research uses qualitative methods to explore the relational drivers and associated factors and to facilitate theory generation. The aim of this thesis work is to uncover:

1. the drivers/determinants of long-term professional exchange relationships between medical professionals;
2. medical professionals' perspectives on the significance of different factors underpinning professional exchange relationships;
3. the role of professional exchange relationships in clinical judgement and referral, when GPs and SMPs refer a patient for specialist medical care; and
4. medical professionals' perspectives on the relational factors critical to best patient outcomes and interprofessional collaboration in the health service context.

Owing to the exploratory and descriptive nature of this research, qualitative methods have been adopted. In line with the position of Onwuegbuzie et al. (2011) regarding the role of qualitative research, the thesis work represents an understanding-seeking effort as regards particular people and cultures in context (Onwuegbuzie, Johnson & Collins 2009); SET and RMT are viewed as key to developing an understanding of the thesis topic. however, the researcher is not closed as to these being the only 'way in' to shedding light on the stated aims. It is the researcher's aim to develop new or understandings, particularly those which account for (or position) the findings in relation to SET and RMT.

4.3.1 Assessing the Constructs

The key constructs of interest to this work are:

1. Inter- and intra-personal factors related to trust, professionalism, collaboration, reciprocity, altruism, agency, and reputation; and
2. Pragmatic factors relating to referral and both GP and SMP outcomes in providing cancer care. Patient outcomes are also of significant factorial interest to the work,

though these have not been subject to data collection and are considered in proxy fashion, in light of GP and SMP reporting/discussion re them.

Methods for data collection in the present study are concentrated on the use of structured in-depth interviews as a means of uncovering these factors and how they relate to each other. Of particular interest is how the inter- and intra-personal factors relate to or 'drive' self-reported pragmatic behaviours relating to referral practice. The interview method is the most appropriate data collection technique, and as stated by Onwuegbuzie, Johnson and Collins (2009), will help to shed light on the research questions related to the thesis aim. Interviews will be used for data collection to explore professional-to-professional relationships between:

- GPs and specialists; and
- between specialists (i.e. specialist to specialist; see Appendices 9 and 10 for the GP and specialist interview guides). Although this could be said to be two studies (GP–SMP and SMP–SMP), the rationale for integrating is to facilitate triangulation and enhance research validity. Responses from participants will be coded, categorised into themes and explored for emerging patterns.

The section that follows is an overview and justification of the choice of data analyses methods for the present research.

4.4 Thesis Method

The Consolidated Criteria for Reporting Qualitative Research (COREQ) Framework (Tong et al. 2007) has been used to outline the thesis method in detail.

4.4.1 COREQ Domain 1; Research Team and Reflexivity

4.4.1.1 Personal Characteristics

All research interviews were conducted by the researcher who is an experienced oncology service provider with more than 30 years' experience as a director, researcher and healthcare expert.

4.4.1.2 Relationship with Participants

The interviewer had variable levels of prior knowledge of/contact with participants in the study. In some cases, participants had been involved in prior consultation with the researcher about the research topic domain (and how to best study it). In other cases, participants did not have this prior exposure to the study's goals. According to Botsford, Clarke and Gibb (2012), the credibility of qualitative research across contexts relies to some extent upon the depth and character of the relationship between researcher and participant.

There was a purposive character to the sampling method for both the qualitative studies undertaken. Purposive sampling is a useful/fruitful option especially when the researcher has a view about the relevance of those chosen to the particular research topic being studied. It is also a useful sampling technique for difficult to reach or specialised populations (Neuman 2006). Berg (2004, p. 75) defined interviewing as 'a conversation with a purpose'. The more formal the contact, the more important it is to establish rapport (Bryman 2004).

The researcher initiated the consultation process with GPs and SMPs to determine the best methods for collecting data to answer questions about GP–SMP and SMP–SMP relationships. This involved meeting informally with individuals and groups and clarifying and gaining understanding regarding views and experiences about medical professionalism, referral and best practice for patient care processes and outcomes in oncology.

A semi-structured interview schedule was drafted, and GPs and SMPs were invited to give their views on this, with a section attached at the end of the schedule for their feedback and suggestions for change. This was a consultative pilot phase, and the recommended changes were incorporated in the schedule. Both GPs and specialists found all the questions of relevance and proposed few additional questions.

Once the study received ethical approval (Human Research Ethics Committee approval number: ETH17-1464), these volunteering informants were invited to be part of the research, as were other GPs and SMPs who were not consulted in the pilot phase. Prior to consenting to participate in the study, they were required to read an invitation letter that included a study information sheet, and a participant information statement

(attached). If they agreed, they then signed a consent form (attached). The researcher took a purposive approach to sampling since he was seeking a wide cross-section of views and experiences. As a practitioner-researcher, he had access to a large group of potential interviewees and applied a purposive selection process to include participants from diverse practices and backgrounds to ensure a wide-variety of viewpoints were provided. Given this and the researcher's involvement in the sector under research, he was very clear in emphasising that he held no assumptions about the area under study and that the interview process was guided most of all by theory (e.g. SET, RMT). He also emphasised his personally neutral stance regarding anything that study participants shared with him in the interview—he emphasised and assured participant confidentiality (see attached Participant Information Confidentiality Form).

4.4.2 COREQ Domain 2: Study Design

4.4.2.1 Theoretical Framework

Two major socio-psychological theories underpinning this research are SET and RMT, wielded in the context of medical professionalism. SET may be defined as 'any behaviour that is motivated by an expected return or response from another' (Heath 1976, p. 2). Homans (1983) described social behaviour as being an exchange of rewarding or costly, tangible, or intangible exchange activity between two people. Blau (1964) noted that social exchange can be seen in friendship and love, and not just market relations. SET has its origins in anthropology; hence, exchange is characterised by reciprocal transactions governed by a different morality from that of the economic market.

Exchanges have different sets of meanings for the participants involved. These could be social, religious, utilitarian, sentimental, jural and/or moral. However, all interpersonal exchanges involve the exchange of resources (Foa & Foa 1980). A resource can be anything that is transacted and could be material or non-material, concrete or symbolic, particularistic or universal. Central to social exchange is the creation and maintenance of reciprocity—that rewards and benefits should flow to both parties over time (Gouldner 1960; Molm 2003; Strauss 1969). Key elements of any reciprocal exchange between professionals relate to the nature of the relationships created and the nature of resources exchanged, which might be implicated in the relationship (Foa & Foa 2012; Organ & Konovsky 1989). Because reciprocal exchange is largely non-economic and usually

involves social structures, it leads to the obligation to repeat and to the experience of both gratitude and trust (Masterton et al. 2000; Molm 1994; Price & Arnould 1999). It is also likely to include a socio-emotional exchange element and a commitment element and is thus long term in nature (Lawler & Yoon 1996). However, to create long-term relationships, the rewards received, and the costs incurred need to be ultimately balanced between exchange partners and value needs to be understood (Sparrowe, Soetjipto & Kraimer 2006). Long-term professional exchange relationships are likely to have an investment-return character, and again, a return on investment must ultimately occur if the relationship is to endure (Shore et al. 2009).

RMT is a more recent theory of social relationships, postulated by Alan Fiske in the 1990s, which perceives social life as comprising individuals who are developing relationships, remaining committed to the same and working to sustain these. Fiske proposed a four-factor framework that might be used to classify all social relationships, including moral behaviour. RMT introduced new domains of social exchange, such as cognitive foundations, exchange of resources, moral judgements, and decision-making. All of these are significant in assessing the role of professional-to-professional relationships in referral practice.

In the present research, SET and RMT are both viewed in the context of medical professionalism. Medical professionalism has some theoretical underpinning (as outlined in Chapter 3), but is primarily understood not as a theory, but a fundamental social contract between knowledgeable practitioners and the general populace. In this sense, it functions as a fundamental foundation to the current civil society. Medical professionalism demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity and providing expert advice to society on matters of health.

4.4.2.2 Pragmatic–Critical Qualitative Design

In embarking on a plan to study the complex phenomenon of interprofessional referral in oncology, the researcher took the view that this was a practice or action that had both interpersonal and sociocultural phenomenon characteristics and drivers. He discerned the exchange-related aspects of the process very early and formed the view that SET might be a 'way in' to understanding the drivers of processes and practices around it. He also

felt that RMT was likely relevant to an understanding of the process, given that separately from exchange, there were many implicit relationalities at play.

From here, the researcher settled on taking a pragmatic approach to the proposed qualitative research (Creswell and Miller 1997). This approach allowed for his own precognitive position or 'feeling' about the phenomenon to be combined (i.e. that SET was relevant to it), with a naïve inductive research approach that simply sought to explore the phenomenon among samples of study participants who were engaged in the phenomenon. For Creswell and Miller (1997): 'what counts as knowledge in pragmatic studies, is both an external "out there" perspective and an individual perspective'. Such a research stance reflected the researcher's own views since he viewed the phenomenon under study as at least to some extent a problematic. Thus, his stance regarding the location of knowledge (i.e. SET and RMT) had secondary importance to developing an understanding of the possible problem (or phenomenon) itself—interprofessional referral in oncology (Creswell 2014).

Once the researcher had settled on a pragmatic approach as a 'way in' to the phenomenon, he further reflected on his proposed approach. He subsequently formed a view that the proposed pragmatic approach may not adequately account for the implicit power relations that exist between players in the interprofessional referral process and the wider sociocultural context within which oncological medicine is practised today. For this reason, he chose to overlay a secondary critical (or post-structurally informed) analytical overlay to his research design.

A critical theoretical approach is often used context-specifically as a way of laying bare the implicit drivers of behaviour and/or thought, which lie outside of the individual-to-individual relationship—instead, such drivers are understood via a sociocultural lens. By this, it is meant that the lens seeks to account for societal and institutional pressure and influences, which come to bear on individual decisions and practices. The approach is often used in a context-specific way. By this, it is meant that the researcher attempts to 'lay bare' wider socio-political influences upon a given real-life context (in the case of the researcher's work, GP–SMP and SMP–SMP referral), by analysing participants' utterances with the specific intent of locating where and how their speech 'replicates' dominating sociocultural power-driven influences. So, interview text is appraised for utterances that reflect implicit power relations. Such thematically grouped sets of

utterances can be categorised as replicating, opposing or neutral to theoretically identified sociocultural 'discourses' or communication streams of sociocultural influence.

Thus, the thesis research design can be categorised as pragmatic–critical. Such an approach may also be regarded as mixed methodological. Both analytical approaches can be described as interpretive (or qualitative). The first (pragmatic) seeks to 'out' the key individual-centred and relationship-centred drivers of interprofessional referral via an analysis built on (but not limited to) a SET- and RMT-informed precognitive position. This means that both template coding and open coding will be used in the examination of transcripts, such that potentially important drivers emergent from literature reviewed across Chapters 1 to 3 will be used as *a priori* themes (see Table 4.1 for a summary) that will be built upon as data are examined inductively. The second (critical) seeks to locate findings from the pragmatic analysis with reference to larger external social forces influencing the practice of medicine (and hence referral) and to potentially introduce new driving factors not accounted for in the pragmatic analysis.

In the researcher's view, employing both approaches to analysing the interview text should yield the strongest potential to shed informed light on fruitful directions for any future change-oriented actions taken in relation to interprofessional referral in oncology.

Table 4.1: Table of Potentially Important Factors

Factors Potentially Influencing GP–Specialist & Specialist–Specialist Relationships	Seminal or Key Source	→	Factors Potentially Influencing GP–Specialist & Specialist–Specialist Relationships	Seminal or Key Source
Initial view following completion of Chapters 1 (Introduction) and 2 (Evidence Literature Review) – *3 key lenses are relevant:*			*Enhanced view following completion of Chapter 3 (Theory Literature Review)*	
SET (theoretical),	Homans (1983)		√	√
RMT (theoretical)	Fiske (1991)		√	√
Medical professionalism (sociocultural)	Freidson (1967)		√	√
The following are specific factors of potential interest:			*The following are further specific factors of potential interest:*	
Trust	Molm (2010)		√	√
Reciprocity	Blau (1964)		√	√
Service orientation/quality	Grönroos (2001)		√	√
Positive emotions	Payne & Holt (2001)		√	√
Knowledge/skill set	H. Hall (2002)		√	√

Factors Potentially Influencing GP– Specialist & Specialist–Specialist Relationships	Seminal or Key Source	→	Factors Potentially Influencing GP– Specialist & Specialist–Specialist Relationships	Seminal or Key Source
Cohesion/commitment	Gouldner (1960)		√	√
Loyalty	Molm (2010)		√	√
Status/reputation in the community	H. Hall (2002)		√	√
Reputation for professional excellence	Price & Arnould (1999)		√	√
			Relational dependence	Emerson (1976); Molm (1994)
			Value	Stewart (2011)
			Economic dependence	Clark & Mills (1979)
			Economic resources	Blau (1964)
			Reinforcement	Homans (1983)
			Negotiation	Homans (1983), Blau (1964
			Risk/uncertainty	Blau (1964); Axelrod & Goold (2000)
			Reward/Cost	Strauss (1969); Molm (2003)
			Material/Non-material	Foa & Foa (1980)

4.4.2.3 Participant Selection

For the present study, the participant selection rationale is based on a sampling strategy that is pragmatic, flexible, and appropriate to further the research aims. According to Marshall (1996), probability-based sampling techniques used for quantitative studies are rarely suitable for qualitative research. He stated that 'qualitative studies aim to provide illumination and understanding of complex psychosocial issues and are most useful for answering humanistic "why" and "how" questions' (p. 522). The sampling strategies used are purposive sampling and theoretical sampling. In purposive sampling, researchers use their knowledge or expertise about a group of people to select participants who represent that population (Berg 2004). In some instances, purposive samples might be selected after field observations, or following one phase of research, in which case it could be referred to as theoretical purposive sampling. Here, the researcher decides what information to collect next and where to obtain it (Davidson & Tolich 2001). Generalisations here are based on typical cases; however, the results will have validity for all stakeholder groups. Both types of purposive sampling strategies are used in the present research.

Theoretical sampling is essential to both develop and refine a theory (Breckenridge 2009). Theoretical sampling is continually directed by the emerging theory. As leads emerge in the data analysis process, this necessitates more data collection to continually refine emerging theory. The theoretical sampling process begins with data collection, and then proceeds to analysis, which involves coding and further data collection, further analysis and memo writing as well as forming conceptual categories and searching for emerging patterns. While codes are generated rapidly in the initial stages, it is through the simultaneous process of theoretical sampling and memo writing that codes are further refined and integrated to the core category. Theoretical sampling is subsequently focused on new data that are only relevant to the core category and its related properties. This approach leads to the data collection becoming focused on the core category and related concepts, and through constant comparisons, on the category with incident/s and the category with category, to enable the emerging results to become dense and integrated, for theory to be formed.

The sample size determined for the first phase of research included a participant group of 32-40 professionals, namely, 16-20 GPs and 16-20 specialists. According to Marshall (1996), an appropriate sample size for a qualitative study is one that helps answer the

research question. The nature of the sample was also considered, with the participants characterising within-group homogeneity (GPs and oncology specialists), and between-group homogeneity and heterogeneity (GPs, oncology specialists and related specialists). While the interview schedule was predesigned, it is acknowledged that in the context of the present study, each interview triggered unplanned questions, which were followed through to their conclusion. Marshall (1996) stated that 'the number of required subjects usually becomes obvious as the study progresses, as new categories, themes or explanations stop emerging' (p. 523). This phenomenon of cessation of theme emergence is referred to as data saturation. Justification for the sample size is in accordance with data saturation in qualitative research (Francis et al. 2010; Townsend 2013). Further, to accord with a theoretical sampling approach, new participants were in some cases invited to be a part of the interview process in a second round of data collection (Francis et al. 2010). Participants were invited from six distinct Local Government Areas in NSW. These being, City of Sydney, North Sydney, Northern Beaches, Sutherland, Wagga Wagga, and Western Sydney. Invitations were sent via email and telephone. The second phase approach to sampling was finalised subsequent to the first phase data analysis (Baker & Edwards, 2012).

4.4.2.4 Setting

The interviews were conducted in the offices of the participants. In some cases, these were held over the telephone, and sometimes, a research assistant was present. All interviews were audio taped.

4.4.2.5 Data Collection

A dynamic approach was taken to interviewing, with ongoing feedback sought from the participants on the interview process, which helped inform and progress the data collection. The interview schedule served as a structural guide to the depth interviewing process. The style of inquiry was though highly flexible. The approach taken, accommodated and acknowledged the virtues, knowledge, and experiences of each participant in the study. The emerging results were also communicated to medical professionals (both GPs and specialists) during Education Evenings for GPs facilitated by specialists during the course of the research as well as through presentations at

academic conferences. The feedback from both these settings reinforced the approach taken as well as the emerging themes and outcomes.

The data collected are in line with Australian medical sector professional guidelines. According to the Australian Medical Association (2015), medical professionalism refers 'to the values and skills that the profession and society expects of doctors, encapsulating both the individual doctor-patient relationship and the wider social "contract" between the profession and society' (p. 1). These principles were taken into consideration all through the research process, informing each process stage.

The Australian Medical Association (2015) has stated that society values the medical profession's highly specialised knowledge and skills as serving a unique and vital leadership role in the healthcare system, and doctors are expected to use their unique expertise to set and maintain high standards of practice, competency and conduct through an open and accountable process of profession-led regulation. These include:

- ethical codes and standards of behaviour and professional conduct; clinical standards, professional standards and an advisory role; and
- a core set of values for all members, including, but not limited to, respect, trust, compassion, altruism, integrity, advocacy and justice, accountability, protection of confidentiality, leadership, collaboration, advancing knowledge and innovation, teaching, mentoring and collegiality, and practising and promoting responsible stewardship of healthcare resources.

4.4.2.6 Analysis and Findings

As stated, the inquiry position for both studies was informed by applying SET- and RMT-related constructs to the interprofessional referral context, which is considered to be bounded within the sociocultural context of medical professionalism. The project is concerned with the problem or issue of interprofessional referral in health care and oncology. The reason that it seeks to understand the dynamics of this phenomenon is that the researcher is interested in informing debate with regards making improvements around it. Therefore, the initial analytical approach taken is pragmatic (Creswell & Miller 1997). Sense-making is sought, not entirely naively (as might be the case under a pure grounded theory approach), but in light of theories thought to potentially inform or predict interprofessional referral behaviour, that is, SET and RMT. A second critical theory-

informed qualitative analysis was then conducted to further explore the data with specific reference to the power dynamics at play in the current healthcare environment, and where and how socioculturally defined power relations intercept/drive interprofessional referral practices and behaviours. Therefore, the methodological approach adopted for the inquiry can be characterised as pragmatic–critical.

A theory-informed pragmatic–critical approach to research inquiry entails interpretation. Morse (2009) proposed that in qualitative inquiry, while one spends a great deal of time describing data, the most significant aspect of the work is interpreting the data. Interpretive analysis draws on the creative output of the researcher, underpinned by the theoretical drivers of the research, identifying the meaning through analysis, 'making the trivial profound, and the obvious significant' (p. 379). Morse (2009) stated that analysis involves a delicate balance between gleaning and presenting information, which is useful, insightful, and accurate:

> When we do interpretive work, we use all our theoretical memories and skills, our own beliefs, values, and desires to discover something interesting and new. We are also working with the softest of soft data – people's recollections, beliefs, attitudes … Trying to get it right, while looking in from the outside. These stories belong to people, to others. And we are not only limited in the interpretation, but we are also limited in our abilities to disguise and conceal identities. (p. 379)

Researchers have presented varied, yet quite similar, strategies for qualitative data analysis. Strategies relevant for the emerging data to yield valid results were used during the process of analysis. The entire data analysis process adhered to the processes of openness, logical progression, rigour, and theoretical verification.

Data analysis in qualitative research shares features with social anthropology, and applied studies in fields such as education, health care, family studies, program evaluation and others, which focus on theory generation or theory refinement (Miles & Huberman 1994). Analytical processes involve coding, reflective coding, seeking commonalities and differences, isolating patterns and processes, re-entering the field, collecting data, coding, forming patterns, generalising within a formalised body of knowledge, developing theory and drawing out emerging questions. While substantive codes are the categories that emerge from the data, from the substantive area being researched, and help to build the substantive theory, they are not theoretical codes. Theoretical codes are used to construct

the abstract model, which emerges when sorting mature substantive coded memos. They also help form patterns when sorting substantive codes and memos to provide integration to the central code. Without substantive codes, theoretical codes are empty abstractions. However, substantive codes can be related without an explicit theoretical code, although without it, the results may be somewhat confused and theoretically unclear as to integrative connections between codes that form themes and sub-themes. Theoretical codes are typically the dimensions of a core concept.

The researcher has to maintain openness and stay open to the emergence of codes that are relevant, followed by sorting the memos into theoretical and substantive codes.

4.5 Analytical Approach Taken in This Thesis

4.5.1 Pragmatic Analysis

Seeking to make sense, raw data were organised into conceptual categories to extend themes or concepts emergent from the literature reviewed in Chapters 1–3, and then transformed into a form that communicated the study's findings (Neuman 2006). To achieve this, the coding strategies of Strauss and Corbin (1990) were adopted for the present research:

1. Open coding was used to develop categories by locating themes and assigning initial codes to condense the mass of data into categories (Neuman 2006, p. 461). The process involved constantly comparing, contrasting, and revisiting events, actions, ideas, concepts and individuals (viewpoints) in the search for patterns and emerging concepts.

2. Axial coding was used to examine the relationship between categories (Larossa, 2005). Emerging codes were organised and linked, and key analytic categories were discovered by asking about causes and consequences, conditions and interactions, and strategies and processes and by seeking categories or concepts that clustered together (Neuman 2006, pp. 462–3).

3. Selective coding was employed to decide the main story underlying the analysis (Larossa 2005). Previous codes were examined to identify and select data that supported the developed conceptual coding categories. Once concepts were well-developed and the overall analysis was organised around core ideas that

encapsulated the variety of responses found, theories developed (Neuman 2006, p. 464).

In addition to examining what was evident when analysing data, attention was paid to negative evidence as a process to uncover new lines of enquiry that could lead to unknown factors. This, in turn, led to more robust data analysis and conclusions (Neuman, 2006). Pieces of information from the interviews that contrasted with one another were explored in depth, and perhaps form a significant component of key informant interviews.

Yin's (2010) prescriptions regarding qualitative data analysis were also considered. He stated that a qualitative data analysis moves through five phases: compiling, disassembling, reassembling, interpreting, and concluding. The first analytic phase involves compiling data into a formal database. The second phase, disassembling the data, can involve formal coding. The third phase, reassembling data, is less mechanical and is based on the researcher's insightfulness and knowledge of the subject area to see emerging patterns. This is aided by creating data arrays, which help reveal pattern formations. While computer software can assist in the analytical process, the researcher must make all the analytic decisions. The critical aspect of the qualitative data analytical process is the commitment to rigour, which is supported by:

1. checking and rechecking the accuracy of the data;
2. ensuring the analysis is as thorough as possible rather than cutting corners; and
3. continually acknowledging that unwanted biases imposed by one's own value systems do not impinge on the analytical process. Using memos helped in ensuring rigour. Memos are methodological notes of the process taken. Other techniques include making constant comparisons, being alert to negative instances, developing opposing explanations and continually posing questions about the data as one progresses through the analytical process. Each of these techniques is important since there is no universally accepted routine for qualitative data analysis. For the present research, memoing was used, as appropriate, during the course of the interviews.

Memoing was followed by establishing substantive themes to reorganise the different codes into groupings and sequences. This process may be facilitated by graphic depiction of the data, or by arranging them in lists and other tabular forms. Establishing themes and coding can be a cyclical process, with new themes and new codes emerging.

Computer-assisted qualitative data analysis software aids in the data analysis process. It is very useful in handling large volumes of non-numerical data. Unlike quantitative data analysis, where the analyst provides a set of input data and the computer arrives at the result, the challenge for qualitative data analysis is that there is no such set formula. The analyst must develop the entire underlying substantive procedure, and be involved at all stages such as sorting, coding, and grouping into themes and substantive themes. The computer must be given step-by-step instructions for each procedure. The analyst must explain the logic and validity of each procedure. In this study, NVivo software version 12 was used for analysing the qualitative data. It has proven to be an extremely efficient and effective computer-aided data analysis tool to assist with coding and generating themes and patterns.

4.5.2 Critical Analysis

As already stated, the opening pragmatic analysis 'problematises' interprofessional referral to seek deeper understanding, which may inform efforts to improve or change. Critical analysis is also problem-oriented (or may view the research subject as a 'problematic'). Critical analyses are concerned with shedding light on the sociocultural conditions and implicit assumptions behind real-world problems. When assumptions are made explicit, a wider view of the problem (in this case, interprofessional referral) may be obtained, which accounts for prevailing norms. Hence, a critical analytic approach to analysing the interview data was rooted in an interest in how the language of the study participants reflected sociocultural power-related 'discourses' or streams of communication that reflected underlying ideology. It was felt that its use may enable access to some of the ideological and/or power-related assumptions behind interprofessional referral practice as described in any emergent model identified by the initial pragmatic analysis. In this sense, the critical analysis augments the pragmatic analysis with a goal of yielding an ultimate explanatory model that accounts for individualised social exchange dynamics (SET-informed, explored pragmatically), relational dynamics (RMT-informed, explored pragmatically) and professional / sociocultural dynamics (explored critically).

A critical analytical position implies that the investigator believes that although there is a reality, it is subjective and based on values. Change occurs through mounting a critical challenge to the dominant values. A critical researcher challenges the accepted wisdom

and dominant social reality through critique and analysis of the values and vested interests of those in power. Ideology is at the centre of explanations. As Neuman (2006) noted, the purpose of this approach is to expose myths in such a way as to empower people who may be under the influence or constraint of sociocultural (or institutional/ideological) power expressions. The critical researcher makes a deliberate attempt to enable their subjects to make sense of a world that hitherto they had accepted without challenge. Similar to an interpretivist, a critical theorist believes that 'objectivity' is a myth and any interpretation of data by a researcher is 'subjective'. Interpreting what one sees in a test tube or in a set of survey figures is always a subjective act. Data are particularly sensitive to values-based interpretation. Nevertheless, the onus is on the researcher to provide sound reasons for their interpretation. Critical theorists prefer qualitative methods, such as interviews and questionnaires that are qualitatively analysed. The purpose is to clear away the myths and ideology associated with the social phenomena and bring about change through critical reflection.

4.5.3 Data Analysis Processes

Yin (2010) outlined a comprehensive approach to the process of qualitative data analysis. It guided the analytical processes pursued with the aid of NVivo software. It is important to now detail Yin's rigour-enhancing approach and how it helped to inform the progressive analysis in this thesis.

Stage I—Compiling: The analytical process began with compiling data. The data comprised transcribed interviews, memos and field notes. This was continually reviewed along with other data sources from documents. Questions considered were:

1. What were the distinctive features of the results?
2. How did the data relate to the research questions?
3. What were the new insights that emerged?

These questions were iterated throughout the analytic process. A glossary of coding categories was developed to keep track of progressive analytical thinking and analysis. Each code was assigned meaning to ensure there was no duplication, and fine differences were clearly articulated (Yin, 2010).

Stage 2—Disassembling data: The second phase involved breaking down the compiled data into smaller fragments to generate codes. During the process of disassembling, memo generation facilitated reducing confusion later when half-formed ideas developed into a new concept or construct. Coding involved assigning codes to phrases or sections of the transcripts/data. Yin referred to this phase of coding as Level 1 coding or in-vivo coding. As the analysis progressed, level 1 codes were analysed further to find ways in which they related to each other. This process of coding helps progress the data analysis to a higher conceptual level, which provides insights into the results that answer the research questions (Yin, 2010).

Stage 3—Reassembling data: At this phase, broader patterns were sought. The qualitative analysis software was very useful in this stage of coding since it helped with retrieving similar data from the entire database, ascribing codes to them, manipulating the codes to the broader or finer levels, assessing the findings in the context of extant literature, and undertaking theory testing and theory generation. Questions at the reassembling phase included:

1. Do the emerging patterns make sense?
2. Are they progressing to a substantively important plane?
3. How do the patterns relate to the underpinning concepts and hypotheses?
4. Do the patterns become more complicated or expansive on reviewing additional data?

Using arrays: Yin (2010) used this term to refer to arranging the codes into themes in a progressive manner. Boolean operators aided the process of comparing different combinations of codes using computer-aided software. Hierarchical arrays were built with concrete codes at one end and a more abstract code representing the concrete item/s at a higher level, and so on. The codes developed became cumulative in progression, with each level of the hierarchy bringing together a larger group of similar items at the next level below. Grouping data thus helped create different classes or typologies in a structured, logical and progressive manner, with clarity regarding how the associations have been formed. Many hierarchies can be created, but ultimately, only a few became the basis for bringing together the findings into a summative result of codes, themes, patterns and relationships. This process helped the final result to stay true to the original data collected and helped track for accuracy in interpretation.

Arrays can also be displayed as matrices, which involve a two-dimensional array (or more) of rows and columns. Matrices can be either time-ordered (chronological), role-ordered (according to people's roles) or conceptually ordered (set of categories arrayed against another set). In the columns, other variables can be displayed, enabling cross-tabulation of dependent variables with demographic data to assess for correlations. Such a matrix can enable a search for patterns of similarities and differences.

Reducing bias: This is a critical aspect of qualitative data analysis and was regularly brought into play throughout the analytical process. There are three ways to minimise bias: by making constant comparisons, searching for negative cases and engaging in rival thinking. 'Constant comparison' involves seeking similarities and dissimilarities in the data and questioning the choice of items made to fit similar or dissimilar categories, in an ongoing manner, during the process of reassembling. 'Searching for negative cases' involves uncovering items that on the surface might have seemed similar but differ when closely examined. If the data are coded and arrayed, this can challenge the robustness of the code and lead to necessary changes. 'Engaging in rival thinking' involves searching for alternative explanations to the initial observations. The analysis should show explicitly the lack of evidence for any competing explanations, before concluding that any one factor was a significant 'cause' for any outcome under study. Following developing broader themes, by arraying data, researchers are ready for the fourth and fifth phases, interpreting and concluding the analysis.

Stage 4—Interpreting data: Interpreting may be considered the craft of giving one's own meaning to the reassembled data and data arrays. This phase brings the entire analysis together and stands at its pinnacle (Yin 2010, p. 207). The phase of interpretation provides coverage to critical portions of the data and the deepest meanings. Yin suggested striving for the following five attributes during the interpretation phase, which was adhered to in the present study:

- Completeness: The interpretation should have a beginning, a middle and an end.
- Fairness: Others with the same stance should arrive at the same interpretation.
- Empirical accuracy: The interpretation should fairly represent the data.
- Value added: The interpretation should be new, and not a repetition of the literature.

- Credibility: The interpretation should be acceptable to esteemed peers and others in the field.

The three modes of interpretation are description; description and call for action; and explanation.

Description as a major type of interpretation: The best descriptions embrace a study's data. The data can be highly diverse, including profiles of individual people based on the interviews, historical data from documents and numerical data from archival sources. The data usually have been reassembled, which can continue during the process of descriptive interpretation.

Description plus a call for action: This step involves description together with promoting some subsequent action. The action might involve a call for changes in public policy or policy agenda. This could result in readers reinspecting the data with a different type of scrutiny. The author calls for caution, and when presenting any policy topic or substantive advocacy issues in the context of the research literature, must do so with scholarly care.

Explanation as a type of interpretation: Explanation serves as a descriptive interpretation. In some research, interpretation in its entirety is dedicated to explaining how or why events occurred, or how or why people pursued particular courses of action. In such a situation, where a study is driven by an overarching explanation, the explanation drives the structure of the entire study and is not limited to a part of the study. The most effective explanation is that which also provides alternative or rival explanations, making the relevance of the research doubly compelling. It is important to validate the interpretation in light of extant research and the theoretical framework underlying the research.

Yin (2010) also suggested maintaining a continuous dialogue with peers who know something of the topic of research and seeking their help to review the preliminary drafts. The external, yet informed, perspectives will help reveal gaps or oddities in the explanatory frameworks, which need to be rectified. Hence, it is important to discuss the research from the inception by maintaining ongoing interactions and thus develop an insightful interpretive framework for the study. This has been an ongoing aspect of this research, with the consultative phase with GPs, specialists, and other stakeholders a major feature of the study.

Stage 5—Conclusions: Each study's conclusions are unique and highly specific. Yin (2010) defined a conclusion as a type of overarching statement or series of statements that raises the findings of a study to a higher conceptual level or a broader set of ideas. The conclusion captures the broader 'significance of the study'. Conclusions can be made by calling for new research, challenging conventional generalisations and social stereotypes, proposing new concepts and theories about human social behaviour, by making substantive propositions and by generalising to a broader set of situations.

A study's conclusions are considered relevant for generalising to situations, other than those that were part of the study. It is a process of analytic generalisation and entails defining a particular set of concepts, theoretical constructs, or a hypothesised sequence of events. The conclusion from the present study facilitates answers to the research questions, informs theory development in the field of medical professionalism and informs medical professionals about the theories governing referral practices. This should enable timely referral of patients and hence best outcomes in terms of both treatment and survival rates.

4.6 Chapter Summary

Qualitative interview studies among purposively sampled groups of diverse GPs and SMPs will be conducted. The approach to interview and analysis is informed by, but not limited to, SET and RMT. The research goals are both exploratory and theory-building oriented. A pragmatic–critical approach to analysis will be taken to interpret the text arising from the interviews in order to locate individualised, relationship-based and society/culture-based drivers of decision-making in relation to interprofessional referral in oncology.

Chapter 5: Results

Qualitative researchers rely – implicitly or explicitly – on a variety of understandings, and corresponding types of validity in the process of describing, interpreting, and explaining phenomena of interests. Joseph Maxwell (1992)

5.1 Overview

Using semi-structured interviews, this thesis sought the perceptions of GPs and specialists about referral processes; the role of the patient in referral processes; the development and maintenance of interprofessional relationships; medical professionalism; and the provision of HVC. Interview transcripts were analysed and then coded using RMT and SET as informants in the process of identifying key themes and subthemes.

Using triangulation (Denzin 1978; Denzin & Lincoln 2008) to develop a comprehensive understanding of the phenomena (Patton, 1999), this thesis examined each transcript from the specialist sample group and the GP sample group against the research questions that were identified from the literature and theoretical reviews (Chapters 2 and 3). The key themes of trust, reciprocity, collaboration, communication, patient experience and accessibility were identified from the data. These themes help build a story that describes the nature of the referral and interprofessional relationships formed between GPs and specialists in the Australian oncology setting.

To identify areas of development that can improve patient experience, reduce medical error and help in HVC provision, the participants from both sample groups identified key aspects for potential change: improving communication to reduce testing duplication; increasing accessibility, to limit delays to specialist consultation; improving GP education in oncology to facilitate more accurate referrals; and developing system-wide protocols to reduce instances of the impact of competition between public and private systems.

5.1.1 Sample Characteristics

Forty ($n = 40$) participants were recruited into this study. Two naturally occurring groups were included: general practitioners (GPs; $n = 20$), and specialist medical providers (SMPs; $n = 20$). Saturation was reached in the GP group at ($n = 18$), and in the SMP group at ($n = 14$) when the themes and sub-themes were exhausted, and no new data emerged

(Liamputtong 2009). The participants were recruited from Greater Sydney and the rural areas of NSW, Australia. The SMP group comprised 14 males and six females aged 20–65 years (see Table 1.1, for the specific age breakdown), and the GP group comprised 16 males and four females aged 35–80 years (see Table 1.1 for the age breakdown).

5.1.2 Patient Population and Referral Patterns

The total number of patients under active care in the GP and SMP groups differed greatly (see Table A8.2). In the GP group, 16 participants saw more than 400 patients per month, whereas only one SMP saw more than 400 patients per month. This disproportion in patient numbers per month can be attributed to a number of factors: the specialist group only see patients in their narrow field of medicine/organ system(s), whereas the numbers reported by the GP group represent the full gamut of patients that present with all forms of illness from all organ systems. The specialist can only see a patient who has been assessed as suitable for their specialty and referred to them by a GP or other specialist; whereas a GP does not require a referral and can see any citizen who walks into their practice.

Participants from the specialist group are dependent on referrals to generate initial consultations. These referrals are sourced from both GPs and other specialists. The number of new patients referred to a specialist per month ranged from less than 20, through to 100–150 (see Table A8.2). The number of follow-up patients a specialist saw per month varied from 20 to 30, through to 350 to 400 (see Table A8.2). There is clearly a differentiation of referral numbers amongst SMPs. One of the aims of this thesis is to better understand why.

The relationships required to build a specialist practice can be viewed via the lenses of RMT and SET. Through this view, it can be agreed that the specialist relies on referrals for patients, and to obtain referrals they must be able to produce positive patient outcomes as well as have a relationship based on good service with GPs and other referring specialists. The aspects of practice that build an interprofessional referral relationship are explained in greater detail in Section 5.2; however, Fig 5.1 offers sentinel themes to understand and overview key factors identified by GPs, which drive their SMP referral practices.
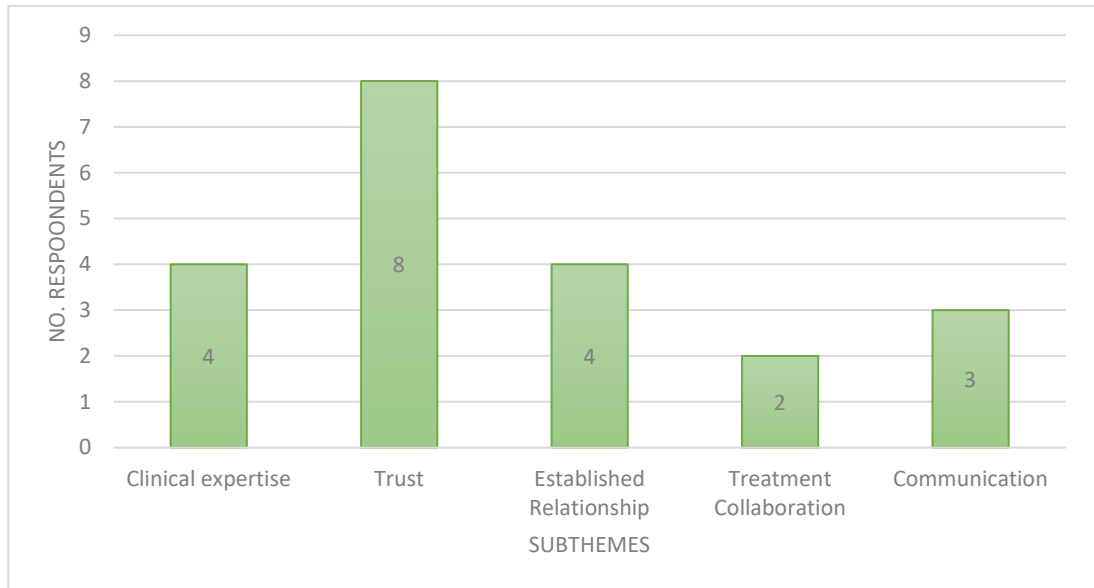
Figure 5.1: Factors Leading GPs to Refer to SMPs

GPs do not rely on referrals to obtain patients; they are required to market to the community in order to build their practice. Despite the multitude of mediums of advertising at their disposal, 19 out of 20 participants ranked word-of-mouth advertising as crucial to the growth of their clinic. Word-of-mouth advertising is built upon providing good service and a good patient experience. In return, the patient will send other potential patients to the clinic (Lee et al, 2014). Word-of-mouth endorsements can be considered as predictable by both RMT and SET in this context, because the GP is indirectly leveraging positive patient recommendations for excellent service, results and experiences.

Other marketing methodologies employed by GPs to build their practice are having a prominent clinic location with effective signage, obtaining referral from specialists and other GPs as well as from complementary and alternative medicine practitioners, advertising through websites and engaging with the community (see Table 1.4). See Figure 5.2 for an overview of the themes attributed by GPs as contributory to GP practice growth.
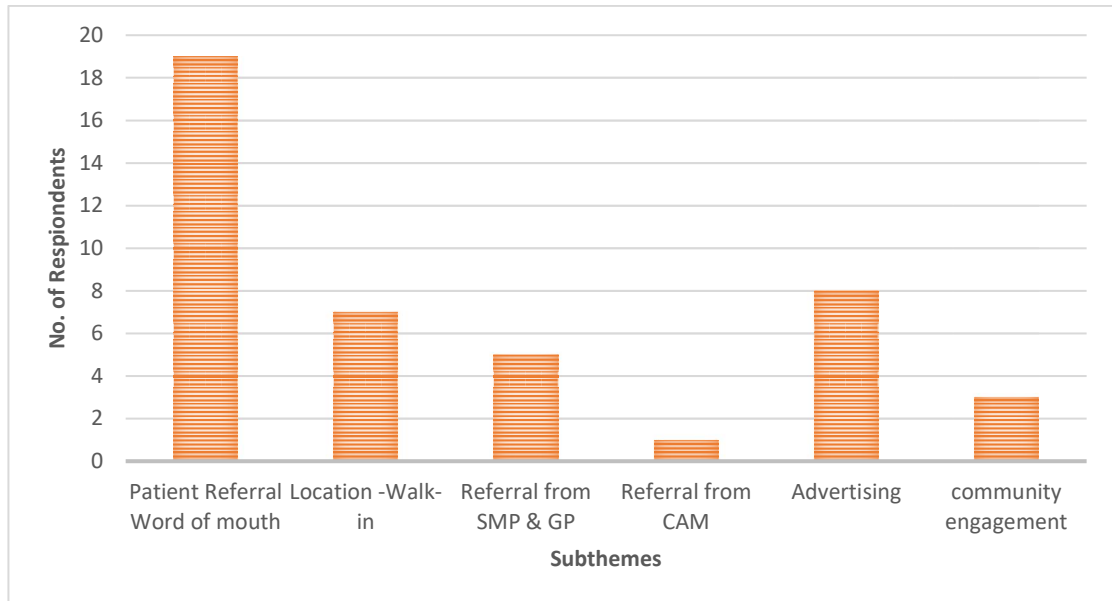
Figure 5.2: General Practice—Obtaining Patients

5.2 Drivers of Professional Exchange Relationships that Determine Referral Practices from GP to SMP and from SMP to SMP

Professional exchange relationships are an important determinant in a referral relationship. To understand the formation of these relationships, one must examine the structure outlined by Alan Fiske (1991, 1992, 2004) in his RMT, which outlined that people want to relate to each other and feel a sense of commitment and obligation to their relationships. In the context of referral and maintaining relationships, Blau's (1964) study must be examined. Blau postulated through SET that relationships are driven by an exchange that leads to personal obligations and unspecified commitments, which promote feelings of gratitude and trust. These two theories allow us to explore the themes and subthemes (see Table 5.1) that help understand the drivers of professional exchange relationships that determine referral practices in the field of oncology.

5.2.1 Forming Interprofessional Relationships (GP to SMP)

Forming interprofessional relationships is an important aspect of medical practice. The reasons that GPs form interprofessional relationships are different from those of SMPs. GPs are at the frontline of medical treatment; they see a diverse range of patients, so they require a broad spectrum of knowledge. When they are confronted with a patient with a complex disease, such as cancer, they need to have a network of specialists to whom to refer complex cases. This gap in specific medical knowledge and the subsequent need for

advice/referral forms the basis for the GP to build interprofessional relationships with specialists as evidenced by SMP1 comment below.

The SMP is so named because their area of expertise is compartmentalised to specific organs and diseases, or diseases of specific organs. A patient with prostate cancer cannot go directly to a urologist, and they first need to visit a GP for a specialist referral. Because of this necessary step, it is imperative that specialists form interprofessional relationships with GPs and other specialists to have access to patients who might require their services. The need to build a mutually beneficial relationship with a GP can be viewed through the lens of SET and RMT, because the relationship exists in order to exchange a service for a need.

> SMP1: I think as a specialist, you're there, your role is to provide assistance to them. Like the GPs are in charge of running the patient, and you're there to, I mean you help.

From the patient's perspective, they cannot go directly to a specialist since they lack the requisite knowledge about their diagnosis to successfully choose a specialist who can address their medical needs. Hence, the patient requires the GP's medical knowledge to navigate their way to the correct specialist. As previously identified, the GP's knowledge and ability to refer patients to the appropriate specialist is beneficial to the specialist as well. This is because the specialist's time will not be wasted by seeing patients with diagnoses that are not appropriate to their skillset, and hence, they can focus their appointed consultation times on patients with diseases in the organ systems that they can adequately address:

> SMP5: Well, I think they expect that you'll be accessible and available to see their patients when they want you to. My expectation is that get all necessary information for that consultation, so I'm not chasing up bits of paper, and I guess, importantly, that they've told the patient whether referring to me, as a person to me, because they've got cancer.

The GP and specialist form interprofessional relationships for the betterment of the patient through a variety of methods. The GP and/or specialist may have already established referral networks via meeting colleagues through prior working environments, such as hospitals and shared practices, or by other means, such as university, church, and other social groups. Having established relationships through

common interests, education or group affiliations allows the relationship to grow beyond just medical need to include common interests that may improve communication between the medical professionals. The other aspect of establishing such a network is that it has the potential to limit the scope of the referral to those within the referrer's social network, which may present a problem should the specialist be too busy to see the patient in the requisite timeframe, hence creating a situation of treatment delay:

> GP20: There's a GP network, which I'm a member of, I can't tell you the exact name of it, but it's the local network, they run monthly meetings which I go to occasionally…
>
> Interviewer: What factors determine the choice of these relationships?
>
> GP20: Common interests, I think, church affiliation.
>
> SMP10: Someone who trusts you implicitly will or may be happy to wait for several weeks for a particular person to see you and that doesn't necessarily come easily, it comes with time, and it comes with, often with, years of experience.

Participants in both GP and specialist cohorts indicated that establishing new interprofessional relationships for referral may be best achieved by networking at education events and conferences; attending small group learning and meetings, where a specialist will present, and events hosted by third parties, such as pharmaceutical companies; sharing a mutual patient; meeting via written and telephone communication; and in some cases, cold calling a GP to arrange a time to meet them.

GPs indicated that they need and value the education provided by SMPs and require the referral avenue to provide a medical solution for a patient:

> GP4: Ok, well with the specialists, the best way is to go to all the doctor meetings where the specialists give lectures, and then, you just talk to them at the meeting and talk to them after the meeting, and when you're at the meeting, you see the cut of the jib, so you can see whether they are a nice bloke, good person, whatever … Ok, so you've got the uni old-boy network, you've got the drug company meetings, you've got the [redacted location] District Medical Association meetings and some specialists actually take the initiative to go round and cold-call and canvass GPs, which is good.
>
> SMP4: With GPs, there are two mechanisms. First one has been, I guess, proclaiming yourself in a public forum, such as taking part in GP education sessions and so on. …

The other would be when the GPs receive letters, so they know that one of their patients is being referred by another specialist.…

Interviewer: How do you form a relationship with other specialists?

SMP4: Most of my relationships were developed really one to one because we talk about patients on the telephone or in the corridor. This was before MDT, so I got to know a lot of the older surgeons through that mechanism, so it became a very personal relationship and they'd just ring, 'I need you to see or do XYZ, can you do it tomorrow afternoon?'.

5.2.2 Maintaining Interprofessional Relationships (GP to SMP and SMP to SMP)

Social Exchange Theory helps us to understand the interprofessional relationship between referrer and referee as being heavily dependent on clinical need. The patient presents with a diagnosis that is beyond the skillset of the attending physician, so the doctor then needs to decide who to refer that patient to. It was identified that often, the choice of referee was within the referrer's existing network, because this choice of referee came with a history of experience and therefore created an element of influence over the factors that could enhance a patient's experience that would ultimately reflect on the referring doctor:

GP8: I guess I'd look for somebody that I think it's good at doing their job so that's a clinical factor? Yea, I look for people who I guess will give me the most appropriate and timely feedback of the interaction; and I don't really like people who charge ridiculous fees.

An overview of themes and sub-themes can be seen in Table 5.1

5.2.2.1 Aspects That Maintain Interprofessional Relationships between GP and Specialist

Aspects that enhance or impede an interprofessional relationship from a GP's perspective were varied. Using RMT and SET as a frame to identify themes and subthemes, it became apparent that most aspects that enhanced or impeded an interprofessional relationship were built around clinical need, such as clinical expertise of the referee, communication, accessibility, patient feedback and the willingness to collaborate. However, clinical need was not the only aspect that a GP relied on to build an interprofessional relationship; they also considered the referring partner's character and examined factors such as: interpersonal connection, trust, interpersonal issues and reciprocity:

GP3: If I knew two, it would be the one who was more engaging, felt approachable, wasn't arrogant; Yep, more approachable, not arrogant.

Interviewer: What else?

GP3: And available.

5.2.2.1.1 Interpersonal Connection

Interpersonal connection (or a feeling of friendship) was the strongest theme identified in relation to what GPs consider to be important in an interprofessional relationship. A specialist's or GP's friendliness should not reflect on their medical ability to address the needs of the patient, but medical knowledge is only one aspect of the consultation. As reported by participants, the patient has to also like the specialist in order to build rapport with him/her and subsequently comply with treatment and future follow-up appointments. The patient trusts the GP to refer them to a specialist who can treat their illness; if the specialist is not friendly (or likeable), then it reflects on the GP as the referrer. If the patient requests a referral to a different specialist, it could delay time to diagnosis and treatment, and in oncological conditions, the delay can affect treatment outcomes. The lack of interpersonal exchange between the GP, the patient and the specialist can ultimately end the referral relationship. GPs stated:

GP2: I might phone a specialist, to get advice over the phone, and if they're helpful, we can move forward …

GP15: I look for them to be friendly to be communicable.

GP9: Well, that you know I can talk to them, hopefully they've got a good sense of humour. Yeah. And if I see what they present to me is quite professional. I make that assessment from the information they might give me on how they do things.

5.2.2.1.2 Communication

Communication is an essential component in an interprofessional relationship. It is the only means for the referrer to know the diagnosis and treatment plan that the referee sets for the patient, and via the nature of treatment-related collaboration, communication is the basis for trust in this exchange. Most participants in the GP group stated communication to be an important component in enhancing an interprofessional

relationship. Via the lens of SET and RMT, it was highlighted that quality, timely communication was an effective tool in building other aspects, such as trust and collaboration between the GP and the specialist(s).

Many respondents in the GP group identified the quality of communication as a reason that can hinder their relationships with the specialist. Poor communication was discussed as hampering the way a GP consults with their returning patient; without specialist reports they have no means to relay information or explain aspects of the specialist consultation with the patient:

> GP18: The quality of the letters is invaluable, if somebody sends me a detailed letter that explains their thinking and their process, I really do appreciate that very much because even if the specialist hasn't been able to explain that to the patient, I am able to, and then I feel empowered and I can empower the person I'm caring for, which I feel is absolutely essential in the process of caring for somebody.

> GP17: Well, language problems are a real hassle, if there's a real difficulty understanding the specialist well, then it makes it difficult to refer to him. Unless I get a letter off him, now that's the thing that communicates…

See Appendix 1 (5.1.2.1 Communication, GP7, 12, 17).

5.2.2.1.3 Patient Experience

Some GPs also discussed patient experience with a specialist as a relevant factor in the interprofessional relationship. The thematic analysis suggested that how a patient perceives the interactions with the specialist can affect two things: patient willingness to return to the specialist for further appointments, and GP willingness to continue referring to that specialist. Many respondents from the GP group reported that the inability of the specialist to manage a patient can impede an interprofessional relationship. If a patient returns with negative feedback about a specialist, about their treatment methodology or about their bedside manner, the trust a GP has in the specialist can erode:

> GP3: Yeah, I mean, you know, you get a patient with a, with a melanoma and you refer them off to a general surgeon, and even though it might be a thin melanoma, all they hear is the word …So if the surgeon actually isn't quite clear about the outcomes and prognosis, which often they are not, then that creates a lot of anxiety for the patient.

GP5: If they don't care about the patient, have poor communication with me or are not professional in their approach, I probably won't re-refer.

See Appendix 1 (5.1.2.1. Patient experience, GP16, 17).

5.2.2.1.4 Collaboration

Collaboration is an important aspect in the patient's treatment experience. The GP is the initial contact for the patient and has the initial rapport with them. This makes the GP an important contact point for the patient to help understand the diagnosis or the treatment process. The GP can only provide valuable information to the patient it they are in a collaborative process with the SMP; their involvement in treatment collaboration hinges on the information the specialist provides them on the patient's progress. Collaboration can be an important tool that can be utilised by the specialist in fostering a positive interprofessional relationship with the GP and in providing a positive patient experience:

GP8: I do like specialists who use a more consultant model, they would perhaps say 'we'll look at a few choices here, let's try A, B and C and why don't you as the GP put that into place', and then if A, B and C haven't worked then back to… I've never really liked the specialists that like to take over the patient.

See Appendix 1 (5.1.2.1 Collaboration, GP6, 13).

5.2.2.1.5 Trust

Using the RMT- and SET-informed thematic analytical frame, it was seen time and again that trust is the most important aspect of an interprofessional relationship in this thesis context. Trust takes time to establish but can be destroyed in a very short period. A GP's trust in a specialist is a strong reason they refer patients to them. They rely on them to provide diagnosis and treatment and manage their patient. For instance:

GP5: When they think the same way you do, friendship and trust in judgement in managing the patients develops.

GP14: Are they good doctors? Are they decent people?... Well, I think its knowledge and skill. But also, the way they treat patients and their clinical decisions, you know that sort of thing.

5.2.2.1.6 Accessibility

Accessibility was discussed as an important factor in interprofessional relationships. The meanings of accessibility and availability perhaps overlap in this context, and hence, the terms have been linked together. Accessibility was linked to the ability of the specialist to see a patient for a consultation in a timely fashion; it could also indicate the ability of the GP to contact the specialist directly (usually by phone) in cases of patient emergency:

> GP12: Well, it depends. Sometimes, I might phone a specialist, to get advice over the phone, and if they're helpful or if they see a patient you know, urgently.

> GP10: If they are not accessible to me … maybe they are moving around a lot and not available to me, I am less inclined to refer.

See Appendix 1 (5.1.2.1. Accessibility, GP1).

5.2.2.1.7 Reciprocity

Not many GPs specifically flagged reciprocity as an enhancer of interprofessional relationships. When this was mentioned as an enhancer of the interprofessional relationship, it related to receiving education from the specialist in return for referrals. The direct exchange of services in the form of education from the referee as a reward for a benefit in the form of a referral from the referrer is a hallmark of SET (Molm, 2010). It seems likely that through this exchange there is improved GP knowledge of oncological disease, which can positively influence the referral process and ultimately benefit the patient. If education and improved knowledge on the SMP's specialty area are delivered to the GP prior to referral, initial GP diagnoses could become more accurate, better referral pathways could ensue, leading to improved time to treatment. Where there was a 'quid pro quo' attached to such reciprocal exchange for GPs was not explicitly stated. Some GPs clarified:

> GP2: My expectations are that it would be of mutual benefit, and this would be educationally and professionally.

> GP19: I think a face-to-face meeting, which probably would generally have a teaching component, I don't feel very strongly that there needs to be just purely socialising, but I think the two can be done effectively together, but face to face probably is the key.

About improvement in HVC, some specialist respondents identified that improvement in GP education in oncology could benefit the patient and the sector more generally:

> SMP14: I'm thinking about a breast cancer patient I saw in the clinic, she had pain in the arm and neck. The GP did refer to a specialist. The patient first went to a neurology centre, but no one examined her physically. If they had, they would have found the large breast cancer. By examining the patient correctly, much time and trouble could have been avoided.

5.2.2.1.8 Clinical Expertise

Perceptions and experience about clinical expertise were shown to be a factor that can impede an interprofessional relationship:

> GP14: Obviously, if you think they're making poor clinical decisions, you're trying to discuss it, and they are just powering ahead.

5.2.2.1.9 Interpersonal Issues

Interpersonal issues (beyond friendly connection) were identified in the thematic analysis. Negative interactions between GPs and specialist, incorporating disrespect, rudeness, arrogance, personality clashes and/or dismissiveness were all discussed by the GP cohort:

> GP6: Where a specialist is not friendly with the GP, snobbish, that is the word.

> GP8: I guess somebody who was really offensive to the patient or to me, obviously wouldn't get a second look.

> GP3: Lack of respect.

5.2.2.2 Maintaining Interprofessional Relationships in the SMP-to-SMP Context

SMPs regularly need to refer to each other once the initial case is established via the GP referral. The specialist's perceptions about the maintenance of interprofessional relationships with their referring peers is of similar importance as that of their relationship with referring GPs. Following a SET/RMT-informed thematic analysis, it was established that key aspects that maintain interprofessional relationships among SMPs from their perspective were trust, collaboration, availability/accessibility, reciprocity, and clinical expertise.

5.2.2.2.1 Trust

SMP responses strongly suggest that trust enhances the interprofessional relationship. Terms and phrases such as honesty, integrity, confidence in the professional and having their patient's best interest at heart were all used by SMPs to describe the nature of trust in the interprofessional relationship:

> SMP6: I expect honesty or integrity, I am not sure which it is the right word, in the motivation of the other specialist. That is, that the other specialist has my patient's best intentions at heart, versus, for example, some other motivating factors.

Trust is a strong factor that impedes an interprofessional relationship among the specialist cohort:

> SMP7: I think a failure to adhere to those basic principles of mutual respect, professionalism and ethnicism. That would be the seed that would lead to a breakdown of that relationship. They can come from all sorts of areas, but I think it's very all-encompassing. Basically, you need to adhere to those three basic principles.

The SMP's trust in the referring GP was strengthened through reciprocal acts of courtesy and professionalism.

> SMP3: Patients come to me who say that the specialists or doctor referring to me speaks highly of me, and I say the same in return, and they come therefore with a strong air of confidence that they're on the right road. And that is a very good platform to build trust both in the doctor and the patient in a relationship platform.

See Appendix 1 (5.1.2.2 Trust, SMP5, 2).

5.2.2.2.2 Collaboration

Collaborating around treatment was a strong theme for SMPs. They emphasised having a patient-centred focus and ensuring that all medical professionals involved in the treatment and management of the patient are up to date with the exchange(s) of information to ensure diagnosis and treatment can progress in a linear fashion, while avoiding the duplication of testing and streamlining treatment:

> SMP7: This just means ensuring that everything you do is patient-centric, and collaboration can be practical in terms of avoiding duplication. Collaboration can be

practical in terms of trying to save the patient one or more trips to theatre, and if you can do two procedures at the same time, it is obviously a benefit to the patient.

See Appendix 1 (5.1.2.2 Collaboration, SMP4).

5.2.2.2.3 Accessibility

SMPs emphasised that accessibility and availability can enhance the specialist-to-specialist interprofessional relationship. Availability and accessibility are used in conjunction here because availability in this context refers to fast access to an appointment for a patient. For SMPs, accessibility could also refer to the availability the referee has for the referrer to contact them. This was noted to be particularly so in cases of emergency, for which an expedited treatment timeline is medically necessary for a patient:

> SMP10: Nothing else breaks down the relationship faster professionally than just not being able to stick to a time, being able to see the person in a timely fashion or having constant locums seeing your patient. This does not bode well for the patient or for the relationship with the professional.

> SMP11: I want my colleagues to be available and I think friendly, in terms of just being able to pick up the mobile phone, call someone and vice versa; them being able to do the same in return at any time just to get advice. I think further to that is to be able to be available to sort someone out on behalf of another specialist or GP quickly or at least give them an action plan over the phone if nothing else, so that you know that you've got a good working relationship and trust.

See Appendix 1 (5.1.2.2 Accessibility, SMP1, 8).

5.2.2.2.4 Clinical Expertise

Many participants in the specialist group identified clinical expertise as a component that enhances the SMP-to-SMP interprofessional relationship. Trusting a colleague with a patient who has entrusted them with their health can influence their future relationship with the patient if the referee is not ultimately perceived to be clinically skilful:

> SMP6: I'm attracted to high standards; you know, people that work hard to do the best job possible.

SMP8: Clinical skill is key to trust. So, if good clinical skills are at play, the patients will be happy with that particular doctor.

5.2.2.2.5 Reciprocity

As was the case when GPs were discussing reciprocity in terms of relationship enhancement/maintenance, only a small number of SMPs flagged this as an important enhancer of their relationship with each other. Some SMPs were emphatic in stating that failure to refer patients back and breaking a reciprocal referral relationship were reasons for impeding or curtailing an interprofessional relationship:

SMP4: My expectation is that if I refer a patient to a surgeon knowing that they need to have surgery, I expect that patient to be referred back to me. So, that would certainly cause a break down in our relationship, or a strain in the relationship…'

SMP6: Based on my knowledge, I think in the private sector it's much more relationship driven. It's much more: who you know and who deals with this? So, I think it's probably true that the strength of interpersonal relationships between specialists has a bigger influence in private practice than it might in public.

See Appendix 1 (5.1.2.2 Reciprocity, SMP4, 5, 7)

5.2.2.2.6 Interpersonal Issues

Interpersonal issues between SMPs raised in the interviews related to issues such as professional jealousy, dislike and/or poor attitude. Many SMPs flagged interpersonal issues as both enablers and impeders of an interprofessional relationship. Such issues can affect a patient if the referee has an issue with the referrer and then refers the patient to a different specialist in the same field as the initial referring specialist. Professional jealousy can involve disputes over treatment rooms in a shared practice, the greater success of one of the specialists and professional respect from peers. All these factors can impede an interprofessional relationship:

SMP18: Jealousy is a big factor between specialists…As practitioners we are sometimes competing in the same marketplace. So, this is the same as professional jealousy.

Interviewer: Anything else which gets in the way?

SMP18: Business relationships breaking down over a set of rooms or an investment.

See Appendix 1 (5.1.2.2 Interpersonal issues, SMP4, 9, 14).

5.2.2.2.7 Unethical Behaviour

Some SMPs raised unethical behaviour as a reason that impedes an interprofessional relationship. Unethical behaviour may not be illegal or requiring investigation by the medical board; it can also be as simple as speaking derogatively about colleagues to patients, a conflict of interest or behaviour judged to be unprofessional by a colleague:

SMP16: I suppose if you thought, I suppose you can talk about unprofessional behaviour, lack of respect and, I suppose, I think it comes with a lack of insight. Lack of, how can I put it? Almost like a lack of effort.

See Appendix 1 (5.1.2.2 Unethical behaviour, SMP4, 8, 17).

5.2.2.2.8 Communication

Numerous respondents in the specialist group reported that bad communication, or slow communication, was a factor in impeding an interprofessional relationship. Poor communication was flagged as influencing other factors in the relationship, such as accessibility, collaboration, trust, and interpersonal connection. Without good communication, the ability to practice in a patient-centric fashion is diminished. As one SMP asserted:

SMP12: You can have difficult personalities among your referring colleagues, and then, you can have to think about the other things which make people difficult and often it can be because you're extremely busy and making the time to communicate is not as good.

See Appendix 1 (5.1.2.2 Communication, SMP13).

Table 5.1: Theme Summary of Drivers of Professional Exchange

Subthemes	Forming Interprofessional Relationships		Maintaining Interprofessional Relationships	
	GP	SMP	GP	SMP
Clinical need	✓	✓		
Educational events	✓	✓		
Networking	✓	✓		
Collegiality	✓	✓		
Interpersonal issues				✓
Communication				✓
unethical behaviour				✓
Collaboration			✓	✓
Trust			✓	
Accessibility			✓	✓
Reciprocity			✓	✓
Clinical expertise			✓	✓
Interpersonal connection			✓	
Patient experience			✓	
Interpersonal issues				✓

5.3 Perspectives that Underpin Lasting Professional Exchange Relationships

Themes and subthemes underpinning lasting exchange relationships that were identified through a pragmatic thematic analysis of transcripts using the methodologies of RMT and SET were trust, collaboration, and reciprocity (see Figure 5.4). These themes and subthemes were further explored using the lens of medical professionalism to understand their influence on the referral process.

5.3.1 Referral: Purpose, Process and Significance

Referral in the Australian medical setting starts with a GP seeing a patient, and then, if the patient requires care that is beyond the purview of the GP, the GP will refer the patient on to an SMP who has a more extensive knowledge in the particular area of medicine that

the patient requires. The purpose of the referral is for the specialist to provide a further diagnosis of the patient and then decide whether they can treat the patient or whether the patient requires further investigation by different specialist(s). This system seeks to ensure that the patient is sent on the right path of treatment to ensure correct testing and diagnosis, and so that treatment can start in an appropriate timeframe.

In oncology, once the patient is referred to an oncologist there is often a further referral to other oncology specialists in the fields of medical oncology, surgical oncology, and radiology oncology. Timely and efficient referral of a patient to the correct stream of medicine can lead to prompt diagnosis and treatment and can ultimately have a positive outcome for the patient. Conversely, inappropriate referral can negatively affect the patient and the medical system through unnecessary testing and a series of expensive, invasive procedures in search of a correct diagnosis (O'Donnell, 2010).

To understand the other factors that influence the referral pathway, in this thesis, GPs and specialists were both interviewed to try to ascertain the reasons and barriers that shape referral decisions (see Figure 5.3 for an overview of the themes).
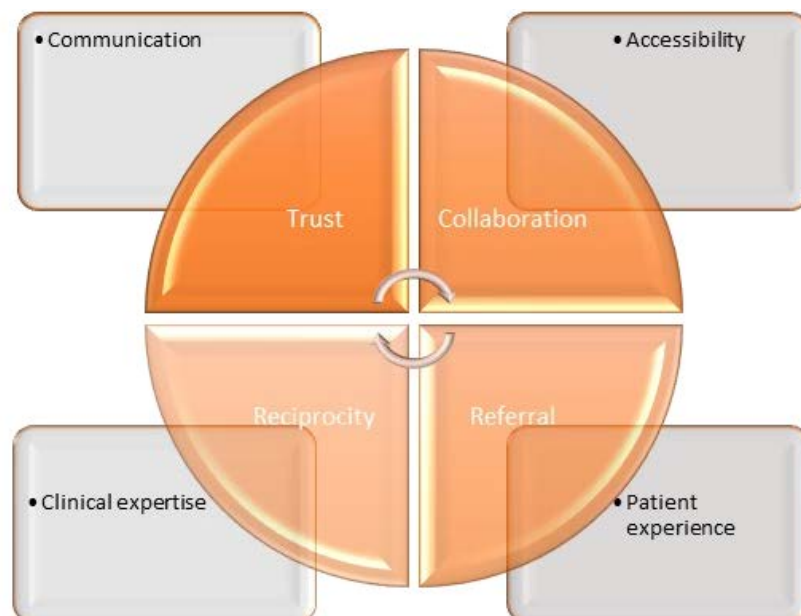
Figure 5.4: Overview of Themes

5.3.1.1 Trust

Trust is an umbrella that overarches this relationship. It is a strong theme that is intertwined with other themes in both negative and positive ways. These are often characterised by the referrer's perception about the medical partner's capacity/record for both action and inaction. To understand trust, one must view it from the perspective of both GP and specialist using the frames of SET and RMT to examine the strengths and weakness that help hold the threads of a relationship together to form a collaborative team that provides a positive patient experience. As one GP asserted:

> GP6: Trust is the most important thing. That's how we both look after the patient, and I trust his knowledge to look after the patient properly, the best possible medical care; and cancer medicine—the empathy, he may have to spend time with the patient. There are some specialists who spend 2 to 5 minutes with the patient. Especially first consultation, they need to spend a lot of time.

5.3.1.1.1 Trust from the GP Perspective

The importance of trust to professional exchange was unanimous among the GP group. Trust appears to underpin all themes and might be the critical factor in the referral relationship:

> GP2: If you do not have trust, you do not have anything.

> GP7: Okay. Trust is a given. It's a given. Okay. As I know and come to know better these specialists right.

This statement is echoed through the transcripts and highlights how important trust is to maintaining a relationship.

1. Trust through clinical expertise

Trust relationships in health care are between the patient and the physician or between one physician and another. The theme of trust was identified as central to the nature of the relationships between specialists, referring doctors and patients. It was discussed as being indispensable, both for referring GPs and referring SMPs, since there is uncertainty in the future actions of the specialists regarding diagnosis, treatment strategy and treatment outcome. A cancer diagnosis is a traumatic experience for a patient and their

family; the patient will rely heavily on the GP for information and trust that they will do their best to find a specialist who will help their patient. The GP has to trust that the specialist has clinical expertise, empathy, communication and the willingness to collaborate, so that the patient's best interests can be met:

> GP14: I guess it's pretty important really, to trust they're making the right decisions, to trust that they know what they're doing, they're treating people appropriately and not only medically but also, you know, as a person. And I guess the trust comes back that they hope that as a GP, we're looking after the patient as well.

2. Trust developed through a positive patient experience

It's reasonable to assume that the patient may not be able to judge the clinical expertise of the specialist (or the GP), but that they will be aware of the specialist's bedside manner, communication skills and empathy level. If a patient does not like the specialist, or has a poor clinical experience, then it may be that the patient will not comply with the latter's treatment strategy. This is the point where a patient might provide feedback to the referring GP on the specialist's approach. An application of RMT to this highly relational environment might suggest that this may be a vital point in the growth or lack of growth in the patient–doctor relationship:

> GP18: It's a really good question. It's partially knowing the limits of what that person can do, knowing what they can and can't do, knowing what their tendencies are, what their ability to communicate is, knowing how they play the game with people, you know, some people are very aloof, some people are very involved, we are all different humans, so it's partly knowing how people behave in their clinical role.

Understanding the specialist's personality is an important aspect in a GP's process of identifying the right specialist to trust with their patient. For the consultation to be effective, and for the patient to trust the specialist to deliver care, the patient and the specialist will have to develop a level of rapport. To help foster the trust of the patient, the GP has an important role in developing this relationship by matching the personalities of the patient and specialist. Such relationally literate processes are emphasised in RMT as predictors of positive relationship outcomes. For instance:

GP10: There have been a number of instances I have seen specialists working at high levels, providing good care and high level of communication; that enhances my trust of them.

GP5: Most important because the patient trusts that you are acting in their best interests; I trust that the SMP will do the management and investigation that the GP believes the patient needs.

3. Trust through communication

Communication is an important aspect of trust in the interprofessional referral relationship. Several participants in the GP group nominated communication as an important aspect of trust. Good communication helps shape all subthemes that form under the theme of 'trust'. Patient feedback on their experience with the specialist is very important in shaping a future referral relationship between GP and specialist. SET helps us to understand this: The GP will provide the specialist with a referral, and in return, the specialist must provide communication on the patient's progression:

GP4: Ok, they've got the ability, the skill, they are nice to you, they will contact you, some surgeons will contact you after the operation and say, 'Yes, I thought this is going to be a terrible operation; it's turned out all right'.

Interviewer: Give you honest feedback?

GP4: Honest feedback; so, it gets back to, yeah, the quality of their work'.

4. Trust through collaboration

The GP must trust that the specialist will 'keep them in the loop' in order to be involved in collaborative treatment strategies; communication is crucial in maintaining this relationship and keeping the GP updated on treatment approaches, test results and further specialist referrals. The GP may be required to bridge the communication gap between the patient and the specialist regarding the explanation of medical jargon; the nature of testing and next steps in treatment; and possible changes in treatment strategies and medication. As one GP clarified:

GP2: Well, trust is very important in the sense that if you send a patient to, put in my own words so that you can convey this, if you send the patient to a particular doctor for a particular reason which is his specialty, you'd expect him to be able to deal with that

specialty and communicate on that specialty. It is important that he also send the patient back to the GP for follow-up. Very often, that's forgotten, they see the patient, and they do not communicate and don't tell the patient anything, and I think that that is fed also by the important point that the GP has to provide relevant information to the specialist, as to why he is referring the patients. So, there's got to be detail from the GP as well as detail from the letter from the specialist. The arrows go both ways.

See Appendix 2 (5.2.1.1 Trust, GP4).

5.3.1.1.2 Trust from the Specialist Perspective

All the SMP group participants indicated that trust is important in their interprofessional relationships. The drivers of trust between specialist and GP were centred on the patient receiving the best treatment to provide a positive patient experience; communication between specialist and GP, and specialist to specialist; collaboration; and clinical expertise.

1. Trust through patient experience

Many SMPs took a patient-centred view when discussing best evidence-based treatment as a cornerstone of trust. This builds on the GP's response about patient feedback being an important factor of trust in the interprofessional relationship. The patient's perception of how they were treated is an important aspect that exists beyond their clinical outcome. The referrer's expectations on treatment of the patient by the referee is that the patient will experience a positive experience in relation to empathy, communication, and patience—all elements that will also foster trust from the patient, for in relation to oncology diagnosis, the patient trusts the referrer's choice of referee with their very life. In line with this view, an SMP stated:

> SMP17: Ehhm, trust is very important in our practice, because you need to work with someone who you trust that they would give the best care to the patient.

2. Trust through collaboration

Collaboration was found to enhance trust in the interprofessional relationship. In the oncology context, it is extremely important for the medical team to work in unison since each aspect of treatment from surgery to radiology, to medical oncology, involves a different specialist. For the patient to obtain the best therapeutic outcome, and the best

treatment experience, each specialist must collaborate with the others to ensure that treatment is aligned and most appropriate for the patient's condition. To ensure the GP is included in the collaboration, the specialists should communicate via sending results and reports to the GP so they can help convey important information to the patient should the need arise. The GP, as the initial referrer and primary patient contact, often has a strong rapport with the patient, and through that rapport a level of trust develops in the patient. The GP can use this in the collaborative process to help explain treatment and medication changes should the need arise. As one SMP said:

> SMP11: I think in terms of referring to me, I know that if I get something in practice or they've asked me to see someone, it's because they have a very sound rationale to do so, and that I believe what they're saying is true; I know that I'm going to get a distinct clear history and it can be relevant and I know where I stand right from the get go.

See Appendix 2 (5.2.1.2 Trust, SMP4, 11, 13).

3. Trust through communication

Communication was found to be an important aspect of trust in the interprofessional referral relationship. In keeping with a SET-informed understanding, a strong referral relationship is likely to exist alongside the exchange of quality feedback. Good communication underpins other themes that fall under the umbrella of 'trust'. The patient's experience is reported via feedback, and collaboration appears most effective if the attending physician(s) report on their treatment methodologies and outcomes with the other physicians with whom they are collaborating. Effective communication fosters trust in the referral relationship because it enables full transparency in treatment, results and timelines. Without communication, there can be no transparency and therefore no element to base trust upon:

> SMP9: Accuracy of information being provided (scans, blood tests) with the referral and the precise question they are after is so important when it comes to trust.

See Appendix 2 (5.2.1.2 Trust, SMP3).

4. Trust through clinical expertise

Clinical expertise was also raised by SMPs in the context of trust. The specialist's skill is one of the first reasons to refer to them, because the referrer trusts the referee's ability to provide a clinical outcome for the patient. Once this aspect has been fulfilled, other reasons for referral will commonly cascade below it:

> SMP4: I think trust is a very high priority; I don't want to send patients to a specialist that I don't trust, that I don't have confidence in.

Trusting in clinical expertise as the primary factor in a referral relationship can create a situation where a referring GP or referring specialist will wait in a queue in order to send a patient to a particular specialist. This delay to see a particular specialist could then create a chain reaction of delay: delay to further testing, delay to diagnosis and, ultimately, delay to treatment. O'Donnell (2000) stated that the real cost to the health service may lie not with the patients who are referred unnecessarily, but with the patients who are referred later or not at all. This is a challenging issue in oncology since timely diagnosis and treatment are essential to improved patient outcomes. The GPs' judgement and understanding of these implications should sway them to refer to a specialist who provides timely access to the necessary treatment. From an SMP's viewpoint:

> SMP10: Someone who trusts you implicitly will or may be happy to wait for several weeks for a particular person to see you, and that doesn't necessarily come easily, it comes with time, and it comes with, often with, years of experience.

5.3.2 Reciprocity

Reciprocity is the exchange of goods or favours for mutual benefits. Under a SET-informed view, it feeds relationships (Organ 1994). A role for reciprocity in the referral relationship between GP and specialist and among specialists was evident for some although, for many participants, largely unexpressed. The GP's role as the 'gatekeeper' of patients and an acceptance that they were almost exclusively the referrer in the patient's relationship with the specialist was discussed. One thing that became apparent in the analysis was that the GP expectation of reciprocity differed from that of a specialist. The expectations the GP had of the referral relationship with the specialist were primarily built around the treatment and management of the patient. The specialists' expectation of the referral relationship with the GP was to receive patients and, in return, provide good

management and treatment of the patient. When discussed with SMPs, reciprocity among them seemed to be built around a referral-for-referral model:

> SMP2: If I was to pick a new specialist to refer them, then I'd probably to someone else because of that lack of reciprocity. I think it's sort of, it's difficult.

> SMP11: Who (GP) sometimes just seeking help, and I may not know them, but you know there's actually that sort of element of trust that the GP or someone who you may not know has referred to you in the belief that they have heard about you, or they know your reputation, and I think that, in its own right infers trust.'

When viewed through the lens of SET, it seems clear the patient should be the consideration in all levels and facets of the reciprocal relationship(s). Given they are the prime commodity in the exchange, their benefit from the situation should be paramount. In the GP–specialist referral relationship, the patient can benefit from quality communication and transparency in treatment plans, and expedited access to specialist appointment in the time of an emergency. In the specialist-to-specialist relationship, the benefit to the patient is not as clear as described in the GP-specialist relationship. One SMP expressed:

> SMP8: Yeah, as I said, you've gotta trust their clinical acumen. If I had to rank what I thought were the factors that caused others to refer people to me, I wouldn't necessarily think that trust was really high. I think, more often than not, its habit.

5.3.2.1 Role of Reciprocity in the GP-to-Specialist Referral Relationship

The role of reciprocity in the GP-to-specialist referral relationship appears to be patient focused, not self-focused. Key themes identified as influencing this relate to communication, collaboration, and respect (see Figure 5.2.2). In a reciprocal relationship the GP expects the specialist to communicate results, procedures and processes, treatment outcomes and changes in medication. Collaboration was also an important theme for GPs for a continuing referral relationship; if they refer a patient to a specialist, it is important that they are 'kept in the loop' in all the aspects of treatment and further referral(s) of the patient when they are under specialist care. The GP expects a level of respect from the referral relationship; if a GP feels there is no mutual respect in the referral relationship, they are not getting a fair exchange in the relationship, and as understood via a SET lens, are likely to refer to another specialist. In this regard, GPs said:

GP3: Probably the biggest thing for that would be a specialist who belittles the referring GP to the patient.

Interviewer: Anything else?

GP3: Any patient that gets referred to a doctor is reflected; the specialists that has been referred by the GP is a reflection on the GP himself. So, if a patient goes to a specialist and they are treated poorly, then it really reflects poorly on the referring GP, if they have a bad experience and whatever that is.

5.3.2.1.1 Communication

When a GP refers a patient to a specialist, they do so because they believe the patient requires treatment that is beyond their scope in medicine (Hutchinson, 1991). They rely on the expertise of the specialist to further diagnose and develop a treatment plan. The specialist obtains the patient from the GP, and in return, the GP wants data on the patient's status, and they want it in a timely fashion:

GP8: This is a reciprocal relationship, isn't it, really. I need to provide things and they need to provide things back, and if that falls down, then I probably don't look to continue the relationship.

See Appendix 2 (5.2.2.1 Communication, GP14).

SMPs also identify that communication is an important aspect in maintaining a referral relationship with the GP. Reciprocity with communication allows the GP to do their job and converse with the patient on their experience with the specialist:

SMP9: What I like from my relationship with a GP is approachability, ease of access, send a good report—summarise the case, that they understand the complexity of the situation, the deliberation of the treatment options and outcomes. They come to us looking for answers to complex questions.

See Appendix 2 (5.2.2.1 Communication, SMP4).

5.3.2.1.2 Collaboration

Certain aspects of collaboration contain an expectation of reciprocity attached to them. It was widely held among participants that GPs should be included in treatment

collaboration with specialists and that it is imperative that the SMP communicate with the GP on all aspects of the patient's outcome and any potential referrals. The role of the GP in collaborating exists beyond the initial specialist referral; the GP has a rapport with the patient and can aid the specialist(s) by communicating with the patient any changes in medication, testing and treatment:

> GP5: Feedback and discussions with the GP about the patient are vital. Results of investigations and letters providing full details including information about the SMP referring the patient to another SMP need to be sent to me also. It is essential that the GP is kept in the loop re the patient.

> SMP2: I'll try and get back to them as quickly as possible. I'd like to discuss the patients with them, and if I don't do that, then I try and have a succinct but fairly accurate letter in a timely fashion.

See Appendix 2 (5.2.2.1 Collaboration, GP7, GP4).

Collaborating among specialists has reciprocal characteristics. They must trust that their peer will refer the patient back to them and not refer on to a different specialist. This tit-for-tat exchange of patients can be viewed via a SET lens. Some specialists indicated that they would only refer to another specialist if they had an existing relationship. Importantly, this behaviour was rarely expressed in terms of potential benefits for the patient, but rather, an 'accepted' way of working:

> SMP8: So, if I have someone who refers patients to me, I'm more likely to refer patients to them definitely. So, it is it is a quite interesting concept actually because you could argue that that then narrows your scope of referrers.

See Appendix 2 (5.2.2.1 Collaboration, SMP6).

5.3.2.1.3 Respect

For GP participants, respect is to understand and value the role the GP plays in the patient's journey towards a positive treatment experience and, ideally, a positive treatment outcome. SET prescribes that respect cannot be unidirectional but needs to be reciprocal. This is borne out in the data:

GP3: I think it's like all relationships; if there's reciprocity, you build a better relationship. You can't have, I mean, generally, one-sided relationships don't work.

See Appendix 2 (5.2.2.1 Respect, GP4).

5.3.2.2 Role of Reciprocity in the Specialist-to-Specialist Relationship

It is important for the specialist to build a practice and maintain a steady patient base. Ideally, referral is about filling treatment gaps the referrer does not possess and enhancing the patient's treatment experience and outcome, but this was not always emphasised by SMPs. Instead, they emphasised the 'quid pro quo' basis for referral. This may not necessarily be in the best interest of patient outcomes:

SMP10: I think, historically, there's been a very, it's a two-way street, and people who refer to you will get a lot more referrals back than people you may not know within the realms of general day-to-day specialist practice, and often it is to do with the type of patient that you're sending to these people.

SMP11: I think again, it's right up there, because it is exactly that; I mean it's a two-way relationship and I can't think of a single patient that I manage, and in particular, my subspecialty, where it is not both ways all the time.

See Appendix 2 (5.2.2.2 The role of reciprocity in the specialist-to-specialist relationship, SMP8, 9).

5.3.2.2.1 Communication

Communication was discussed as key to reciprocity by SMPs. Obtaining feedback on the patient's progress was discussed as a definite reciprocal factor among SMPs, and neglect of this exchange could affect the referral relationship moving forward:

SMP5: Speed of communication is important … getting everybody into the speed of communication. So, you don't get material too late.

5.3.2.2.2 Collaboration

Collaboration is working together as a team to produce an outcome. It can be understood via RMT in the sense that its success or failure will often rest on relational factors. According to the AHPRA (2014), 'Effective collaboration is a fundamental aspect of

good practice among medical practitioners. The care of patients is improved when there is mutual respect and clear communication' (section 4.4).

Given that it is common for GPs and specialists to work in separate locations, their ability to collaborate relies heavily on effective communication (Hespe 2010). True collaboration will involve an element of trust that each party will perform their role and then communicate their plans and outcomes in a timely manner (Mechanic & Meyer 2000). Clinical issues that are beyond the breadth of the treating physician should be discussed with specialists and/or subspecialists to find a solution, and all referrals that occur beyond the initial GP referral should be communicated to all parties so that everyone has a complete understanding of the patient's current status of treatment (Westerman et al. 1990).

The response to the aforementioned AHPRA quotation on collaboration by GP and SMPs was mixed (see Figures 5.5 and 5.6).
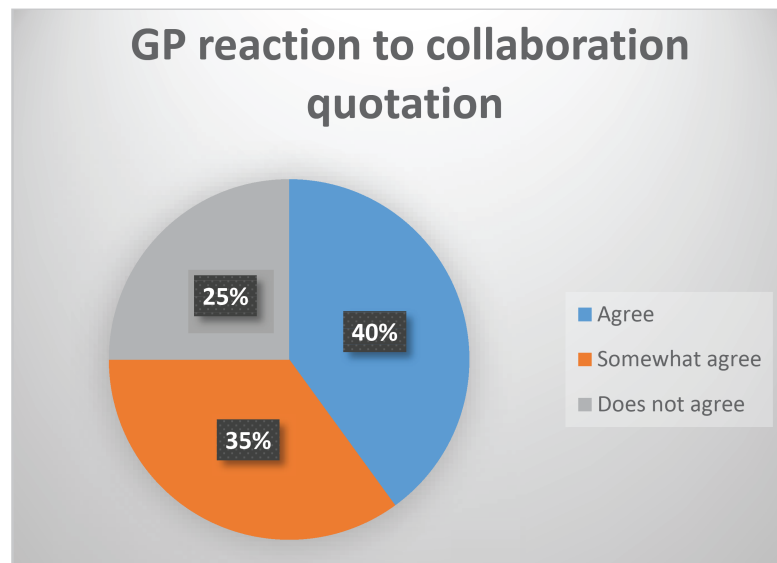
Figure 5.5: GP Reaction to Collaboration Quotation from AHPRA (2014)
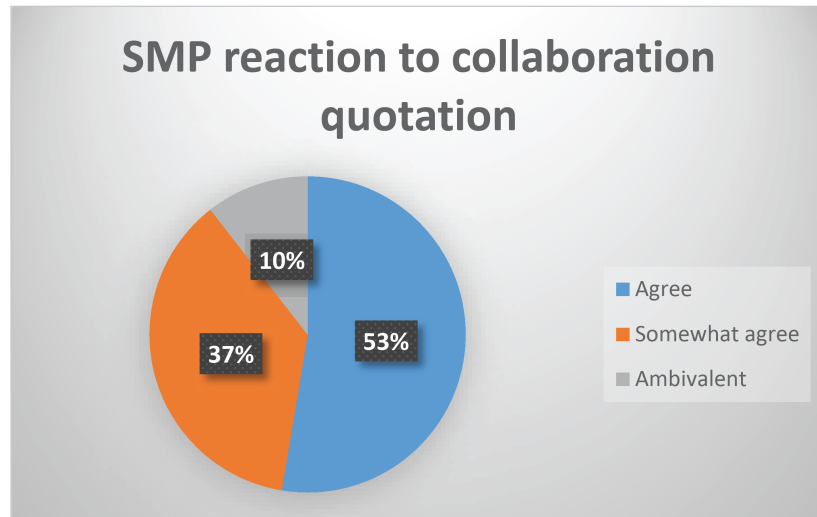
Figure 5.6: SMP Reaction to Collaboration Quotation from AHPRA (2014)

Differently to the GPs, the specialists' reaction to the AHPRA (2014) quotation on collaboration showed a somewhat more definitive response in the sense that disagreement with the quotation was uncommon.

5.3.3 Drivers of Collaboration

5.3.3.1 Significance of Interprofessional Collaboration in SMP Provision

Interprofessional collaboration among specialists is an important aspect of the patient experience and a driver of patient outcome (Pearson et al. 1999). For an effective working relationship among treating physicians, there needs to be trust, respect, and shared knowledge (Pearson et al. 1999). Collaboration among specialists is necessary when the nature of the disease is complicated, and more than one specialist is required to treat the patient and resolve the disease. In the case of oncology, a patient will be referred by a GP for further diagnosis, and usually, the first referral is to a surgeon. Once the surgeon has consulted with the patient and reviewed the relevant case history, they will take the patient's relevant details to an MDT meeting to discuss a treatment plan with other oncology specialist such as medical oncologist and radiation oncologist, that will be based on the current diagnosis. SMP study participants have outlined that for the MDT process to be effective, there needs to be respect among the cohort and constructive communication:

> SMP6: The specialists participating in the MDTs need to be expert, you know; so I
> know that in the current curriculum frameworks, it's well recognised that doctors need

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to be more than just medical experts, but they do have to be that, you know, so people need to know the literature, and they need to be authoritative, in order to speak to their specialty, but then they also need to be able to listen to others.

5.3.3.2 Respect in the Collaborative Process

Respect in the collaborative process is important in the MDT meeting to improve service to the patient, the MDT within itself needs to be functional and cohesive. Many SMP study participants highlighted the need for respect of all participants to improve MDTs in order to improve interprofessional collaboration. The importance of the functionality of the MDT rated very highly among SMPs, and if/when it functions sub-optimally, is an obvious impediment to improving the patient experience and patient outcomes. One SMP said:

> SMP3: Yeah, there is a risk that MDTs are dominated by the loudest person, the more dominant personality. But that changes over time as you build trust in each other.

See Appendix 2 (5.2.3.1 Interprofessional collaboration, SMP7, 9).

For MDTs to collaborate effectively, there needs to be respect among the membership:

> SMP5: Well, it's exactly what it does, it provides that ability to have that mutual respect. It provides that ability to communicate both the positive and the negative feedback where if there's a difference in opinion on something that that difference can be resolved. So, you've got the opportunity of resolution.

See Appendix 2 (5.2.3.1 Interprofessional collaboration, SMP7).

5.3.3.3 Communication in the Collaborative Process

From a GP's perspective, the significance of interprofessional relationships with specialists in terms of collaboration is based strongly on communication. The GP, as the initial referrer in the collaborative relationship, needs to know the diagnosis from the specialist, decisions on treatment based on diagnosis and any changes in medication/treatment protocols. Without prompt and thorough communication from the specialist, the GP's role in terms of collaboration would end:

> GP5: A specialist will generally call re urgent cases and discuss the patient and any changes they've made that need to be monitored (ahead of formal correspondence).

See Appendix 2 (5.2.3.1 Interprofessional collaboration, GP19).

The role of the GP in the collaborative process needs to be respected by all parties. The GP has the existing relationship with the patient. The GP may be the one that removes stitches from the patient after surgery or explains medication changes and side effects. If the patient experiences illnesses alongside the disease that the specialist is treating, then the patient will visit the GP, and it will be up to the GP to understand whether the illness is treatment related or a different illness altogether. One GP asserted:

> GP17: I would probably go back to that fact that the patient sees us as collaborating, and that even starts when the specialist gets my referral letter, if he reads it, in front of the patient, not just reads it, but in front of the patient, even glances at it. Many specialists don't even look at the referral letter; because I put a bit of effort into my referral letters, so I like to know that he's read them and the patient knows that he's read them, because it's not only what's done but what's seen to be done.
>
> Interviewer: I see.
>
> GP17: Yeah, so that there, collaborating, it's all communication really, isn't it?

See Appendix 2 (5.2.3.1 Interprofessional collaboration, GP9).

5.3.3.4 How Does Communication Affect Collaboration?

Clearly, communication influences collaboration: Every aspect of treatment and testing that needs to be included in the collaborative process requires communication to transmit the results. Lack of communication can delay treatment and testing, can cause tests to be unnecessarily repeated and can subsequently negatively affect a patient's treatment outcome (Banks et al. 2014).

The GP's role in the collaborative process is somewhat eliminated. In oncology, specialists can collaborate via the MDT meeting and hence have face-to-face time to communicate about patients they are collaborating with, but the GP is not a part of this process and must rely on other means of communication to remain in the collaborative loop. When GP study participants were asked whether specialists need to provide ongoing communication with them regarding the treatment facilities and procedures used, most agreed. Figure 5.7 highlights that SMPs agree with the importance of communication in the GP–SMP collaborative process.
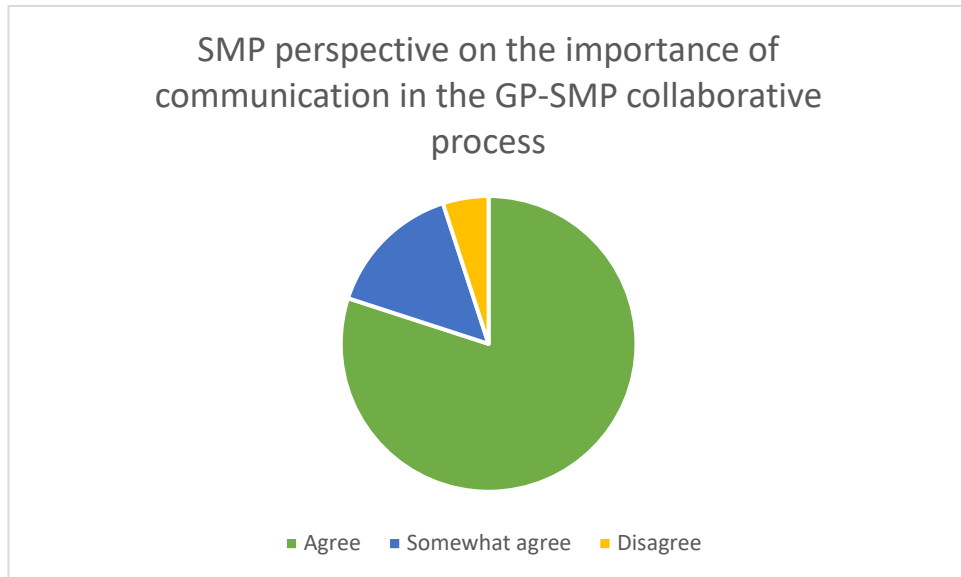
Figure 5.7: SMP Perspective on Importance of Communication in GP–SMP Collaborative Process

Ongoing specialist communication about treatment facilities and procedures used involves imparting pertinent knowledge that allows the parties to make an informed choice in the referral process. Without knowledge of the specialist methods and facilities, the GP cannot adequately communicate with the patient to prepare them for their impending consultation/procedure. This lack of knowledge impedes their ability to be relevant in the collaborative process and may affect patient outcomes:

> GP1: Yes, every time something new is done or there is a change in plans, I want ongoing information. This is important to ensure that the GP understands what is happening with their patient, as they are the manager-of-care of the patient. The GP has to be informed about ongoing treatment.

GP study participants were asked about the nature of the communication they prefer from specialists to be relevant in the collaborative process. All reported that they wanted written communication after the patient sees the specialist, and if the patient's condition is urgent, they expect a phone call informing them of the details. One participant reported they would like a shared data platform so that access to the patient's information would be at their fingertips (see Figure 5.8).
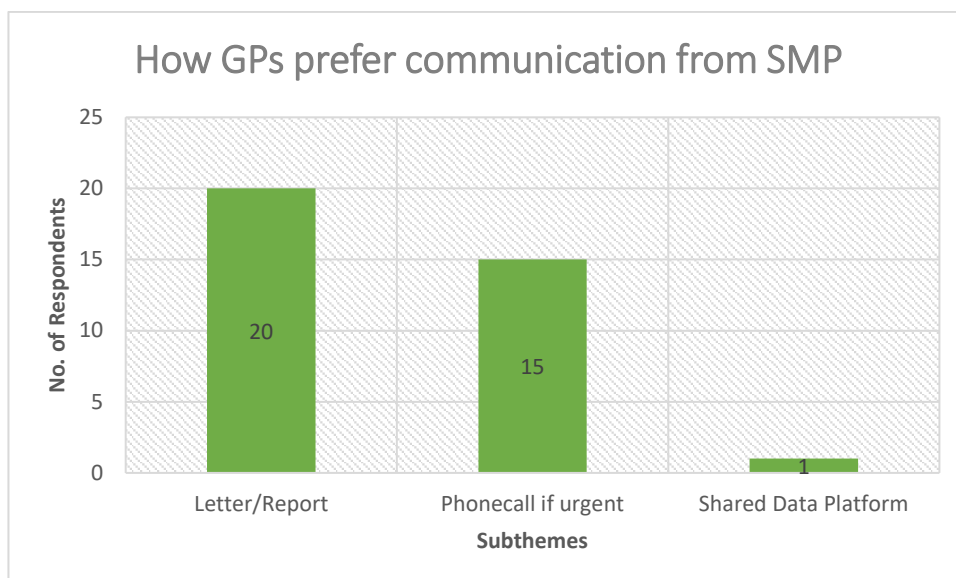
Figure 5.8: GP Communication Preference

From the specialist's perspective, most of them perceived communication to be a driving factor in maintaining an interprofessional relationship:

> SMP4: I think personal communication; nothing improves your image among GPs and all specialists, more than a quick phone call to bring them up to speed. Particularly if there's a change in what's happening to the patient, a quick phone call could make all the difference in the relationship.

See Appendix 2 (5.2.3.1. Impact of communication on collaboration, SMP8).

Table 5.2: Theme Summary of Perspectives that Underpin Lasting Professional Exchange Relationships

Themes	Clinical Expertise	Patient Experience	Comm-unication	Collaboration	Respect
Trust from GP perspective	✓	✓	✓	✓	
Trust from SMP perspective	✓	✓	✓		
Collaboration			✓		
Reciprocity in GP–SMP relationship		☐	✓	✓	✓

Themes	Clinical Expertise	Patient Experience	Comm-unication	Collaboration	Respect
Reciprocity in SMP–SMP relationship			✓	✓	✓

5.4 Significance of Professional Exchange Drivers as They Relate to Clinical Judgement and Decision-Making during Referral Practices / Processes

Professional exchange drivers and the influences on the referral process were examined from the viewpoints of GP-to-SMP referrals and SMP-to-SMP referrals, the perceptions of SMPs about why they are referred to and the influence of the patient in the referral process. Themes and subthemes were developed through thematic analysis of the transcripts informed by SET and RMT, to develop an understanding of how these different perspectives and motives from the contributing parties influenced clinical judgement through the referral process (see Table 5.3 for a summary of the themes and subthemes in this section).

5.4.1 GP-to-Specialist Referral

5.4.1.1 Linking GP Referral Practice and Survival

Substantial research illuminates the grim reality of delayed referral, inappropriate examinations, delayed diagnosis, and poor patient outcomes among those diagnosed with cancer (Banks et al. 2014; Genden et al. 2006; Gomez et al. 2010; Goff et al. 2000; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). This thesis seeks to understand the types of decisions referring doctors make when choosing an SMP (oncologist) and when referring interprofessionally as well as to identify the key influences on referral practices and, ultimately, on patient outcomes.

Most patients assume that if their family doctor cannot treat their disease, they will be referred to a specialist who has been scrutinised by their own doctor. This dependence and trust of patients on their GP's skill level and influence in the medical community can be understood via RMT, in the patient–doctor relationship context. One GP said:

GP8: There might be situations where I think somebody will particularly deal with a clinical problem well; it might be that their personality might actually deal with a particular patient, and I like to share the load a little bit too to be honest, so I think it's good for us to have relationships with as many people as possible in our area.

5.4.1.2 Accessibility to Timely Treatment

A GP's ability to obtain quick access for specialist consultation can be limited at times. This is an element that may cause delay in treatment and may also lead to medical error. Factors such as seasonal holidays, geographical locations, cultural preferences or a busy SMP schedule can affect the patient's ability to obtain a timely appointment:

GP5: Yes, at Christmas time. It can be difficult finding an SMP who can attend to patients.

See Appendix 3 (5.3.1.2 Accessibility to timely treatment, GP6, GP7).

5.4.1.3 Identifying the Correct Specialty

The time taken to understand the correct specialty to refer the patient to may increase time to treatment. Referring complex patient issues and navigating the specialist and subspecialist fields can be frustrating without appropriate education. Sullivan (2012) asserted that the number of specialist and subspecialist fields has nearly doubled in recent years. For instance:

GP11: Sometimes, it's hard to know who to send someone to, they've got a complex issue that… where that issue is dealt with by a range of specialties.

SMP9: Urgency of referral is a real factor. Education is important, so that oncologist practitioners understand what patients in our view require urgent referral.

See Appendix 3 (5.3.1.3 Identifying the correct speciality, GP10).

5.4.1.4 Communication to Reduce Error

Taking a SET-framed view about communication would suggest that providing a good patient outcome through timely diagnosis and treatment is likely to be dependent on the exchange of precise patient information. The referral letter has been identified by both GPs and SMPs as the best opening vehicle for this exchange. The provision of clear and

concise communication is an important area to improve, in order to prevent medical errors because of delayed diagnosis and treatment, and the replication of testing. The participants clarified:

> SMP14: Communication and documentation are the biggest risk to my practice. Being able to collate all of the relevant diagnostic and clinical assessments to enable me to reach an early conclusion as to the diagnosis and factor in all the comorbidities for treatment.

> GP6: GPs have to give a very detailed letter, so that we don't waste time on the investigating—going over the same investigations… Presenting symptoms, your examination, you need to have all investigations done where we know all the medications.

5.4.1.5 Interpersonal Connection

The theme 'interpersonal connection with the specialist' was mentioned by some GPs as a reason to refer to a specialist. The likeability of the therapist is likely to be a factor that can build trust with both the GP and the patient; however, it presented much more strongly in the data as a reason not to refer to a specialist. This can particularly be so if the GP is disrespected as a clinician by the SMP:

> GP3: Probably the biggest thing for that would be a specialist who belittles the referring GP to the patient.

See Appendix 3 (5.3.1.5 Interpersonal connection, GP4, 11).

5.4.1.6 Location

Location is a strong theme among referring GPs, with many indicating it to be an influencing factor in their choice of specialist for their patient. Location is the geographical position of the specialist in relation to the referring GP and the patient the GP is referring for specialist consultation. In choosing location as a motivating factor for specialist referral, the GP has to weigh up more than one variable. The GP might need to advocate for the patient by balancing the accessibility and the ability of the patient to attend specialist consultation and ongoing treatment, against the skillset of the specialist(s) in the area. For instance:

GP10: There is a discussion between the patient and me that takes into account location and my trust and experience with the specialist, and of that specialty.

See Appendix 3 (5.3.1.6 Location, GP8, 11, 12).

5.4.1.7 Patient Experience

Many GPs emphasised the role of patient experience as important in their choice of specialist referral. Patient experience is a wide-ranging construct that includes communication, empathy, examination, evaluation, diagnosis, prognosis and intervention (Sanders, Omar & Webster 2015). It differs from patient outcome, which refers to clinical morbidity, quality of life and mortality outcomes and is tied up with the patient response to treatment. Under a SET frame, we would expect an exchange dynamic to be at play such as the GP to expecting a positive experience for the patient and from there, be motivated to provide more referrals:

GP3: Manner; actually, manner is a pretty big one in oncology…Because for the patients it's [cancer] a confronting thing.

Interviewer: Any other factors or alternatives present when you think about referrals and your patients?

GP3: You know, things like how promptly they're going to be seen, what the waiting times are like, the levels of service, so it's not just the quality, it's the levels of service.

GP6: If I get bad reports from the patients, especially in relation to empathy and particularly in cancer medicine...'

See Appendix 3 (5.3.1.7 Patient experience, GP13).

5.4.1.8 Trust

Trust is a term that is a cornerstone of any relationship; it is anchored deeply in both RMT and SET, and both theories are used to understand this theme. In a referral relationship between a GP and a specialist, trust in the referral context means the GP believes the specialist has the abilities to treat and manage the patient towards a positive outcome. In the case of oncology, where a diagnosis can inflame a patient and family's emotions, the trust in the specialist must be paramount. A clinical outcome is very important, but so is empathy, compassion, patience, and communication. When a GP refers to an oncologist,

they want all the aforementioned experiences for the patient; in return, the interprofessional referral relationship will be strengthened:

> GP1: I would trust the specialist will be like I am, do the right thing for patients, and ensure the best clinical outcome, rather than the best financial outcome. So, if I know a specialist is doing unnecessary tests or procedures, then I would lose the trust I have with that specialist.

The theme of trust or the lack of trust was mentioned by many GPs. In the context of this thesis, the term trust is used as a theme that is linked closely to terms or phrases such as respect, reputation, integrity and judgement. The lack of trust can ruin a referral relationship, particularly when it relates to patient management or patient feedback. A GP explained:

> GP20: There's an orthopaedic surgeon who sends letters saying that he'll bulk-bill everybody, which he does, but he's dreadful; he throws things in the operating theatre, so that's probably one thing. I know that some specialists probably charge more than others, but reputation and attitude is a big part of it.

See Appendix 3 (5.3.1.8 Trust, GP9, 14).

5.4.1.9 Cost

Many GPs flagged the affordability of the specialist as a factor the GP to consider on behalf of the patient. Cost can be an impeding factor to a GP's choice; if they have a patient who requires fast accessibility to treatment, and there are no specialists available within the timeframe that is affordable, the GP is forced to make an inferior decision based on the financial position, rather than a clinical need:

> GP13: The cost is one factor; the cost that my patient tells me is prohibitive.

5.4.2 Perspectives of SMPs on Why GPs Refer to Them

5.4.2.1 Trust

Trust arises as the key factor that specialists believe drives a GP's decision to refer to them:

SMP11: I think it's got be right up there, I think in terms of referring to me, I know that if I get something in practice or they've asked me to see someone, it's because they have a very sound rationale to do so and that I believe what they're saying is true; I know that I'm going to get a distinct clear history and it can be relevant, and I know where I stand right from the get go.

Such a finding is predictable by both SET and RMT. As has been stated thus far, there are other reasons that can influence a choice to refer, such as the patient's choice in SMP, referral to a new field of medicine or location and/or cost. These reasons may exist beyond the object of trust and may contribute to the growth of a trusting relationship:

SMP7: A pattern of care based upon their prior practice, where they know that their patients were really looked after. Prior experience.

See Appendix 3 (5.3.2.1 Trust, SMP6).

5.4.2.2 Factors that Influence Referral in a Collaborative Relationship

5.4.2.2.1 Respect

The participants in the GP cohort felt that respect can be a major barrier to referral in the collaborative relationship, if the GP feels disrespected their point-of-view may not be heard in the ongoing treatment process, and they may not receive adequate communication so their role in the collaborative process may diminish:

GP6: Where a specialist is not friendly with the GP, snobbish is the word.

GP7: One word I can think of is arrogance on the specialist part of that.

The GP's ability to communicate effectively with the patient requires the SMP to communicate all steps of treatment, and if the SMP feels the patient would benefit from a subspecialisation or a different SMP, then it is important that they inform the GP on the new referral:

GP1: Without appropriate reciprocal communication from the specialist, it is of no use. It is not a template. If the patient outcome is not achieved, there is loss of trust. Some SMPs refer to other SMPs without discussing with us GPs. It is important to at least ensure that we are kept informed.

Participants cited that disrespect was often represented through poor communication and the negative impact on collaboration could have a detrimental effect on the patient. The inability to openly confer with the referee about a patient's condition could be a barrier to future referrals, subsequently ending the exchange relationship:

> GP14: Not an impediment, but it's a difficulty because, you know, I might turn around and go, now I don't need to ring him up about that or sending him a letter or something, but the others, you know, all say, I best check on this. So, and you know, the specialist why is he ringing me up for that, you know, but they've been trained to do that. Do you understand what I mean? I don't wish to be derogatory; it's just a difference in training and talk to the specialist, maybe they might turn around say that's not the case nowadays.

> GP17: The apparent willingness of the specialist to talk to me, because I want to feel like I'm a doctor as well in the eyes of the specialist, so you want to feel a little bit special.

Respect through quality communication in a collaborative relationship can also have a positive impact on the patient. The positive exchange where the SMP provided information that is beyond the purview of the professional lens, can result in a strong relationship that will yield future referrals. As these GPs confirmed:

> GP12: Well, I guess on that note; like sometimes a specialist might give advice over the phone and then say, you know, 'I recommend you do this and this', and I'll see them in a few days' time, if it's something urgent, more urgent, doesn't need to go to hospital, that you feel you need to do something immediately and you're not quite sure what to do, and if you speak to a specialist, they give advice over the phone and they might follow up and see the patient in a few days' time. That's very helpful.

> GP16: Sometimes, you'll see the specialist ringing up and saying [name redacted], 'Just to let you know we had to take this guy to theatre because of that and I thought you'd like to know that'. I mean that makes you feel that you're part of the loop and makes you feel happier that you're just not being bypassed by the system.

5.4.2.3 Referral through Established Networks

SMPs referred to their reliance on established relationships in obtaining GP referrals. An established relationship in this context is a past affiliation a specialist has with a GP that

has yielded mutually beneficial results in terms of, but not exclusive to, patient outcomes, communication, reciprocity, collaboration, and trust. The symbiotic nature of the relationship can be simply defined as follows: A GP has a complex problem that needs solving. The specialist solves this problem while communicating the process along the way; once the problem is solved, the specialist sends the patient back for management. For example:

> SMP3: Probably it's a number of things. Prior experience with shared patient care, previous referrals, ease of referral, communication in response to the referral and an ongoing relationship with the referrer in the shared care of the patient.

> So, you are keeping them informed, you are keeping them a part of the care, you're not just saying. 'Thanks very much, it's my business'.

See Appendix 3 (5.3.2.3 Referral through established networks, SMP2).

5.4.2.4 Clinical Expertise

Perceived clinical expertise is also foundational to the reason for referral. Specialists recognised this as an important exchange for their referral relationship with GPs. For example:

> GP9: They understand the complexity of the situation, the deliberation of the treatment options and outcomes. Patients come to us looking for answers to complex questions.

See Appendix 3 (5.3.2.4 Clinical expertise, SMP6).

5.4.2.5 Communication

SET would prescribe that the referral relationship between GPs and specialists must have an aspect that benefits both parties. Ideally, once the GP has sent the patient on to the specialist care, the only mechanism that allows the GP to stay involved in the management of the patient is if the specialist communicates all aspects of the diagnosis, the management plan and any other subsequent referrals that the specialist deems necessary. For this:

> SMP7: Good correspondence, good communication.

See Appendix 3 (5.3.2.4 Communication, SMP3).

5.4.2.6 Collaboration

Only a few SMPs identified collaboration as a reason for GPs referral to them. This lack of importance is interesting, because it raises the question: Do the specialists ignore the GP's role in collaboration? Or do they believe the GP does not wish to collaborate and is simply sending a patient with a problem that needs solving?

The small number of specialists who nominated collaborative treatment as a reason that GPs refer to them did appear to have a good grasp on the GP's role in the collaborative process:

> SMP3: So, you are keeping them informed, you are keeping them a part of the care, you're not just saying, 'Thanks very much, this is my business'.

See Appendix 3 (5.3.2.5 Collaboration, SMP5).

5.4.3 Specialist-to-Specialist Referral

In certain circumstances, the specialist might need to refer to a different specialist, or a subspecialist, for a more complete diagnosis or for collaborative management. Using SET and RMT, this thesis explores the motivating factors that drive the choice of a particular specialist, the challenges that these relationships with medical peers pose, the factors in referrals that work best and the aspects of referral that produce best patient outcomes. Several themes were identified (see Figure 5.7 for an overview of the themes and subthemes).

Reasons for referral to a particular SMP
- Clinical expertise
- Accessibility
- Trust
- Clinical need
- Patient feedback
- Reciprocity

Challenges in relationship with referring doctors
- Communication
- Managing emerging/changing relationships
- Disagreement in treatment
- No issue
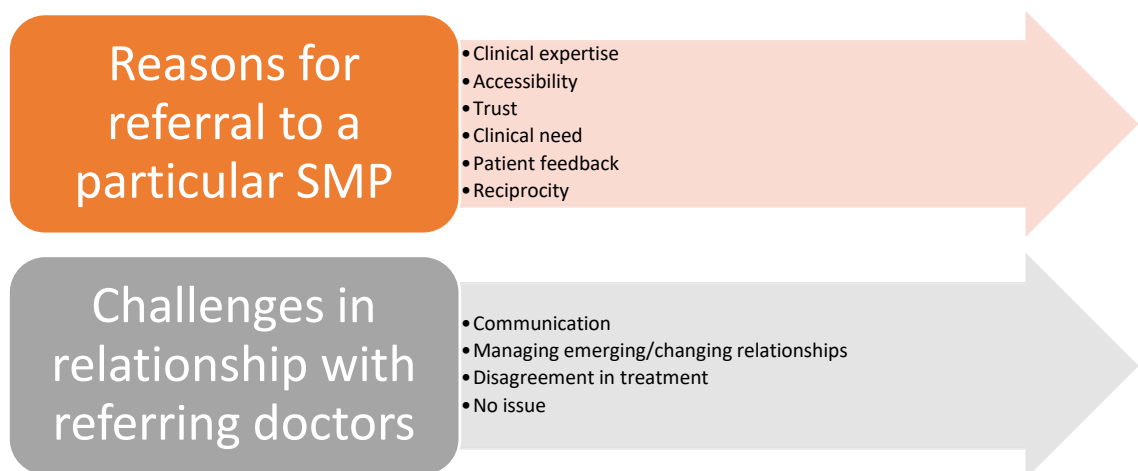
Figure 5.7: Overview of Themes and Subthemes

5.4.3.1 Reasons for Referring to a Particular SMP/Factors Determining Decision to Refer a Patient to an SMP

Specialists require patients for building a business; the specialist cannot market directly to patients to garner their favour; instead, the specialist has to rely on GPs to refer them the patient. To build a reputation with other specialists, the specialist must show own worth to the relationship through clinical expertise, accessibility, communication, trust and reciprocity. Under a SET frame, via this peer-to-peer exchange, the patient becomes a commodity of exchange:

> SMP5: I started with sort of the two different things. I started with the concept that any personal or professional relationship was a friendship type thing… But now, I think that there's a lot more to the business communication aspect of maintaining a working relationship of cross-referral.

Although theorists diverge on particulars, they do converge on the central essence of SET: Social exchange comprises actions contingent on the rewarding reactions of others, which over time provide for mutually rewarding transactions and relationships (Cropanzano & Mitchell 2005, p. 890).

5.4.3.2 Factors Determining Decision to Refer a Patient to an SMP

5.4.3.2.1 Clinical Expertise

Clinical expertise was often mentioned as a reason for referring a patient to a particular specialist. Although this theme was commonly expressed by SMPs, their responses here often lacked depth:

> SMP16: Ok, subspecialty interest…I mean basically, that specialist's ability to care for them (patients) adequately. Yeah, with their best interests at heart sort of thing.

See Appendix 4 (5.3.3.2 Clinical expertise, SMP6, 9, 19).

This lack of depth is interesting, because when specialists were asked why they thought GPs referred to them, clinical expertise was ranked very highly and discussed at greater depth (In Appendix 4, see 5.3.2.3 Clinical expertise, under SMP's perspective on why GPs refer to them).

5.4.3.2.2 Accessibility

Most SMPs discussed accessibility as an important reason to choose an SMP for referral. Both SET and RMT frames are useful in unpacking this view since SMPs often spoke of wanting to leverage an existing relationship in order to gain greater accessibility for their patient:

> SMP9: You don't want to delay, if we want to get someone quick; and it is hard here, the guru might not have the time; hence, a compromise to the next best.

See Appendix 4 (5.3.3.2 Accessibility, SMP2).

5.4.3.2.3 Trust through Existing Relationship

SMPs repeatedly raised trust as developed through an established relationship as a guide for specialist-to-specialist referral. An established relationship refers to a past affiliation a specialist has with a specialist who has yielded mutually beneficial results in terms of, but not exclusive to, patient outcomes, communication, reciprocity, collaboration, and trust.

Although referring to a known, trusted entity is a common choice in referral pathways, it was also important to ensure that this specialist is accessible, and that treatment delay would not occur:

> SMP11: One is your relationship with that specialty, that specialist, full stop; is it someone you talk to every day, every other day and you know you can pick up the phone and will answer? The second one is your trust, and that trust may come from professional outcomes, it may come from their research or their reputation. I think thirdly is vice versa, is it someone that reciprocates, is it someone that sends you patients equally? And therefore, it's a symbiotic relationship.

See Appendix 4 (5.3.3.2 Trust through existing relationship, SMP7, 12).

5.4.3.2.4 Clinical Need/Specific Specialty

The reason to refer a patient on to a specialist is based on a clinical need beyond the specialist's scope of treatment. This could be as simple as an oncology patient who also has cardiac issues and therefore needs the opinion of a cardiologist:

> SMP11: I look for, is it something that I can deliver? In other words, is it radiation, is it surgical intervention, is it psychiatry, is it clearly another discipline? That's the first thing.

> Interviewer: So clinical discipline?

> SMP11: Second, geographical area; is it reasonable for the patient to be seen by me as opposed to another centre?

See Appendix 4 (5.3.3.2 Clinical need/specific specialty, SMP2).

5.4.3.2.5 Patient Experience

Patient experience as reported via patient feedback was often mentioned by SMPs as an influencer of their referral choice to another SMP. Patient experience is an implicitly subjective construct, although increasingly recognised as important to the ultimate health outcome. As information, which is interpretable by a referring SMP, depends on the actual content of the information received from the patient and whether it was positive, neutral, or negative. Positive patient feedback is not necessarily a measure of a specialist's clinical expertise, but perhaps more a commentary on their interpersonal style. In contrast, negative patient feedback could be a red flag to a referrer, which may negatively affect their business and therefore their referral decision(s):

> SMP6: That's a good question, you choose the one that your patients have given you good feedback on. Probably you choose the one that you are most comfortable and work most frequently with, and some of the motivation for that's likely to be around familiarity.

See Appendix 4 (5.3.3.2 Patient experience, SMP15).

5.4.3.2.6 Reciprocity in Referral

Under a SET frame, the role of reciprocity in the referral process in the SMP-to-SMP relationship is quite important for the specialist to build a practice and maintain a steady patient base. Referral-making is dependent on the quality of relationships, but the reciprocal exchange in referral represents an investment in the relationship. The choice of referee should be about filling gaps in expertise the referrer does not possess in order to produce a better patient treatment experience and outcome. Interestingly, reciprocity

was not commonly mentioned by SMPs as an influencer of their referral behaviour. When it was mentioned, this was usually in the context of another driver:

> SMP6: Probably you choose the one that you are most comfortable and work most frequently with, and some of the motivation for that's likely to be around familiarity, it's going to be around confidence that what you need to be done will be done and there's probably going to be a reciprocal element in here as well, in other words, investing in this relationship.

5.4.3.3 Challenges in Relationship with Referring Doctors

Challenges in relationships with referring doctors could affect the interprofessional association going forward. As detailed in chapter 3.3 herein, Alan Fiske (1991, 1992, 2004) conceptualised RMT as a four-model construct that explained social life as a process, with people generally wanting to relate to each other and feel a sense of commitment and obligation to their relationships. This process entails seeking, making, sustaining, repairing, adjusting, judging, construing, and sanctioning relationships. RMT was helpful as a viewing frame here. The factors located included poor interprofessional communication, navigating difficult relationships, resolving difference of opinion in regard to treatment methodologies, and basic management of referral relationships as they change and evolve as challenge oriented. Importantly, there was variation at play here - not all participants reported difficulties in the interprofessional referral relationship and felt comfortable with the 'status quo"

5.4.3.3.1 Communication

Poor communication in an interprofessional referral relationship can negatively affect the association moving forward. Not many SMPs flagged communication as important among referring specialists, yet this is an important aspect in terms of treatment collaboration and treatment transparency (Hespe, 2010). Communication, on the patient's diagnosis, treatment plan and prognosis (if applicable), is the means to inform the referring specialists on the patient's status. A SET-informed view might highlight this exchange and elevate it as naturally important to the referrer. Such a view makes a lot of sense as having this data is vital to the referring doctor who will need to inform the original referring GP and communicate with the patient. The communication is expected to be in the form of reports, and if urgent, a phone call. One SMP stated:

SMP19: One of the biggest challenges is once you have an established relationship, a lot of the doctors will start to use you as their personal specialist and whenever they have a problem, they want to talk to you like immediately, and the difficulty to get them to understand that they're not the only doctor that's referring to you.

Communication is an expression of transparency. An RMT informed view might naturally position it as a means to build a relationship of trust. Conversely, when communication is poor the referring doctor is left ignorant about the patient's status and cannot contribute to the patient's ongoing treatment:

SMP14: Biggest is problems in communication, but this is often a system problem. There can be a lack of background information about the patient that has been referred.

See Appendix 4 (5.3.3.3 Communication, SMP19).

5.4.3.3.2 Managing Emerging/Changing Referral Relationships

Medicine and oncology are dynamic in nature, given the changes in personnel, new diagnostic tools, and evolving treatment methodologies. All of these changes can influence existing relationships and provide challenges in creating new relationships. Moreover, the balance of power can shift between parties. A small number of SMPs identified that managing emerging and changing relationships was one of the challenges they faced in the interprofessional referral relationship. Such challenges could be based purely on forming relationships with a different generation of specialists, or it could be around a new specialist who has just started practice and is finding it difficult to obtain referrals from established specialists:

SMP5: And the older ones, the people who you know, if you were to, if you were, you've got cross-referrals to your age, you've got cross-referral who are older than you. You have got cross-referrals who are younger than you. The cross-referrers who are older than you and are retiring and going out of the scene and dropping off.

Interviewer: Older ones are going out of system?

SMP5: And so, it's a question of being able to make or maintain a relationship with the new ones.

SMP6: Well, without going into details, breast cancer surgery is changing. What we once thought was gospel to do with mastectomy and breast cancer surgery, when

practice changes in one of the 'ologies' there is change in other areas. Medical practice is evolving from a clinical perspective.

5.4.3.3.3 Disagreement in Treatment

Collaboration in treatment means that each contributing doctor needs to agree on the treatment. An RMT-informed view helps us to see that disagreement in treatment may present a challenge in maintaining referral relationships among specialists. Peers generally want to relate to each other and feel a sense of commitment and obligation to their relationships, but this can falter (Fiske 1991, 1992, 2004). For instance:

> SMP13: There might be an inadequate communication later on. It might be that I disagreed with the management plan that they wanted me to implement, or I don't think I have disagreed with things that they've done later on but certainly have had it happen where I've sent a patient for a purpose, and I've said that's not appropriate treatment and people got stroppy about that.

See Appendix 4 (5.3.3.3 Disagreement in treatment, SMP6).

5.4.4 Referral and Patients' Role

The choice of specialist for referral sometimes goes beyond just seeking the best clinical expertise for the patient's diagnosis. The patient's personality, sex, religion, and culture must be considered when referring to an SMP. An RMT-informed view in this context might prescribe that a patient needs to be able to relate to the specialist; there needs to be rapport between patient and specialist for the patient to trust the specialist and comply with treatment. Australia is multicultural society, and therefore, certain religious and cultural backgrounds must enter the decision-making process when selecting a specialist to refer to:

> GP19: I think when you are referring a patient, you have to try to create a cultural shift, I think specialists are mostly so professional that the cultural shift doesn't need to exist, but if you are weighing up everything from the patient-centred point of view, taking into account a patient's psychosocial background, perhaps cultural views are important.

5.4.4.1 Patient's Choice in Referral

The role of the patient in the referral process is a factor a GP and a specialist must consider when choosing a specialist to further diagnose and treat a patient. According to the participants (GP2) the patient's viewpoint is an important consideration when deciding on a referral because the patient trust and treatment experience can be a factor in treatment compliance. The patient's choice is largely based on word-of-mouth referral from a family member, friend, or colleague; this form of choice can bring a sense of both control and comfort to the patient in a time when they are dealing with a scary diagnosis. However, when dealing with patient choice in SMP, the GP has to weigh the reputation of the specialist, the skillset the personality match between patient and specialist and previous patient feedback on the specialist.

GPs were asked about the role a patient's choice plays when they are choosing a specialist to refer to. About half of the sample (see Figure 5.8) asserted that the patient has final choice. The remaining GPs were more concerned with their own match with the SMP. A small number opined that patients do not have a choice here, although they will refer on the basis of location. Among the GPs who agreed that the patient has final choice, it is important to note that most of these would object if the patient's choice of SMP was incorrect on clinical grounds. The GPs said:

> GP4: Yeah, patient choice of where they go, because let's be realistic.

> GP2: If the patient has had a relative who's seen someone and then they told them: 'Look I'd like you to see this patient, you treated me so good'. That's word of mouth for them, and I go along with that.
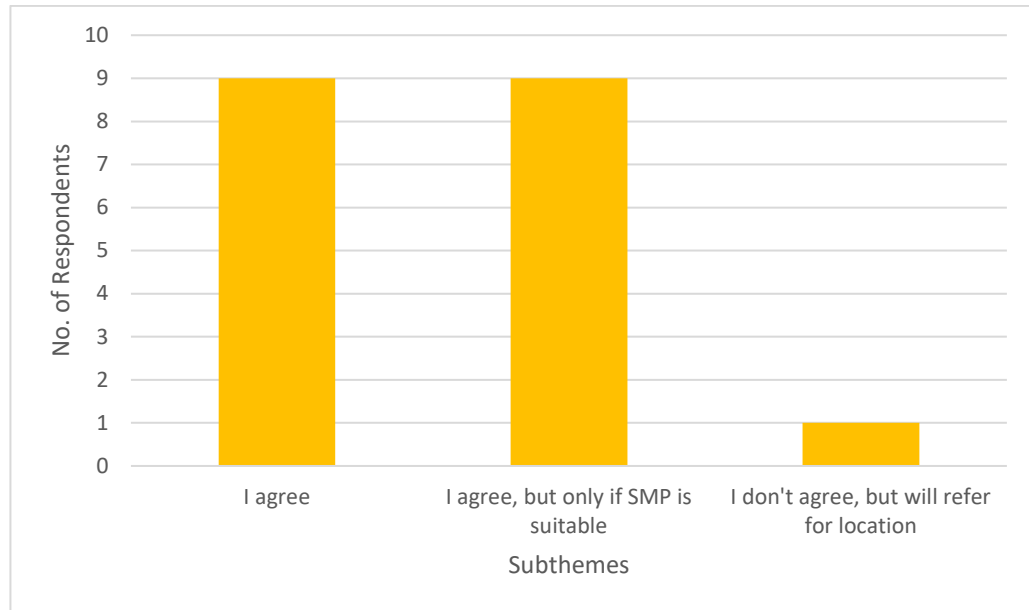
Figure 5.8: Patient's Role in Referral Process

The patient's choice of specialist may not be the soundest, and it is up to the referrer to discern what is best for the patient. If the patient has had direct experience with a specialist before, then there is an existing rapport and trust in the relationship, so referring back to that specialist is an obvious choice. However, if the patient's choice is based on the opinion of a family member, friend or colleague, and the referrer knows this specialist to be a poor choice owing to a mismatch of personalities, or if the specialist has a poor reputation or the situation is serious and requires prompt intervention and the waiting list for the specialist is too long, then the GP can influence the patient's choice by providing more suitable alternatives:

> GP5: Patients have a say, but not often, but when they do, I discuss with them to ensure the SMP is the correct one for their situation.

See Appendix 5 (5.3.4.1 The patient's choice in referral, GP8, 14).

5.4.4.2 Culture as a Determining Factor in Choice of Specialist

The role of culture as a determining factor in the choice of specialist must be considered by a referrer in multicultural Australia. Cancer and other diseases do not discriminate between race, sex or religion; all of these groups will require treatment, and it is necessary that they are paired with a specialist who can accommodate their cultural sensitivities:

GP1: That is important, for instance, you have Muslim women who would like to see;
e.g. Muslim, women, using religion here, would want to see a female rather than a male
and preferably their own, speak their language preferably.

Figure 5.9 summarises the subthemes that form the central theme of culture as a
determining factor in choice of specialist.
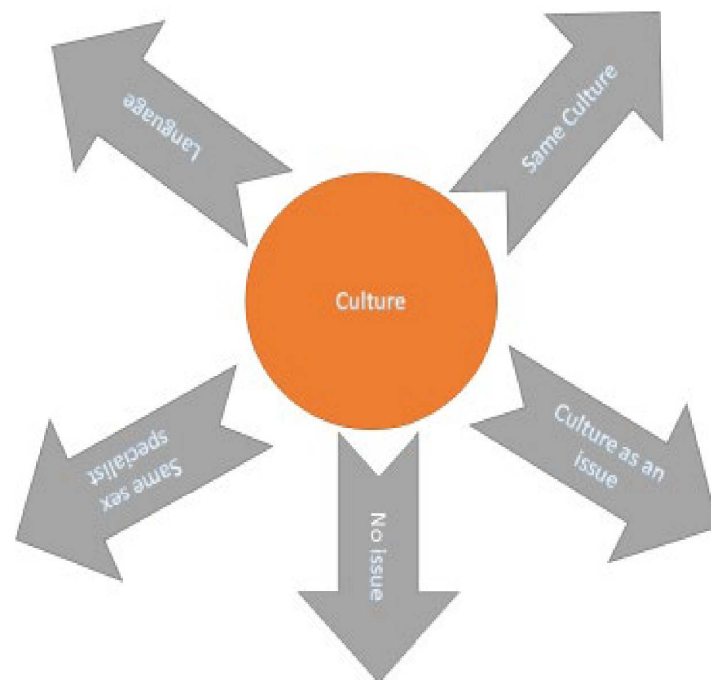
Figure 5.9: Cultural Influence on Referral Decision

5.4.4.2.1 Language as a Consideration

GPs identified language as a cultural barrier that needs to be addressed in the referral
process. An RMT-informed view might prescribe that the ability of the patient to have
unencumbered communication is essential for a satisfactory patient experience, and to
ensure the patient understands change in medication, next step treatment and the nature
of the diagnosis. Although Australia is a predominantly English-speaking country, many
residents do not speak English and an even a greater number do not speak or understand
English well. Pairing a patient with a specialist who speaks the same language is the ideal
outcome, but some of the rarer cancers that require subspecialties may not have a
specialist who speaks the referred patient's language; in this scenario, it is essential that
the patient have an English-speaking family member attend the consultation to speak on
behalf of the patient or an interpreter be organised:

GP6: The older migrant who doesn't speak English very well; then you send them off to a specialist who may speak the language and here I use 'may'.

GP17: Again, they've got to have good communication skills. It's really difficult when a patient comes back and says, 'I couldn't understand him, he kept talking and I couldn't really understand. My daughter told me what he said but I couldn't work it out'.

5.4.4.2.2 Same-sex Specialist

An RMT-informed view might suggest that a patient needs to feel comfortable with their specialist and trust them enough to speak freely; this may mean pairing a patient with a specialist of the same sex. Nearly half of GP participants reported that there are times when a female patient prefers to see a female specialist; often this related to religious belief. Preference for same-sex specialist was not limited to females; one participant reported that they would not refer an older male patient to a younger female doctor:

GP18: Well, it depends on the patient to some extent, some women, and I see a lot of women, of course, because I'm a female doctor, some women will prefer to see a female doctor where they can.

See Appendix 5 (5.3.4.2 Same-sex specialist, GP15, 16).

5.4.4.2.3 Referring to the Same Culture/Background as the Patient

Patients might elect to be referred to specialists of the same culture. Some GP participants reported that cultural backgrounds, such as same race and/or religion, were a factor in the referral process:

GP9: Well, for example in [location redacted] we have culturally diverse specialists, and I mean some of the old farmers they want an Australian.

See Appendix 5 (5.3.4.2 Referring to the same culture/background as the patient, GP7, 14, 15).

5.4.4.2.4 Non-emphasis on Culture

Some participants in the GP group identified culture as only of moderate importance in the referral process. These GPs saw other factors that were more important in the referral process and emphasised that patients trust their GP to refer them to the right specialist:

GP10: I rate this fairly moderately. I would not give this much importance in the area I practice at present.

GP11: I might do, yes. Depending on the patient rather than the specialist.

Table 5.3: Theme Summary of Significance of Professional Drivers and Their Relation to Clinical Judgement and Decision-Making during Referral

Subthemes	GP-to-SMP Referral	SMP Perspective on GP Referral	SMP-to-SMP Referral	Challenges in Referral Relationship	Referral and Patients' Role
Accessibility	✓		✓		
Correct speciality	✓		✓		
Communication	✓	✓		✓	
Interpersonal connection	✓				
Patient experience	✓		✓		
Location	✓				
Trust	✓	✓			
Cost		✓			
Collaboration		✓			
Respect		✓			
Clinical expertise		✓	✓		
Existing relationship		✓	✓	✓	
Reciprocity			✓	✓	
Disagreement in treatment					
The patient's choice					✓
Language as a consideration					✓
Patient's sex					✓
Culture					✓

5.5 Implications for High-value Service Provision in Australia's Private Specialist Medical Sector

In oncology, HVC is the aspect of practice that creates a positive experience for a patient while simultaneously trying to provide a positive outcome. HVC also involves providing a professional, patient-centric approach, holding the actions and inactions of the medical professional accountable to the highest standards of their peers in the field of oncology, their patients, and the medical profession. The themes and subthemes that were identified through the theoretical informants RMT and SET and through the lens of medical professionalism are summarised at the end of this section (Tables 5.4, 5.5 and 5.6).

5.5.1 Aspect(s) of Specialist's Practice Leading to Greatest Patient Satisfaction

Aspects of a specialist consultation that enhance satisfaction are important facets to explore when examining HVC. Following thematic analysis, the themes of patient experience, clinical outcomes, accessibility, and cost were uncovered.

5.5.1.1 Patient Experience

The patient experience was a strong theme that influenced satisfaction. Both RMT and SET informed views would suggest that patients want to be treated with personalised care, as both exchange and relational dynamics are at play here for patients who may find themselves at critically important points in their lives. Patients may want the specialist to take the time and explain the diagnosis and treatment in a language they understand and then be available to answer any related questions they may have. This expectation of the SMP (and thus driver of patient satisfaction) was borne out by GP observations of their patients' experiences:

> GP6: I think how the specialist has approached the patient and explained the problem to the patient is so important to the patient. They need to take a bit of time initially, for the initial consultation, particularly cancer medicine, that's very important and no disturbance in those times, not disturbed by receptionist at all. And he's got to explain it in simple terms.

See Appendix 6 (5.4.1.1 Patient experience, GP9).

5.5.1.2 Clinical Expertise

About half of the GP participants identified clinical expertise as a theme that brings patient satisfaction from a specialist's practice:

> GP2: A reduction in symptoms. Good outcomes.

> GP10: The way they deal with the patients, and outcomes patients can achieve from seeing an SMP, if that is beneficial to their problem.

5.5.1.3 Accessibility

Providing fast, efficient service in relation to appointment accessibility and communication can provide patient satisfaction through prompt service:

> GP3: Availability of an appointment, availability of procedures at public and private hospitals and helpful and friendly staff.

5.5.1.4 Cost

The affordability of the treatment will increase accessibility to the patient. Receiving treatment without undue financial stress will provide a level of patient satisfaction:

> GP9: Well, I think access, cost, out-of-pocket costs and the most important probably is the outcome of these specialists' treatment.

5.5.2 Aspects of Practice that Yield Greatest Value for Patients

It is important that the SMP practice provide value to the patient for building a positive reputation for the practice. The willingness of the practice staff to focus on providing value to the patient will translate to a better patient experience, improved clinical outcomes, greater accessibility, and affordable treatment. Providing value to a patient is to achieve a level of service that produces a positive experience, which will foster patient loyalty and promote positive engagement from all staff within the practice to garner a long-term relationship (Sardana, 2003). As a GP clarified:

> GP7: Not just the specialist, but their staff. I think the reception that they get when they go to that specialist is very important, very important indeed. Let me give you an example … the patient walks into the practice and they're made to feel that that's the

only patient coming into the practice. They're made to feel important; they're listened to and they make them feel comfortable.

5.5.2.1 Patient Experience

A good patient experience can be understood to be a personalised service that incorporates a mixture of traits, such as prompt service, empathy, interpersonal connection, patience, and accessibility. A negative patient experience can damage the reputation of the practice and derail the referral relationship with the GP. Patient experiences are often measured via patient feedback to the referring doctor. Most GPs indicated that patient experience was an important indicator for them that the practice provides value to the patient (Keating et al. 2004):

> GP17: You've got to have staff that attend to the patient when they arrive, nothing worse than hearing a patient say, 'I stood at the desk for 5 minutes while this woman fiddled around and ignored me', so that's number one. Introduction on the phone and when the patient arrives, then the welcome the specialist gives them, brings them in, gives them eye-to-eye contact, touches them, shakes hands something or rather.

See Appendix 6 (5.4.2.1 Patient experience, GP2, 6).

5.5.2.2 Clinical Expertise

Many GPs indicated that good clinical outcome is a strong factor in providing a valuable experience for the patient, because the disease is being managed:

> GP13: The good end result, really. That would be the ultimate. Yeah. When they're sick and they get treated and they get better.

See Appendix 6 (5.4.2.2 Clinical expertise, GP10, 16).

5.5.2.3 Accessibility

Being available and providing prompt appointments was an area identified by some GP respondents as an aspect of specialist practice that can provide value to the patient:

> GP3: How on time they are, how much, whether that could get everything done in one facility, how easy it was to get appointments, how long they had to wait to get an appointment, cost.

GP5: Availability of an appointment, availability of procedures at public and private hospitals and helpful and friendly staff.

5.5.2.4 Costs

The theme of cost was generally not the sole factor in respondents' answers but is an important aspect of providing value because the patient must possess the financial means to attend consultations:

GP14: Appropriately treated and managed, which implies respect and all of that stuff as well. Then, most times they feel that they've got value. So, part of that I guess, is if you…cost involved… people turn around and say, 'It cost me so much, but, you know, I thought that was money well spent'. Do you know what I mean? There is also cost.

See Appendix 6 (5.4.2.4 Costs, GP14).

5.5.3 Medical Professionalism: Professional Lens in Medical Practice

The wider Australian community expects the medical profession to have a high degree of professionalism in the way they conduct themselves in the delivery of care to patients (Royal Australian College of General Practitioners 2019). In addition to being assessed theoretically, the themes developed from the interviews were reviewed using a professional (medical professionalism) lens.

Medical professionalism accounts for qualities and modes of conduct that adhere to a societally agreed upon ethical framework. Practice must provide fulfilment of medical care, while meeting a social mandate that allows discretionary latitude in setting the standards for the education and performance of its members.

5.5.3.1 Competitive Advantage

SMPs with superior marketing skills are more inclined to secure referrals than their SMP colleagues. Traditional advertising methods are not permitted to attract patient referrals, so the SMP must network among colleagues and the GP cohort (*Health Administration Act* 1982). GPs described that the facets of forming and maintaining an interprofessional relationship are often founded on hearing the SMP present knowledge at small group presentations or conferences:

GP2: I think I might need an update on, and you get to know the specialists that way and you might choose to send someone because they've presented a talk.

GP12: Ok, well with the specialists, the best way is to go to all the doctor meetings where the specialists give lectures, and then, you just talk to them at the meeting and talk to them after the meeting.

The competitive advantage garnered by the skilful SMP presenter can create a situation such that some SMPs have extensive waiting lists of patients and other SMPs within the same speciality have relatively empty lists. However:

GP1: Availability. If I can't get patients in, after a while, I just don't bother.

The competitive advantage of strong interprofessional connections that are developed through publications and/or presenting at medical conferences and group learning can be lost simply by providing a poor level of service to the patient, which is ascribed through a negative patient experience:

GP13: The only time I will stop referring the patient to that specialist [is] if the feedback from the patients is bad. I think these days, most patients are well trained. I don't think there is anybody who is bad, in essence they did. They soon weed themselves out.

5.5.3.1.1 Bringing About Sector-wide Change to Facilitate Excellence in Service for Better Patient Outcomes

Subthemes identified by the SMP group participants, to bring about sector-wide change to enhance HVC, had a universal tie to uniformly improving accessibility for all patients to timely treatment, from all levels of medicine. Creating a non-competing system of medicine improves the utilisation of scarce resources and creates a better balance between public and private hospital systems, improving patients' accessibility to the SMP for timely treatment and augmenting the referral process to promote a more collaborative approach in referral decisions, and thus, ensuring patients are directed to the correct specialty (see Figure 5.10).
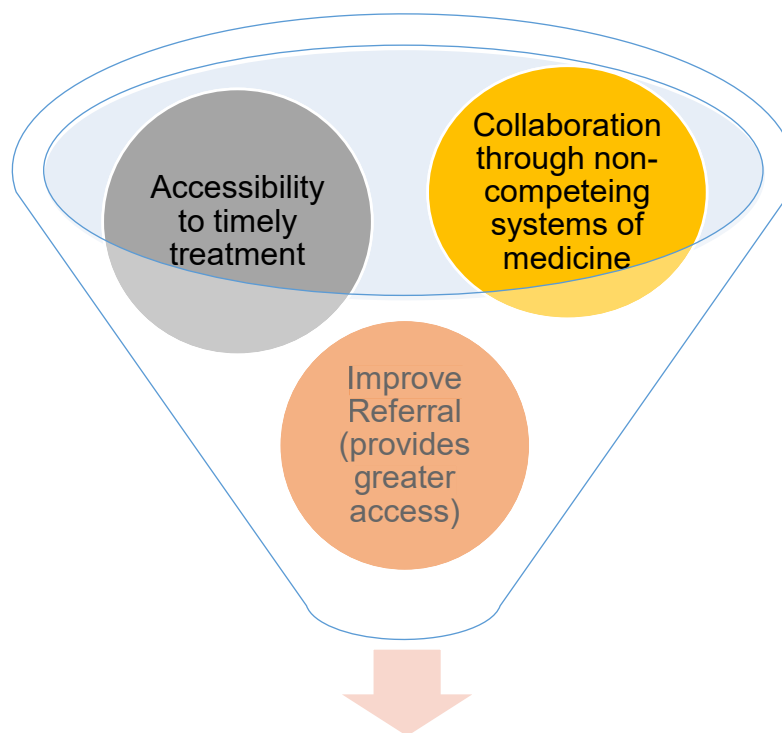
Bringing about sector wide change to facilitate excellence in service for better patient outcomes

Figure 5.10: Bringing About Sector-wide Change

1. A non-competing system of medicine for better collaboration

Some specialists believed that creating a system that is non-competing between public and private players would ultimately provide HVC. Such a view was often accompanied by a stated belief that the sole focus should be on providing the best outcomes for patients. There is little doubt that collaboration at system levels between public and private players would improve efficiencies, reduce costs and improve the patient experience (White & Collyer 1998). Improving relationships between GPs and specialists and having them practice in a more central location rather than in isolation would also likely improve collaboration and efficiency (Summerton 2000). One SMP expressed:

> SMP4: I think a more integrated public/private sector where it's not a competition for those that are privately insured but focuses on the best outcomes, which are almost certainly going to be a better price for the taxpayer, for all concerned. I think the problem at the moment is that there is competition for patients who are privately insured, and in many ways, they are helping prop up the public system. If they were

dealt with fully in the private system that would be ultimately a, quite possibly, a cost saving.

See Appendix 6 (5.4.3.1 A non-competing system of medicine SMP2, 3).

2. Accessibility to timely treatment

Providing prompt service with no waiting lists for treatment was raised as an important way to improve the patient experience. In the following quotation, the specialist indicates it as the reason for going into private practice. The participant also identified unethical practices in the public system in regard to double charging for treatments:

> SMP5: Yeah. I mean I think that there's a major rort happening in that government-funded medical practitioners or specialists are able to use resources that aren't theirs and cost the government for something that has already been paid for, so there's a lot of double dipping particularly in private radiotherapy. I mean that's why I went into private because I felt that it was the honest way of dealing with the situation. How do you ensure speed? We don't have waiting lists; we have prompt reviews.

Another specialist participant agreed with the abovementioned point regarding the need to provide patients with fast access to appointments, assessments, and treatment. However, this specialist differed from the previously quoted specialist regarding the benefits that can be provided by the large public system:

> SMP1: Yeah. Look, I think you've got to offer a good service to patients. Some patients will need to see you because of an opinion on some abnormal result, or because they have a disease that needs assessment treatment, and I think you have to offer them the world's best care or the current standard of care. If you can't do that, then you might have to refer on to the public system because maybe they are too complex to handle. I'm quite optimistic. I mean, I think the public system is very busy.

3. Improving the referral system to provide greater access

Competition in the referral system can be viewed through the lens of SET, in the sense that there exchange related differentials at play between actors and potential actors. Discussion about competition raised the possibility that it was a limiting factor in providing good service to patients. Respondents in the specialist group asserted that sector-wide changes in the referral system could facilitate excellence in medicine.

Specialist respondents suggested that in oncology, the referral process may be smoother if the initial decision-making is performed via a collaborative approach, such as an MDT meeting. This would mean that all specialists were on hand to facilitate diagnosis, and referrals could then be channelled to specialists who could provide the treatment for that diagnosis (Rosell et al. 2018). One SMP said:

> SMP6: I think what I would do would be to change the sector so that it drove initial decision-making through Multidisciplinary (this in cancer specifically), so that it drove initial decision-making through MDTs.

Reducing politics within the referral system in public hospitals, and adopting a collaborative approach for a more equitable distribution of referrals, could improve the patient experience by their gaining access to treatment by an available specialist, rather than having assessment and treatment delayed and waits to ensue for a popular specialist:

> SMP8: In my experience of the public sector, there's still too much competition among individual practitioners. Instead of working together, working together so having a more centralised process for distributing referrals.

5.5.3.2 Public Sector and Private Sector: Participant's Perspective on System-level Collaboration

Collaboration at the system level between the private and public sectors of medicine was examined in the interviews. The aim was to understand the respondent's perceptions of the differing approaches to care of the private and public sectors and to ascertain whether these differences influence collaborative efforts that can or cannot be undertaken by specialists working in the different systems (see Figure 5.11).
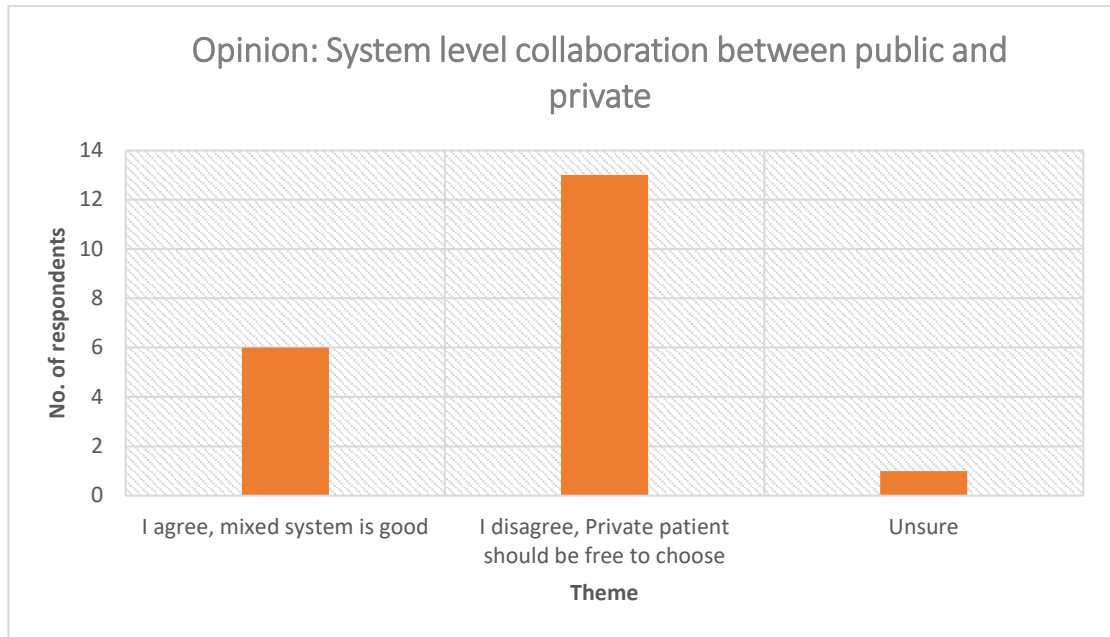
Figure 5.11: System-level Collaboration between Public and Private Sectors

The participants who believed that a mixed public and private system is beneficial (Figure 5.11) felt that a collaboration between the two systems was important to service the needs of the patient and provide a better experience. At a system level, the larger public system may have the ability to provide treatment and testing that some of the smaller private hospitals do not. It is the perceptions of the participants that the public system is often underfunded and can be overwhelmed by large patient numbers; and the private system could take some of the burden by providing greater accessibility to patients. Participants also drew comparisons between the balanced Australian model versus the heavily demarcated UK models where the public system dominates and the US system where the private system dominates:

> SMP17: The Australian health system is unique as it has a good balance between private and public. Just for example, in the UK it's completely or mostly public, and in the US it's completely or mostly private.

> SMP17: I think this model is good because if public hospitals cannot look after their patients within a reasonable timeframe, I think it is a good practice to outsource those patients to private system.

> Interviewer: But what about the public hospital trying to pick up private patients?

> SMP17: Again, if someone gets a better care within a good time period. So, if the best place for the patient is public hospital, then they should get the private health benefit.

> SMP12: I certainly agree. I think the public patients should, private hospitals should contract to treat public patients in appropriate environment, particularly when a public hospital is overwhelmed, particularly if you're looking at waiting lists and things like that and when you're looking at efficiency. There are certainly instances where the private could easily take public patients.

> Interviewer: Ok, what about public hospitals trying to pick up private patients?

> SMP12: I think xxx Hospital should concentrate on fixing itself up in the public sector before trying to compete for private patients because I think if you look at the models, the private invariably always works a lot more efficiently, whereas with the public, they're definitely not efficient.

The participants who objected to the system-level collaboration between public and private hospitals primarily did so because of the belief that public hospitals actively compete for the increased revenue that comes from private patients. This objection was mainly formed from a business-related viewpoint, rather than patient-centric reasoning. One SMP revealed:

> SMP6: So, I'm aware of a public hospital just where I work who's had a new private inpatient target put in front of it, you know in the 30% range.

Participant SMP5 built on SMP6's response by suggesting that a demarcation between public and private hospitals is necessary, in that public hospitals are specifically for public patients only and that it is unethical for public hospitals to compete for, or accept, private patients:

> SMP5: Public hospitals should not be competing for private patients, public hospitals should not be seeing private patients, end of story.... Anything else as a rort.

Participant SMP4 believed that the private system is more efficient and can provide better quality treatment at a lower price; and the public system is guilty of wasting resources on expenses that are not patient or outcome driven:

> SMP4: If there is a well-run, well-qualified private hospital with the necessary expertise, I don't see why they shouldn't have the right to contract and treat the public patients. They can do it efficiently, well and more cheaply. That's a win for everybody, for patients, for taxpayers.

Respondents that disagreed with system-level collaboration between public and private systems also agreed that there needed to be a collaborative approach between the public and private sectors for the benefit of the patient:

> SMP11: I'm not sure I agree, I think that the private system, or sector should complement the public health system, not work despite of it or in spite of it and vice versa. And I think public hospitals competing for private patients, well, maybe only from a funding point of view. But I think certainly private hospitals, being able to offer services, providing that, you know, it's a mutual win–win, can only benefit both availability and breadth of care and availability more for that point and I think clinical trials is a good example of that. So, I wouldn't necessarily agree I suppose is the answer.

5.5.3.3 Experience with Australian Health Sector Culture of Dependence on GPs for Referral

In Australia, the GP is responsible for deciding whether a patient needs to see a specialist, and then deciding which specialist the patient can see. This model is based on the premise that a patient with an ailment needs an assessment from a medical professional to find whether a specialist is an appropriate avenue for further treatment, and if so, which field of medicine is the correct choice to treat the patient. A SET-informed view might predict that this medical model gives the GP a lot of power over the referral process, and the GPs' choice can influence the flow of patients to a given specialty, as they function as exchange-initiators.

All specialists agreed with the model of medicine where the GP decides whether the patient needs a specialist. However, the degree to which the SMPs approved the model of medicine differed around the reasons that the specialists support the GP patient dispersal role. Participants believed that the system works well because the patient should not have direct access to the specialist and that the GP's role as gatekeeper keeps the system from becoming chaotic:

> SMP8: If you, as a specialist, are looking after someone, and I suppose a GP probably feel this way as well…. You don't want chaos, where patients are just going off and seeing all different people left, right and centre.

> SMP4: It's making, effectively, the GP the gatekeeper, which I think is actually a fair and proper thing to do …I don't think patients should be able to self-refer to oncologists

because they think they've got cancer. I think they really should go through somebody who can do some preliminary things; otherwise, we could be inundated.

One participant identified that this system relies on the knowledge of the referrer, and this can be a limiting factor:

SMP3: Knowledge of referrer. The truth is, and to give you an example, if I had to see an orthopaedic surgeon for a particular person, I wouldn't know who to refer to as best because I'm out of that area, but I'd contact the person with that knowledge and say who's the best person to refer to, using that example. I wouldn't just use a book and says this person's a knee surgeon, you know.

Another participant identified that the GP referral system works well because it provides continuity of care and is cost-effective and promotes collaboration:

SMP7: I think that it ensures that there is continuity of care; it promotes collaboration because you need to keep the GPs in the loop, and I think that it is definitely cost-effective.

Not all specialists were clear about their views. For example, a participant said they believe it works well because their specialty does not rely on a GP for referral, because they get most of their patients via specialist-to-specialist referrals. However, when the interviewer highlighted that an MDT meeting can be dysfunctional when there is a dominant personality controlling the referral-related decision-making, the participant changed this perception and favoured the GP in the gatekeeper role over the MDT meeting:

SMP2: I think the specialist, I think for us oncologists, it probably works quite well because the bulk of our referrals are from other specialists.

Interviewer: No, but for example, at the moment, the utilisation rate for medical oncology is less than 55% based on optimal treatment rates.

SMP2: Right.

Interviewer: So, unless you're the primary source of referral from the GP, the challenge that you face is … there's no Medicare access without a referral.

> SMP2: Some patients who I think would be better off if they referred to us earlier; in fact, there are many patients, I reckon, and even specialists sometimes refer them quite late. And this is really one of the most, and this is one of the leading causes of failure rates for cancer treatment in the UK, is in fact late referral, over 6,000 deaths a year…

5.5.4 Medical Error

Medical error is a major cause for concern in the delivery of quality health care; in fact, it is the third leading cause of death in the US (Makary & Daniel 2016). This thesis sought the perspectives of GPs and specialists on steps to be taken to reduce medical error through the referral process and from a systems perspective (see Table 5.4 for the representation of themes and subthemes).

5.5.4.1 Reducing Risk to Patient from a Specialist's Perspective

SMPs were asked about their expert opinion in reducing risk to a patient through medical error. From the data, the following themes were identified: providing GPs education to improve their knowledge on cancer and to enhance the referral process; improving documentation and communication; and improving the efficiency of systems to prevent mistakes.

5.5.4.1.1 Provide GPs Education to Understand Cancer Better and Enhance Referral Process

Many SMPs indicated that providing GPs quality education in oncology is a sound preventive measure to reduce medical error. Under this view, GPs do not see many oncology patients, and in the cases of rare tumours, the GPs might only see a couple of examples in their whole career. Increasing the education of GPs could benefit the referral pathway and prevent incorrect referrals that affect timely treatments. Reducing GP knowledge gaps in oncology diagnosis may result in quick and efficient referrals, along with improving the identification of what constitutes urgent referrals and avoiding over-referring:

> SMP13: I think it does need to go through a GP, probably still, you'd probably think about things like GP education. You could probably say that each GP will only see 10 cancer patients in their entire career, in fact, probably why they're all absolutely petrified as soon as there's a sniff of cancer comes their way, but with an ageing

population, you know, we're seeing an increasing incidence of most cancers, you know, the training that GPs get is pretty general and their continuing medical education is too.

See Appendix 6 (5.4.4.1 Provide GPs education to understand cancer better and enhance the referral process, SMP16, 9).

5.5.4.1.2 Improve Efficiency of Systems to Prevent Mistakes

Some respondents identified the necessity to improve the systems and protocols of treatment to reduce medical error. This might take the form of improving the efficiency of systems that the specialist uses to track the patient through the treatment process; alongside regular audits to ensure that the process the specialists and GPs in the collaborative team use are in alignment with expectations that are comparable to benchmarks set by hospitals. Standards set by hospitals need to be consistent from hospital to hospital, with guidelines set for specialists to adhere to; and regular audits to ensure expectations are being met:

> SMP5: Audit. Being able to show that you've got outcomes that are consistent with expectations…. you not only can do it at the hospital level, but you can also do at the individual level.

See Appendix 6 (5.4.4.1 Improve efficiency of systems to prevent mistakes, SMP3, 7).

5.5.4.1.3 Good Documentation and Communication

Maintaining good medical records and providing clear and concise communication are important areas to improve to prevent medical errors, according to some participants in the specialist group. Each contributing member of the collaborative team should provide thorough and complete medical records updated with legible handwriting, which document all consultations and all phases of diagnosis and treatment and list all patient medication and changes in medications:

> SMP12: I think one would have to be an improvement in our medical records…. You're relying on, prescribing off chemotherapy, it's done handwritten and there are no electronic records, so that would have to be one of my biggest things that I think puts patients at risk.

See Appendix 6 (5.4.4.1 Good documentation and communication, SMP14, 19).

5.5.4.2 Reducing Risk to Patient from GP's Perspective

GPs were interviewed on their expert opinion in reducing risk to a patient through medical error. From the transcribed data, this thesis identified four themes: Communication, education, accessibility, and collaboration.

5.5.4.2.1 Communication

The theme of communication was identified among the GP cohort as important in reducing risk from medical error. A SET-informed view might predict that communication efforts from all parties in the collaborative team can be a means of exchange that can strongly affect the patient experience. Strong communication begins with a thorough referral letter from the GP outlining the reason for referral as well as the relevant patient history and current medications. Participants identified that miscommunication or gaps in communication are areas that expose patients to the danger of medical error. The GP relies on a strong relationship with the specialist, and hence, in cases of emergency when the patient needs an urgent appointment, the GP can communicate with the specialist directly, using their relationship to leverage a faster appointment on behalf of the patient. As one GP stated:

> GP10: There are so many points where there can be miscommunication; Need to avoid miscommunication and have accurate medication records; accurate sharing of information, accurate history taking and accessibility to that information in a timely manner.

See Appendix 6 (5.4.4.2. Communication, GP8, 12).

5.5.4.2.2 Education

Increasing the education of GPs, staff and patients was a theme that some GP respondents identified as an area that could reduce risk to the patient. Improved knowledge could benefit the referral pathway and prevent incorrect referrals that affect timely treatments:

> GP5: Patient education for preventative measures for chronic disease and follow-up. The GP needs to follow up on the patient to reinforce the areas outlined by the SMP and thus ensure compliance.

See Appendix 6 (5.4.4.2 Education, GP4, 14).

5.5.4.2.3 Accessibility

The GP participants identified that early appointment, early diagnosis and early treatment are all important in reducing risk for the patient; in fact, delays in treatment are one of the components that constitute medical error. However, patients in rural areas do not necessarily have the same accessibility, particularly to the specialists and subspecialists who treat the rarer tumours. Providing greater access to treatment for patients in rural areas is an area that needs consideration at a system level:

> GP14: If it is time from seeing this, you know, and again here, we're fortunate, I think, we're blessed. Very often, we can get people to be seen very quickly, but the poor old doctor, a GP at 'Galarckenbone' who has to wait for the surgeon to come once every six weeks or something that sort of thing.

See Appendix 6 (5.4.4.2, Accessibility, GP15).

5.5.4.2.4 Collaboration

GPs identified increasing collaboration in diagnosis and treatment as an area than can reduce patient risk in medical error. Having diagnosis and treatment recommendations through an MDT meeting will provide multiple viewpoints from different specialities to help form a complete diagnosis, and then provide a treatment plan that is a collaboration from different specialties. The role of the GP in the collaborative effort is communicating with the patient, helping them understand the process, being an advocate for the patient in communications with specialists and making the patient feel as though the treatment is individualised and not just protocol driven:

> GP17: Perhaps if the GP takes a more active role in communicating with patients and the specialist what the patient really wants, getting that message across that we work as a team rather than the specialist doing what is the protocol.

> GP13: Yes, I would encourage more of that; sorry, I forgot about having more MDT meetings.

5.5.5 Forms: Need for Referral Forms to be Comprehensive and Complete

A comprehensive and complete referral form would provide the specialist with full patient information to commence clinical investigations for diagnosis and treatment. With all key

information provided, it will reduce the risk of both treatment delay and testing replication.

5.5.5.1 GP's Perspective on the Need for Referral Forms to be Comprehensive and Complete

GPs were asked about their opinion on the importance of comprehensive referral forms (see Table 5.5 for representation of themes and subthemes). Almost all agreed that this was needed. One GP disagreed about the need for a standardised referral, as the specialist should only be supplied relevant information to the referral (see Figure 5.12 for visual representation).
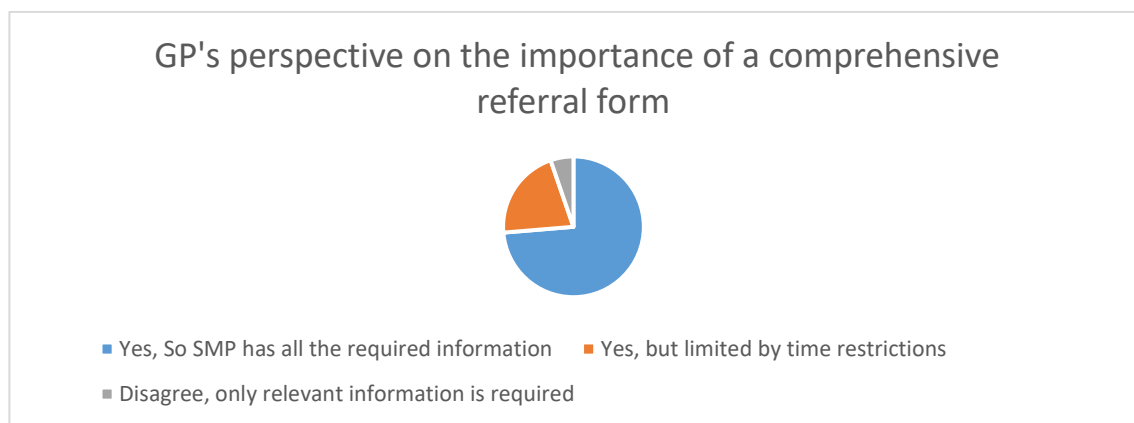
Figure 5.12: GP Perspective on Comprehensive Referral Form

Agreement was based on the view that the reduction of time to diagnosis and treatment can be achieved taking a comprehensive approach, and can result in the avoidance of replicating medical investigations and testing:

> GP9: I agree completely with that. Particularly with the first referral. I mean, you know, we do referrals and for the review-type referrals, the only thing I would put in would be if there's been a change in the situation of the patient.

See Appendix 6 (5.5.4.1, GP15).

A minority of GPs expressed feasibility-related concerns, given the limited timeframe of a GP consultation. Other participants felt that by providing complete and comprehensive information in the referral letter, they are encroaching on the role of the specialists and that the specialists only required information that is relevant to the actual reason for referral:

GP7: I think, again, that the GP has to refer to the reason why he is referring to that specialist, because it's beyond his competence or expertise and you don't know where that line is crossed. I don't think the GP should get involved in some area at which he has little experience and knowledge. I think the GP knows where the line is drawn, 'I can't deal with this, I am confused, I need a specialist for the problem'.

See Appendix 6 (5.4.5.1, GP13, 14).

GP16: Referrals have to be relevant …, the patient, the referral provide what is their main problem, what is their past history, what is their medications they are on, have they got any allergies that the specialist might put them on, but I don't think you have to go back and go through a full social history of a patient and their psychological profile, if they're looking for an in-grown toenail.

As noted earlier (5.4.4.1), the specialists were unequivocal in their opinion on the need for referral forms to be comprehensive and complete:

SMP19: Communication: It's all about communication. Medical error happens when appropriate information is not available and that goes from pathology services, radiology services, referring doctor services; so it's all about proper communication and proper documentation and continuity of communication.

Table 5.4: Theme Summary of Competitive Advantage

Subthemes	Aspects of SMP Practice that Bring Patient Satisfaction	Aspects of SMP Practice that Bring Patient Value
Patient experience	✓	✓
Clinical expertise	✓	✓
Accessibility	✓	✓
Cost	✓	✓

Table 5.5: Theme Summary of Medical Professionalism—Professional Lens in Practice

Subthemes	Bringing About Sector-wide Change	System-level Public–Private Collaboration	Culture of Reliance on GP for Referral
Non-competing system	✓		
Accessibility	✓		
Improving referral pathway	✓		
Agree with Australian referral system			✓
Disagree with Australian referral system			
Agree with system-level collaboration		✓	
Disagree with system-level collaboration		✓	

Table 5.6: Theme Summary of Medical Error

Subthemes	Reducing Risk to Patients: SMP Perspective	Reducing Risk to Patients: GP Perspective	Need for Comprehensive Referral Form
Educating GPs	✓	✓	
Improve system efficiency	✓		
Communication	✓	✓	
Accessibility		✓	
Collaboration		✓	
Agree with comprehensive referral form			✓

5.6 Perspectives on Sector-wide Changes Needed to Deliver High-value Care

HVC helps GPs and specialists to provide best possible patient care, while at the same time reducing superfluous health costs to the healthcare system (American College of Physicians 2012). HVC has a 'triple aim': better care for individuals, better health for populations and a lower cost of health per capita (Martin, Berwick & Nolan 2013). To achieve this threefold aim, the strategies proposed are a combination of relationship approaches, professionalism, and high-value service.

This thesis sought the viewpoints of GPs and SMPs through semi-structured interviews on what they believe is required to bring about sector-wide change, how to improve practice to increase patient satisfaction and what aspects of practice bring about the greatest value for the patient. The participants in both groups provided valuable insights into the components they felt were needed, and the changes they felt to be essential, to achieve the goals of HVC. After analysis, it was identified that some themes between GPs and specialists were quite similar. However, owing to the nature of the differences in treatment stages, there were also differences in responses (see summary of themes and subthemes in Table 5.7).

5.6.1.1 The GP Perspective

Themes around the promotion of HVC have so far emphasised improving the treatment experience and reducing costs. Subthemes such as greater accessibility to treatment, improved communication, GP education programs and treatment collaboration were all factors that were viewed to potentially enhance the patient treatment experience, while cost-reduction methods, such as reducing unnecessary treatments and reducing out-of-pocket expense to patients, also played a role in the provision of HVC.

5.6.1.1.1 Accessibility

Accessibility to treatment is a strong theme that GPs identified as a way to facilitate excellence in service for better patient outcomes. The participants believed that by providing more specialists in oncology to reduce waiting times and more cancer centres in both metropolitan and regional centres, and by incentivising specialists to practice in regional locations, accessibility to treatment could be improved:

GP7: I think proximity of service. Now, in the city and the suburban areas is very important because of the increasing traffic is very difficult. We have a lot of complaints. The patients have indeed, you and I complain about sitting in the traffic for hours, and that I think for the country people, well there's a big one. Must be hell because they have to chase up things that we don't really need to chase up because we are close by.

See Appendix 7 (5.5.1.2 Accessibility, GP9).

5.6.1.1.2 Communication

Accessibility to communication in a timely matter is imperative for better patient outcomes. To achieve this, referral pathways need to be improved and communications such as reports should be thorough; further, it should be ensured that the communication is delivered using reliable means, such as electronically, and not rely solely on a fax machine:

GP8: Ok, so there's one thing that kind of irks me a little bit that's creeping in and its specialists who ask for the GP to fax or send the referral over in some way so that they can then determine triaging the patient. But I think we need to know that something has happened to the patient…

GP1: Improve IT. Make it electronic. Make provision for E-record, which is accessible as an interdisciplinary support system. Need bidirectional communication. For example, we get discharge summary from hospital, and we need a way to correspond back with them if we need more clarification.

See Appendix 7 (5.5.1.2, Communication, GP8, 9).

5.6.1.1.3 Education

To improve patient outcomes, participants believed that being better educated on specialist treatments and on facilities and services available and on the roles the GP and specialists play in the collaborative process would facilitate a greater relationship with the specialist and streamline the referral:

GP2: I would say a better communication between the GPs and the specialists by facilitating better interactions through education facilities. Improving the awareness of facilities, service and ease of referral. Very often, the referral facilities are there, but how to get there is like going through the quagmire.

See Appendix 7 (5.5.1.2. Education, GP6, 1).

5.6.1.1.4 Reducing Unnecessary Testing and Treatments

Reducing unnecessary treatments in patients should be a priority in providing HVC. This aspect was identified as requiring sector-wide change. Moreover, identifying unnecessary practices and investigations, ending treatment when it is no longer beneficial and communicating effectively within the collaborative team to avoid repeating medical tests were all discussed and emphasised. Unnecessary treatment and testing are a financial burden, and avoiding doing so is valuable to the patient since they will not be subjected to treatments that hold no efficacy or medical benefit:

> GP13: Well, I suppose it's not duplicating investigations would be one of the major issues. You'd be surprised [name redacted] if I see my patients and I look back on the screen, they've got blood tests from today, they've got three separate blood tests or full blood count. How did that bloody happen? Right now, we should be on the pathologist's directive, that hey, wait a minute we've got three here. We'll just do one you know.

See Appendix 7 (5.5.1.2., Reducing unnecessary testing and treatments, GP17, 19).

5.6.1.1.5 Costs

According to some GPs, reducing treatment and pharmaceutical costs would make medicine more accessible to the population. Introducing a sector-wide price reduction in medical treatment would promote HVC to the population by allowing greater treatment affordability and therefore increased exposure to patients who would benefit from its availability:

> GP16: Number one is the ability to get quick access to a specialist, treatment is affordable to that patient, that waiting times for procedures are at a minimum, that access to these procedures is assisted, such as getting the radiotherapy, or they can afford the clinics.
>
> GP13: The costs of the treatment. I'm talking about medications, yes, pharmaceuticals.

5.6.1.2 Specialist Perspective

Factors that SMPs identified as potential maximisers of HVC were providing a comprehensive multidisciplinary approach to medicine that considers system-level changes, which seeks to improve every aspect of practice; reducing unnecessary testing and treatment, to save money and preserve the patient; providing better referral pathways to reduce time to treatment; improving accessibility to treatment in cancer care; and practising evidence-based medicine.

5.6.1.2.1 Improve Systems to Reduce Costs

Respondents in the specialist group identified that to maximise HVC, many changes are necessary, implementing which might result in systemic change. Changing the system in which they operate meant examining what constitutes a feasible caseload in a given timeframe while still providing quality treatment; ensuring that a patient received timely treatment; and operating out of a facility that could provide a variety of specialist treatments and testing. It is also identifying that SMPs with specialist knowledge, are a part of a system they need to work within. SMPs said:

> SMP3: I think you need to have efficient systems in place and structures… the ability to see your case load in a given timeframe, to provide timely care, to have an efficient and co-located, ah, in other words, you need to have a purpose-built facility but for the purposes.

> SMP6: The nature of specialist training is that it's very focused on its very problem specific. You know, doctors need to, doctors would benefit from standing back and looking at the fact that they actually do work in a system, not only that but they have an important leadership and custodial role within the system.

5.6.1.2.2 Reducing Unnecessary Testing and Treatments

SMPs identified the need for sector-wide change in terms of identifying unnecessary practices and investigations, concluding treatment when it is no longer effectual and working in a collaborative system with affective communication to avoid repeating diagnostic investigations. A reduction in unnecessary treatment in oncology can reduce costs and increase patients' quality of life. For instance, an SMP stated:

> SMP11: I think we do a lot potentially, we do unnecessary tests as well, and certainly rationalisation of, for example, simple things, repetitive blood tests for example, you know, have clear guidelines of how often we should do things, when things are unnecessary, when things shouldn't be rebated if they're done too frequently for example. In all of those accumulative, where, for example, high-cost scans may have a better impact whereas low-cost scans which we do more readily but far more inappropriately ... Let's base that case along with better technology.

See Appendix 7 (5.5.2.1. Reducing unnecessary testing and treatments, SMP10).

5.6.1.2.3 Prioritising Evidence-based Medicine

Practising evidence-based medicine in oncology to provide HVC was discussed in relation to the use of experimental medicine, or medicine with a low percentage of success in oncology patients. Some SMPs saw this as important for both the patient and the medical industry. From the patient's perspective, experimental medicine or medicines with low success rates could subject them to unnecessary side effects, decrease their quality of life and subject them to unnecessary costs:

> SMP13: I think some of it will come down to providing evidence-based care so that we're providing treatments that have got solid evidence behind them. Because the follow-on from that would be that you have better patient outcomes, that overall, it will be better for the population and that in the long run it would, would presume will balance out to have a lower cost per capita as well. You've got to look at measures like quality in terms of life years and, you know, what the cost–benefit ratio is.

See Appendix 7 (5.5.2.1. Prioritising evidence-based medicine, SMP8).

5.6.1.2.4 Improving Referral Pathways

Improved referral pathways result in patients being referred to the appropriate specialist or subspecialist in order to reduce the time to consultation and to treatment. A better referral pathway also means that patients are referred to MDTs, which provide input on the diagnosis and treatment plan from a variety of specialists including medical oncologists, radiation oncologists, and surgical oncologists, rather than the patient seeking multiple 'second' opinions and delaying time to treatment:

SMP12: Okay, so for captivations; appropriate referrals to treating physicians, appropriate referral through a multidisciplinary—so rather than patients seeking lots of second opinions, you have one appropriate.

See Appendix 7 (5.5.2.1. Improving referral pathways, SMP2).

Referral based on oncological specialty rather than individual SMP could improve accessibility and reduce time to treatment. Some GPs seek patient input and provide choices for the referral. This process may be smoother if the patient is to be provided with an open referral and could then go seek from the list the SMP available first:

GP4: The first question, I say is, 'Are you going to be a public patient or a private patient? If you're private patient, I can give you a shopping list of specialists and you can go to the [redacted], you can go to the [redacted] or the [redacted]…?'.

GP16: The patient has full choice of who they see, and a number of patients will have a doctor that they have already researched that they will want to see.

These examples highlight a referrer's role as an advocate for the patient and to refer, not only based on clinical needs, but other factors as well, such as a patient's wishes.

SMP13: So there are instances for breast and radiotherapy that I could write the referral to the two and then it just gets triaged as to who's got the first appointment, the first patient slot.

SMP8: In my experience of the public sector, there's still too much competition among individual practitioners. Not necessarily in all hospitals, but in the hospital that I work in, it certainly happens. Instead of working together, working together … having a more centralised process for distributing referrals.

SMP20: That, you know, it's up to you to know when that patient's appointment is that you've referred, and if it's not within a reasonable length of time, whatever that might be, then you need to refer on to someone else.

SMPs recognise the dangers of delayed treatment due to inability to obtain a timely consultation, by highlighting the pitfalls of having to go back to the doctor for a second referral because the initial SMP referee was too busy to see the patient. This is a prime example of the value an open referral could have for improving accessibility.

5.6.1.2.5 Addressing Accessibility

Access to specialist oncologist and subspecialist with a range of training and experience in different cancers was often identified by SMPs as potentially maximising HVC. Accessibility to well-equipped treatment centres with specialists available for timely treatment can also be linked to HVC.

> SMP11: Well, I suppose, red tape is a large component isn't it; I think bureaucratic hurdles and paperwork, I think that's got to be an inordinate amount of cost. I think the, you know, if you look at, for example, in a sort of bed-to-bed manager ratios, those components, I mean I know that goes with that infrastructure, but it's cutting out the middleman from that point of view, so there's less middlemen, more of those on the coalface, clinicians, examples; so not taking away from that but taking away from what's behind them.'

See Appendix 7 (5.5.2.1. Addressing accessibility, SMP4).

5.6.2 Overcoming Challenges

The participants in the specialist group were asked in a semi-structured interview what do they feel needs to change in the medical process to overcome the challenges in the present system. Three key themes emerged: review bureaucracy, incentivise high performance and reduce costs (see Figure 5.13 for an overview).
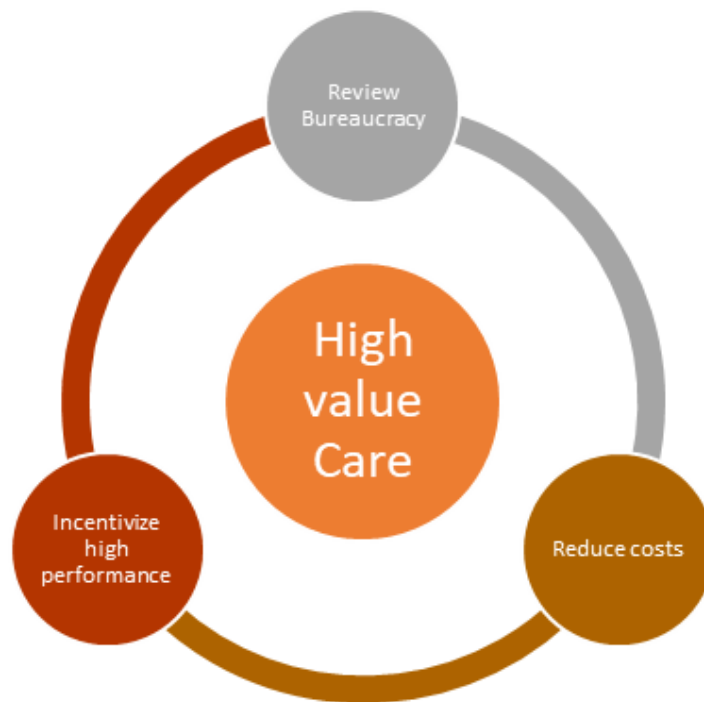
Figure 5.13: Overcoming Challenges in High-value Care

5.6.2.1 Review Bureaucracy

Bureaucracy in medicine needs to be examined and re-evaluated by focusing on the patient experience as they transit through the different systems (public and/or private). The issues of process standardisation and eliminating inefficiencies were often raised. The idea of having a unified board between public and private sectors that works towards eliminating conflicts of interest was suggested. This approach would drive work that sought to provide a standardised system for the patient to follow when entering different hospitals and treatment centres. Such developments would improve their experience by providing a level of comfort in the consistency of the treatment approach:

> SMP2: I mean, on a health-system scale, on a national scale, it has to be a political answer. I think there needs to be an overhaul. I suppose the other way of doing it is to actually provide what we can… if we use the patient as the agent of change and increase efficiency and care for the patient, then, hopefully, we get rid of the conflicts of interest, the multiple conflicts of interests, so using the example of that. So, using that example of the patient who turns up for the first time in a cancer centre, it's very confusing because they have, they get told what to do because that's the system that works at that

hospital, and by the way that system is different to the next hospital. So, if we make the system efficient for a patient.

SMP3: The challenges are in bureaucratic barriers for shared care between different sectors. Bureaucratic barriers for clinical research across campuses, fear, ignorance of the respective values and the strength of its system, and I would say that this is an important one; this is an unnecessary fear of competition.

Interviewer: So, how can the challenges be overcome?

SMP3: Streamline public sector of bureaucracy and have boards that are represented by both public and private sectors.

Interviewer: Represent patients?

SMP3: Across all sectors and aim for idealistic goals rather than individual sector goals; aim for the greater good, if we all aim for the greater good, then we can do it.

5.6.2.2 Incentivise High Performance

SMPs emphasised the importance of incentivisation, whereby HVC is recognised and rewarded, and high-value practice is promoting standards of care that will be recognised among peers. Low value practices should be disincentivised.

SMP6: You can incentivise high-volume practice, you can disincentivise low-value practice, and you can recognise and reward quality care.

5.6.2.3 Reduce Costs

Reducing costs to improve accessibility to consultations, testing and treatment could help overcome challenges to improve patient outcomes. Not all pharmaceuticals are listed on the pharmaceuticals benefit scheme (PBS), which makes them much more expensive, and in numerous cases, unaffordable to the patient. In the case of oncology, a drug that is not PBS listed may be too expensive for the patient and could prevent them from being able to access the best available treatment to combat the disease or a drug to relieve side effects and thus enhance a patient's quality of life. Such a scenario is contrary to the SMP-expressed goal of *evidence-based medicine* (Section 5.6.2.1.3), given that respondents opined that all treatment should be evidence-based, and that the use of experimental medicine in cases where the chance of treatment success is low should be avoided:

SMP14: Choosing the correct drugs for the correct patients using tumour markers and other BM guidance to achieve the most efficacious results, because pharmaceuticals are such an expensive component of care. Much research now (trials) is looking at reducing doses, or stratifying treatment modality; seeing how that impacts, which could reduce costs; retain efficacy. Also good for patients because it reduces (side) effects, toxicity and costs.

SMP18: Yeah, well I think quality care wastes less money than our current funding structure, which is activity-based funding. If we had outcomes-based funding, where funding was based on the quality of the care provided by measurable outcomes, and that would involve collecting a lot of data, because you can have a lot of, because there's no discouragement of getting it wrong and having the patient have to go through extra treatments, at more expense, unnecessarily.

Another respondent suggested that accessibility to expensive pharmaceutical therapy could be improved through a three-way split of payments between the government, the pharmaceutical company and the patient:

SMP9: The cost of medicines, all anticancer medicines are expensive. The government is finding it impossible; it is a huge challenge to keep paying for these drugs. There are newer therapies (immunotherapy), no end in access; nowadays, the government is putting up barriers to drugs coming into PBS. In future, it will be cost-share basis that patients have to pay a certain amount, unless there is evidence that these drugs have an overwhelming benefit for many. Stage I is expensive—financial toxicity caused by immunotherapy; and Stage II = 50:50 split; perhaps a three-way split between the patient, the government, and the drug company.

Table 5.7: Summary of Themes from Perspectives on Sector-wide Change

Subthemes	GP Perspective	SMP Perspective	Overcoming Challenges
Accessibility	✓	✓	
Communication	✓		
Education	✓		
Reduce unnecessary treatment and testing	✓	✓	
Costs	✓	✓	✓
Prioritise evidence-based medicine		✓	

Subthemes	GP Perspective	SMP Perspective	Overcoming Challenges
Improve referral pathways		✓	
Review bureaucracy			✓
Incentivise high performance			✓

5.7 Chapter Summary

Participants in this research were interviewed about their interprofessional referral behaviours and beliefs using a semi-structured interview plan. The transcribed interviews were analysed with reference to two major theories of human exchange, SET and RMT, and also more context-specifically, in relation to the doctrine of medical professionalism. The perceptions of GPs and specialists about the referral process, the role of the patient in the referral process, the development and maintenance of interprofessional relationships, the role of clinical judgement/decision-making and the goal of providing HVC were major topic areas canvassed. A model was developed (Figure 5.14) as a visual representation of how the results were formulated.
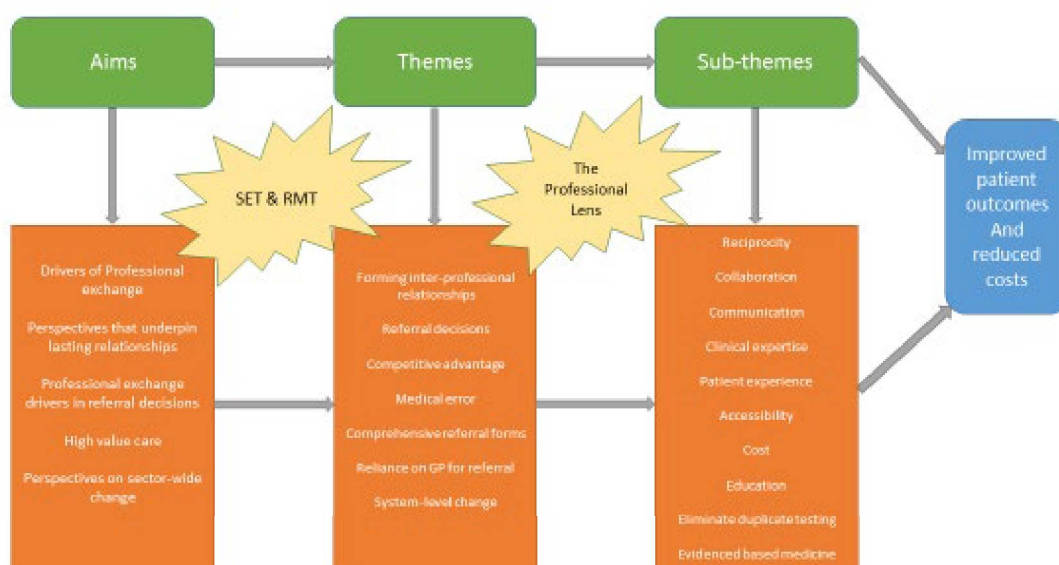
Figure 5.14: Model of Result Formulation

Both SET and RMT were regularly, although not always, predictive of self-reported behaviours and attitudes. SET highlights reciprocity as a core driver of behaviour in exchange relationships. In the thesis study, this was not always found to be so. In particular, it did not emerge strongly when SMPs were discussing their referring

relationships with each other and with the maintenance of their professional relationships over time. Other factors, such as perceived clinical ability and experience-related feedback from patients, were of greater importance. In addition, GPs did not emphasise reciprocity as a driver of their decision to refer to an SMP, nor their maintenance of a relationship with an SMP. Instead, a 'proxy-reciprocity' was described, in the sense that the reciprocity at play in their relationships with SMPs was not personal or self-focused, but external or patient focused. In this way, reciprocity was at play in the GP–SMP relationship as it existed 'on behalf of' the patient. Both RMT and SET emphasise collaboration and communication, although, again, these co-related factors were not always emphasised by SMPs in relation to their relationships with each other. Differently, GPs did emphasise communication in terms of both referring to, and maintaining their relationships with, SMPs. GPs tended to emphasise collaboration, not so much with referral, but with ongoing relationship maintenance. Moreover, for GPs, collaboration was closely linked to risk reduction as it relates to medical error.

Trust is a core component of both SET and RMT. This factor was confirmed by the participants as a fundamentally important aspect of the referral and interprofessional relationships that are formed between GPs and specialists in the Australian oncology setting.

Chapter 6: Discussion

The work of an intellectual is not to mould the political will of others; it is, through the analyses that he does in his own field, to re-examine evidence and assumptions, to shake up habitual ways of working and thinking, to dissipate conventional familiarities, to re-evaluate rules and institutions (Michel Foucault, 1971, cited in Downing, 2018).

6.1 Overview

Chapter 6 discusses the literature around the themes that were explored and reported on in Chapter 5. This qualitative research project explored aspects and dimensions underlying each theme, as they relate to the social exchange relationships between medical professionals. Two seminal psychological and sociological theories—SET and RMT—were employed as informants of the thesis focus on interprofessional exchange relationships and were subjected to critical review via the lens of medical professionalism. This chapter performs a pragmatic and critical analysis of data arising from seminal and modern studies against the themes that emerged from the results reported in Chapter 5, to contextualise and establish the quality of the themes and to determine any knowledge gaps for future exploration.

6.2 Drivers of Professional Exchange Relationships that Determine Referral Practices

6.2.1 Respect, Collegiality and Reputation

Drivers of professional exchange relationships that determine referral practices start with the original meeting and the formation of the interprofessional exchange relationship. Building and maintaining relationships is an essential component in helping a patient through their journey to better health.

Reliance on relationships, the respect garnered during a medical career and the capacity of professional networks to influence referrals and help patients jump the bureaucratic queue in times of emergency can be of great benefit to the patient. However, the system is less than perfect if it does not recognise the merit of the medical need of the patient as enough to warrant referral to urgent care but allows reciprocity as a means to promote patient advancement in the queue. This is highlighted by participants in a 2015 British

study (Green, Atkin & Macleod 2015), in which participating GPs relied on guidelines and the 2-week-wait (2WW) urgent referral routes for potential cancer symptoms. Although GPs valued the 2WW idea, they also highlighted its limitations when symptoms do not meet guideline criteria, causing referral criteria to become a barrier. Several GPs called for a generic route for suspicious symptoms, without success. GPs had strategies to overcome some of the barriers, although they could manage this situation more easily when they had opportunities for dialogue with secondary care colleagues. Participants perceived that the primary/secondary care relationship had changed over time, as cancer care at secondary level became more specialised. For example, 'You know they're not going to be seen for eighteen weeks unless you do something, but they don't fit the two-week pathway, so what do you do?' (Green, Atkin & Macleod 2015, p. 44)

Harris et al. (2016) described that a system that prevents the GP from referring to a named specialist (a specialist with a strong reputation) may inhibit referrals. This SMP group also considered that a high workload may make GPs more likely to refer, in an attempt to reduce follow-up appointments. This view is in line with the results of this thesis, which found some GP participants reporting that they will refer to SMPs with whom they share an existing relationship; however, the theme of accessibility was very strong in the GP cohort of this thesis as both a means to promote referrals to a given SMP or cease referrals to a given SMP in favour of an SMP who can provide prompt appointment times to the patient. The participants in the thesis research did not report that they refer patients to reduce their busy schedule, as indicated by Harris et al. (2016).

6.2.2 How Relationships Are Established

Medical practice is often a collaborative effort of a well-functioning team and support staff; no one medical professional can fulfil all roles for every patient. The GP has a generalist nature in medicine and can resolve minor medical matters; however, when the patient presents with a complex problem, the GP will need a network in order to refer patients for expert consultation. Forming interprofessional relationships is an important aspect of medical practice; as discussed, no databanks of specialists are available for the GP to use when searching for a specialist, and hence, they are required to build a network. SMPs are faced with the same dilemma; however, the reasons for GPs to form interprofessional relationships differ from those of the specialist. GPs are the frontline of medical treatment; all initial referrals reside with the GP. When they are confronted with

a patient with a complex disease, such as cancer, the GP needs to have a network of specialists to refer complex cases to. SET and RMT can help us to understand how this gap in specific medical knowledge forms the basis for the GP to build interprofessional relationships with specialists.

Examining the basics of relationships can help us to understand inter-professionality. Alan Fiske (1991, 1992, 2004) brought to life RMT as a four-factor process that explained social life as a process, with people generally wanting to relate to each other and feel a sense of commitment and obligation to their relationships. This process entails seeking, making, sustaining, repairing, adjusting, judging, construing, and sanctioning relationships. However, RMT does not necessarily accommodate the reality that relationships are often formed on a premise of 'give and take'. This is where SET can be helpful in driving understanding. Seminal research by Blau (1964) postulated that a social exchange involves unspecified commitments and leads to feelings of personal obligation, gratitude, and trust, unlike a pure economic exchange.

Using RMT and SET, it is possible to analyse the themes arising from this thesis research against published research, and the findings of the literature review (Chapter 2), to seek a complete picture of the formation and development of interprofessional relationships in oncological medicine and their effects on the patient through the referral process.

The research result chapter (Chapter 5) has established that the GP and/or SMP may have already established referral networks by connecting or meeting colleagues through prior working environments, such as hospitals and shared practices, or by other means, such as university, church, and other social groups. Having established relationships through common interests, education or group affiliations allows the relationship to grow beyond just medical need and to include common interests that may improve communication between the medical professionals.

To help understand how interprofessional relationships are formed, revisiting Walshe et al.'s (2008) study is informative. Examining the factors that fortify the referral practices of healthcare professionals who provide general and specialist palliative care services, they identified personal, interpersonal and interprofessional factors that determine two core influences:

- perceptions of their own role in providing palliative care, their expertise, the workload, the nature of palliative care and the relationship with patients; and

- insights about the professionals to whom the referral is made, what they could offer the referee and the patient.

It became evident in this study that assessment of the patient's needs was not the sole factor determining decision-making (Walshe et al. 2008).

While understanding about fellow professionals and the services rendered was a key factor in making referrals, participants had poor comprehension of how other professionals work; while acknowledging the variability in professional work patterns, the participants of this research tailored referrals based on their level of awareness of the skill levels and the given specialty of the referees (Walshe et al. 2008).

Lubloy, Keresztjuri and Benedek (2015) examined the interprofessional relationships between GPs and specialists and their impact on patient health and pharmacy costs in Hungary. They found that doctors initially entered into informal professional relationships. Such findings are congruent with the thesis results, which found that a communication approach the SMPs used was to cold-call a GP to inform them of their services. In addition, GPs and SMPs both reported SMP attendance at small group meetings to give talks about their specialty, in the hopes of forming mutually beneficial relationships. Such activity can be understood as a 'seeding' of potential exchange relationships, as described by SET.

The relationship progresses from informal to formal when actual beneficial exchange has taken place.

According to the literature discussed in Chapter 2, trust is recognised as a central component to any interpersonal medical relationship (Pearson, S. & Raeke 2000). Trust resonates strongly with doctors as well as patients. The absence or presence of trust in healthcare relationships can have life-changing consequences for all (Thom, Hall & Pawlson 2004). This is particularly so in relation to high-value professions, such as clinical medicine, where the professional domain is ethically bound, but inherently relational, in the sense that the activity of one medical professional is often ignited by the referral of another.

A European study by Hackl, Hummer and Pruckner (2015) highlighted that not all interprofessional referral relationships are built on strong foundations. They noted that the role of old boys' networks in GP referral behaviour was still strong, and that GPs often referred patients to SMPs within their personal network. Although such behaviour has a likely strong foundation in trust and friendship, it does not account for the fundamentally important patient-centric aspects, such as SMP accessibility and the relevance of the SMP skillset to patient diagnosis. These authors also claimed that GPs often referred patients to an SMP who graduated from their alma mater; while this may reinforce interprofessional relationships based on reciprocity, again, it lacks the patient-centric aspects of referral. The results from the thesis research hold some similarities to the research discussed, in that some participants from the GP cohort referred patients through collegial relationships that were built on trust, strong interpersonal connections and communication; however, patient-centric themes such as accessibility, clinical expertise and overall patient experience, were also highly valued.

6.2.3 How Relationships Are Built on and Maintained

Interprofessional relationships in the oncological setting between GPs and specialists are an integral part of the patient experience. At one level, they are built upon clinical need; the referrer does not have the requisite skillset to address the patient's disease and hence needs to refer to a specialist who can. However, upon examining the transcripts from the semi-structured interviews using the lenses of RMT and SET to formulate the results in Chapter 5, it was discovered that many other aspects transcending clinical need go into both building and maintaining an interprofessional relationship that is mutually beneficial to the referrer and referee. The thesis results suggest that aspects that both enhance and impede a professional relationship include trust, interpersonal connection, communication, accessibility, reciprocity, collaboration, and the patient experience.

Abrams et al. (2003) proposed that in many organisations, informal networks are the primary means by which employees find information, solve complex problems, and learn how to do their work. In the different context of professional medical practice, this proposition aligns with the results in Chapter 5: GPs were found to use informal team meetings to confer with their colleagues, and specialists were found to often present their expertise via education at these meetings. Specialist-led MDT meetings where parties come together to help formulate a diagnosis and treatment protocols for the patient can

also be viewed in this light as relatively informal exchanges that help to form interpersonal relationships.

Interpersonal trust can be defined as 'the willingness of a party to be vulnerable' (Abrams et al. 2003). In the context of knowledge creation and sharing in informal networks, research suggests two dimensions of trust that promote knowledge creation and sharing: benevolence ('You care about me and take an interest in my well-being and goals') and competence ('You have relevant expertise and can be depended upon to know what you are talking about') Abrams et al. 2003). People are likely to rely on the benevolence of a given colleague in determining the extent to which they are forthcoming about their lack of knowledge. Asking for information or advice can make a person vulnerable to another. Benevolence-based trust allows one to query a colleague in depth without fear of damage to self-esteem or reputation.

The imparting of knowledge by specialists at informal GP network groups can be viewed as an act of benevolence; however, this was discussed by participants in the thesis research more as an exchange method. That is, the specialist imparts knowledge so that the GP can make better referrals.

Any referral relationship in health care is a representation of the willingness of one party to acknowledge they do not have all the requisite skills to address all the health concerns of a patient; hence, referring can be seen to operationalise a willingness to be 'vulnerable' as described by Abrams et al. (2003), by placing one's trust in another healthcare provider. In addition to benevolence, the referee that the referrer is placing their trust in must possess the competence to attend to the patient; these two components of interpersonal trust as described by the authors emerged strongly in the thesis research. However, for specialists, factors other than just vulnerability come into play—there was also reciprocity in referral. As noted in Chapter 5, in SMP-to-SMP referral, some SMPs want referrals to be a two-way proposition.

Benevolence-based trust is an important factor in the context of an MDT meeting since involved participants need to trust that they are free to provide input on the given subject without fear of ridicule of dismissal. A succinct quotation from a specialist in the research by Walshe et al. (2008) concisely describes the impact of benevolence-based trust, and the ability/inability to speak freely without fear of judgement and damage to self-esteem:

That is relationships and personalities, which GP I am dealing with, and that is down to negotiating, but unfortunately, it's not negotiating on a professional level is it. It is about personalities. The minute I falter, he is going to say no and that's that … Well, mention your name and it's 'on her again, I don't want to know'. A lot of it is about knowing your own GPs and chipping away and knowing how far you can go in one telephone conversation and think right, I've gone too far now, we'll just finish this and I will maybe ring back with a different tack next week. (p. 143).

6.3 Perspectives Underpinning Lasting Professional Exchange Relationships

6.3.1 Role of Trust from a GP's Perspective

Trust is fundamental to effective interprofessional relationships; we trust that people are who they claim to be and will meet the obligations of their given role (Mechanic & Meyer 2000). Simpson et al. (2007) referred to trust as a fundamental construct that transmutes the meaning of other attributes and descriptors of a relationship.

Trust is fundamental to all relationships in the GP–SMP paradigm; this was well established in the thesis results whereby the GP participants stated emphatically that it was essential to the referral relationship. The role of trust between GP and SMPs was explored by Van Leeuwen et al. (2018), who examined how SMP–GP trust can be an essential component for the GP to perform their duties in oncology care: 'as the meetings ensure steady contact and easy accessibility to ask questions [to the specialists].… I think it is important for the GP's motivation' (p. 173).

Trust relationships in health care exist between the patient and the health professional, or between one professional and another. In the thesis research context (GP–SMP relationships and SMP–SMP relationships), trust was a theme that appeared strongly in the GP group as a driver of relational success. The role of trust is central to the relationships between specialists, referring doctors and patients; it is essential that each participant play their role, from the GP's initial management of the patient, through to the specialist's role in diagnosis, treatment strategy and treatment outcome.

The results from the semi-structured interviews suggested that at the point of referral, the GP must trust that the specialist has clinical expertise, empathy, open communication and the willingness to collaborate, so that the patient's best interests can be met.

6.3.1.1 Trust in Clinical Expertise

A cancer diagnosis is a distressing experience for a patient and their support network; the patient will trust the GP has the facilities and network to manage their condition and that when the disease exceeds the GP's skillset, the GP will find them a specialist who will help them. The ability, training and knowledge of the specialist are important factors that constitute the clinical expertise of the specialist, and the GP and the patient trust that these attributes will help resolve a serious medical issue and subsequent emotional turmoil. Most clinical expertise is a strong motivator in the referral relationship; it can often be the only driver of trust in the initial stages of the referral when the specialist is an unknown entity to both the patient and the GP (Barnett, Song & Landon 2012).

Trust in the specialist can change without losing trust in the clinical expertise of the specialist. This situation can occur as negative attributes of the specialist are learned about over time via patient consultations. Goudge and Gilson (2005) suggested we may trust people who are not trustworthy because we have too little knowledge of their behaviour or are misled by signals such as their reputation. This point is congruent with the thesis result, which showed that if a patient's experience is negative with the specialist, and the patient conveys this via feedback to the GP, then the trust in the specialist will diminish, even if their clinical expertise was excellent.

A recent example of diminished trust through clinical expertise was explored by Fallowfield et al. (2017). They found that discussions between SMPs and patients with metastatic disease about the benefits of novel drugs are often inconsistent, can be overly optimistic and may even contradict published data.

6.3.1.2 Trust in Communication

Trust in the referral relationship is often driven by strong communication. In this thesis, some GPs reported that strong communication from the specialist was a driver of trust in the referral relationship since collaboration cannot occur in the absence of communication. Communication via reports was considered important by GPs because

this is how they receive information on a patient's diagnosis, treatment strategy and any changes in medication. In addition, GP study participants felt that direct contact via a phone call from a specialist in emergency situations was a prime builder of trust in the referral relationship. This finding is consistent with Hespe's (2010) finding that the main driver of GP–SMP referral was the communication that occurred alongside the referral, before, during and after the consultation. Hespe concluded that GPs will refer if they are confident of getting reports, fast advice, and personal contact, if required, either by phone or email.

Communicating patient information at the time of specialty referral is essential to high-quality consultation and coordinated safe patient care as well as being a strong foundation for building trust in the referral relationship. GP and specialist physicians both value this information exchange for shared patients, but GPs can be dissatisfied with the overall referral process (Ghandi, Sittig & Franklin 2000). Often, the reason for dissatisfaction stems from poor communication because of late or missing referral letters and reports, which can be damaging to the trusting relationship. Other reasons include missing information in the referral letter, inadequate time to write a referral note and navigating the specialist and subspecialist field. Ghandi et al. (2000) identified the problem of poor communication between GPs and specialists in terms of timeliness and content. This represents a major opportunity for improvement.

Strategies proposed to improve the communication of referral information are as follows:

1. Schedule the specialist appointment from the referring physician's office and provide pertinent information to the specialist, which have been shown to increase referral completion.

2. Provide the specialist with timely patient referral information.

3. Provide physician training on how to write letters and the value of standardised communication to improve letter quality and consistency from both GPs and specialists. (Ghandi et al.2000).

The aforementioned strategies were congruent with the theme of communication highlighted in this thesis, as the means to reduce medical error through comprehensive referral forms and to promote sector-wide change to deliver HVC to patients through timely, accurate and efficient communication pathways. The importance of

communication in the realm of trust was strongly voiced as a maintainer of interprofessional relationships and a builder of referral relationships.

6.3.2 Trust from the Specialist Perspective

Trust from the specialist perspective in the referral relationship is equally important because GPs and other SMPs must earn trust from specialists to act appropriately when the specialist becomes the referrer, and when it is time to send the patient back to the GP. All SMP participants in the thesis study agreed that trust is important in an interprofessional relationship. The drivers of trust between specialist and GP were centred on their clinical expertise and the communication between them. In the specialist-to-specialist context, collaboration and patient experience were key drivers.

6.3.2.1 Patient Experience

Specialist respondents in this study suggested that patient experience is a moderately important factor in building trust in the interprofessional relationship. The results in this thesis highlighted that specialists consider that how a patient perceives the interactions throughout the consultations and treatment can influence two things: the patient's willingness to return for further appointments, and the inclination of GPs to continue referring to that specialist. If a patient provides negative feedback about a specialist's interpersonal approach, clinical expertise, or bedside manner, it can erode GP trust. Conversely, a positive patient experience can build GP trust in the specialist, enhance the interprofessional relationship and lead to more referrals.

More recent research conducted in Ohio, US, by Palmer Kelly et al. (2020) sought to understand the experiences of cancer patients and the relationship with their oncologist in the context of the healthcare team and healthcare environment. The major themes that emerged around the patient–oncologist relationship, and trust, included relationship with the physician, healthcare team and hospital environment, and patient engagement through decision-making. Subthemes highlighted the importance of the oncologist's communication behaviours and integrity, the impact of other supporting staff on the overall experience and the inclusion of the patient and their loved ones in shared decision making (SDM) in treatment. Similar findings were made in Bisschop et al. (2017); however, Engelhardt et al. (2020) concluded that SDM was not a variable influencing the trust and faith the patient had in the oncologist.

The patient experience is an important aspect to build a practice and has been shown to affect the financial bottom line of SMP practice (Rundle-Thiele & Russell-Bennett 2010). Improving the patient experience to build trust is not a new phenomenon. Its importance as an underpin to the success of clinical medicine has been raised for at least the past 100 years:

> The treatment of disease may be entirely impersonal; the care of the patient must be completely personal. The significance of the interpersonal relationship between physician and patient cannot be too strongly emphasized, for an extraordinarily large number of cases both diagnosis and treatment are dependent on it. (Peabody 1927)

The quotation by Peabody is echoed by the thesis result—participants discussed the aspects of practice that bring value to a patient. The participants highlighted the need to provide a treatment experience with a personalised approach that encompasses high levels of service, attentive listening from the physician, affordable treatment and a rapport that can build trust. The personal approach to health care, with fast, prompt appointments can help build a model of care that promotes a strong interpersonal relationship between physician and patient.

6.3.2.2 Collaboration

Trust in all parties' capacity to collaborate is extremely important because each aspect of treatment from surgery to radiology to medical oncology involves a different specialist. To enhance the patient experience and produce the best therapeutic outcome for the patient, SMPs need to collaborate with each other to ensure that treatment timing is in sync with the patient's condition. The GP's inclusion in the collaboration is in many ways dependent on the specialist's communication skills, via sending results and reports to the GP. For the GP to perform their duties in the collaborative process, there needs to be trust from the SMP (Van Leeuwen et al. 2018).

According to Axelrod and Goold (2000), the relationship between specialist and GP is a reciprocal mutually dependent relationship established on trust, where each party values outcomes under the control of the other; Van Leeuwen et al. (2018) corroborated this finding. Axelrod and Goold described the building of interpersonal trust as an experience by which the patient develops trust in the physician through the journey of sustained care where the physician and patient reach a diagnosis and treatment plan. The SMP–GP

relationship is enhanced through positive patient experience and continues in a mutually beneficial manner since the SMP requires referred patients and the GP trusts the SMP's skill to attend to diseases that are beyond the GP's purview (Axelrod & Goold 2000; Van Leeuwen et al. 2018).

Participants in the GP cohort of the thesis reported that they needed to trust the SMP would communicate results and treatment changes to them so that they could maintain their role in the collaborative process. From the perspective of the SMP cohort, they needed to trust that other SMPs and GPs would fulfil their roles. An Australian review conducted by Jefford et al. (2020) highlighted research that determined that it is both safe and feasible to use GPs for ongoing management of cancer patients after the referred services had concluded. They found that GPs' services were successfully utilised for ongoing management of breast cancer, colorectal cancer, and skin cancer; however, they concluded that the aforementioned data could be extrapolated to other cancer types. This finding emphasises the importance of having a collaborative system in place to allow referring doctors to be involved in the continuity of care (Jefford et al. 2020). The present thesis reported that GPs wanted to be involved in the ongoing management of the patient, and this is an area in they could add value to the collaborative process.

In the collaborative process, this dynamic was recently explored by Dutch researchers, Van Leeuwen et al. (2018). They explored the increased responsibility accrued to the GP in the collaborative process of oncology that was developed through trust from the SMP. GPs played a key role in oncology meetings and individual care plans that attributed to a feeling of shared responsibility for the patients by both the GP and the SMP. The meetings informed the GPs about the patients in the diagnostic and treatment phase, which allowed a smooth transition from hospital to primary care (Van Leeuwen et al. 2018). Through the trust developed in the collaborative process, GPs were better equipped to treat comorbidity and were more confident in providing survivorship care. There was little financial reward for a GP in this program, but the internal motivation was reported as high (Van Leeuwen et al. 2018).

6.3.2.3 Clinical Expertise

The interprofessional referral relationship begins with trust in clinical expertise, and then, other aspects of the relationship either build on the foundation of trust or erode it. The

concept of trust in health care as described by Rowe and Calnan (2006, p. 377) refers to confidence in competence (skills and knowledge), as well as ascertaining whether the trustee is working in the best interests of the trustor as evidenced by the honesty, confidentiality, care and respect shown.

The strength of clinical expertise as a driver of the trust theme among SMP participants in the thesis research was significant. However, trusting in clinical expertise as the primary factor in a referral relationship can also create a situation where a referring GP or referring specialist will wait in a queue in order to send a patient to a particular specialist. This delay to see a particular specialist could then create a chain reaction of delay: delay to further testing, delay to diagnosis and, ultimately, a delay to treatment (Kwon et al, 2015). Discussing the drivers of poor outcomes and system costs, O'Donnell (2000) underlined the importance not of the patients who are referred unnecessarily, but of the patients who are referred later or not at all. This is a challenging issue in oncology because timely diagnosis and treatment are essential to improved patient outcomes. Ironically, negative patient outcomes affect referrer perceptions about the clinical expertise of the specialist. Thus, trust in clinical expertise has 'cyclic redundancy' potential—it can drive positive as well as negative outcomes, depending largely on the role of delay.

Participants from the SMP cohort of the thesis indicated that through the reputation of clinical expertise, they were able to create a waitlist of patients and indicated that referrers were happy to wait in line for delayed consultation times. This contrasts with the value of accessibility (strongly voiced as a driver of referral by GPs), where a referrer's choice of referee could hinge on prompt availability of consultation times. Under the theme *aspects of a specialist's practice that bring satisfaction to a patient* (Section 5.5.1), the GP-voiced subthemes indicated that personalised care where accessibility, communication and cost were as important as clinical expertise would increase patient satisfaction and service quality, whereas having to wait for an appointment would decrease both.

Participants in the thesis rated clinical expertise highly; however, its importance as a positive was rarely elaborated on. Emphasis was more often placed on poor clinical expertise as a dissolver of trust in a relationship. An example of this was discussed in Fallowfield et al. (2017); they found that SMPs who recommended novel drugs to cancer

patients also provided inconsistent information on their potential positive benefits that could contradict published data. This approach to medicine can constitute diminished clinical expertise and can damage the trust in the relationship through potential misinformation.

6.3.3 Reciprocity

Reciprocity and trust have a symbiotic relationship in medicine. Reciprocal trust is the trust that results when one observes the actions of another and reconsiders one's attitude and subsequent behaviour based on those observations (Serva, Fuller & Mayer 2005). Within the realms of reciprocal trust, there is a component of reciprocal confidence; thereby trust possesses both a reciprocal and relational quality. Trust also has a high moral value and thus becomes a means of transference of social exchange. As discussed in Chapter 2, Mollering (2001) stated that Simmel's conceptualisation of trust is based on faith, reciprocity, and moral obligation. Trust without the expectation of reciprocity may be self-destructive (Evans & Krueger 2009). When we trust a stranger, we need to justify accepting the risk that our trust could be violated.

6.3.3.1 Components of Reciprocal Exchange

6.3.3.1.1 Communication

The theme of communication as a component of reciprocal exchange was strong in the thesis research results among the GP respondents. GP respondents of this thesis made it apparent that if they refer a patient to a specialist, then they want information communicated to them on all relevant details related to the patient's specialist appointment. This finding ties in theoretically with both a SET-informed view and an RMT-informed view in that SET would prescribe an exchange-related function for communication, as was shown to be the case. The RMT-informed view would consider communication to be an essential component for the GP to maintain a relationship with both the specialist and the patient, as was again shown to be the case in the thesis.

The ability of the GP to perform their role is dependent on communication from the specialist during each stage of the process; and hence, communication becomes a reciprocal component of the relationship that is tied in with the referral.

6.3.3.1.2 Collaboration

Inclusion in the collaborative process of treatment will be likely accompanied by an expectation of reciprocity. Reciprocity is the mutual exchange of goods or actions. For a GP to be included in treatment collaboration with specialists, it is important that the SMP communicate with the GP on all aspects of the patient's treatment, progress, outcome and any potential referrals. Collaboration in the relationship between physician and specialist calls for robust, effective communication. Langley, Minkin and Till (1997) suggested that guidelines be used to help identify the patient's best interests, and to help maintain an open and supportive relationship among all three stakeholders, by defining the responsibilities of the patient, the physician and the specialist in the process of consultation and referral. The research by Van Leeuwen et al. (2018) is consistent with this finding, and it is congruent with the thesis result that participants discussed that through system-level collaboration, defined roles in treatment and consistency in approach between different centres and hospitals occurred and an enhanced level of service to the patient was provided.

Among specialists, collaboration requires more than just communication. Inclusion in the collaborative process from specialist-to-specialist involves invitation via patient referral, or as a part of an MDT process. The decision to refer based on collaboration for a patient-centric approach is not always the priority for each of the participating parties. This was found in the thesis research, where it was suggested that specialists need referrals to build their patient base, and that this may make collaboration less of a priority.

6.3.3.1.3 Respect

Respect and trust are often interchangeable. Respect yields trust, yet trust is the foundation of respect. Serva, Fuller and Mayer (2005) proposed that implied in all the definitions of trust is the element of reciprocity. Trust has both a reciprocal and interpersonal quality, and a high moral value and thereby becomes a special medium of social exchange.

Some GPs consider respect a form of reciprocity. A two-tiered viewpoint from an RMT perspective highlights how respect in the form of reciprocity in a referral relationship from a GP's perspective is to understand and value the role the SMP plays in the patient's journey towards a positive treatment experience and ideally a positive treatment outcome.

Negative views held by specialists on the GP and the role of the GP can affect the trust in the referral relationship and ultimately cause it to dissolve.

A 1999 Australian study by Kamian, Bassiri and Kamian on 'badmouthing' reported that 12% of medical students had changed their decision to become a GP because of negative comments from SMPs. Disrespect from specialist to GP is humiliating and can ruin a relationship. An RMT-informed view would suggest that without respect, the relationship will fail. Disrespect from SMP to GP was well reported in this thesis, in terms of the SMP badmouthing the GP to the patient as seen in the Kamian et al. (1999) study, as well as excluding the GP from the collaborative process. The GP study participants in this thesis reported that they regularly lost track of the patient's progress because the SMP did not communicate extra referrals they made to other SMPs; one GP participant referred to this action as 'hijacking the patient'.

6.3.4 Collaboration and Communication

Collaboration in health care should modify and/or lessen the hierarchy of power around who controls the patient's management; each contributor to the patient's health has a specific role to play, and each player should have the patient's health goals as their motivator (Pearson et al. 1999; Van Leeuwen et al. 2018). A collaboration is successful if each medical professional performs their given role with a patient-centric focus, and then promptly communicates action or inaction with each party so there can be accountability placed on each phase of treatment to ensure that clinical competence is displayed, and a positive treatment experience is delivered to the patient (Pearson et al. 1999; Van Leeuwen et al. 2018).

6.3.4.1 Collaboration Drivers

As the thesis results show, interprofessional collaboration among specialists is an important aspect of the patient experience and a driver of patient outcome. An RMT-informed view would expect that to provide an effective working relationship among treating physicians, there needs to be trust, respect, and a shared knowledge among colleagues. This expectation was confirmed by the thesis result. Barnett et al. (2011) asserted that access and communication-related factors are key to successful collaboration: 'GPs were significantly more likely to cite reasons relating to patient access

or physician communication when compared with medical or surgical specialists' (p. 509).

This finding is congruent with the findings from this research since accessibility to appointments and effective communication from the specialist were raised repeatedly as the drivers of positive patient experience, by allowing the GP to be a part of the collaborative process. A SET-informed view might expect that this would drive an ongoing referral relationship. This was confirmed by the study findings, which clearly suggested that collaboration made the GP more likely to continue to refer to the same specialist(s).

Cancer is a complex disease process to diagnose. Diagnosis can often depend on collaboration among an array of specialists to resolve intricacies associated with each patient presentation. After initial referral by the GP, the patient will then meet a specialist in oncology (often a surgeon). Once the surgeon understands the important components of the case and has viewed the patient history, they will take the relevant details to an MDT to obtain further input on diagnosis and discuss a treatment plan for the patient. Specialist participants in the thesis study confirmed that for the MDT process to be effective, there needs to be respect and constructive communication among the collaborating cohort. Taking a slightly opposing view to this finding, Barnett et al. (2011) asserted a greater role for reciprocity, not collaboration, as the primary motivating factor to refer. Under this understanding, referral becomes a tit-for-tat exchange; the surgeon refers to the physician because the physician refers to them. This tit-for-tat exchange in SMP–SMP referral was reported in the results of this thesis; however, other important subthemes relating to reciprocity in referral, such as accessibility, clinical expertise, trust, and patient experience, were also voiced.

Collaboration among treating physicians will involve an element of trust that each party will perform their role and then relay diagnosis and treatment outcomes in a timely manner. The availability of the specialist to discuss issues that are beyond the breadth of the GP to help guide the referral process can reduce incorrect referrals and subsequent delayed treatment time Barnett et al. (2011). The perceived importance of the GP's role in the collaborative process should be demonstrated by SMPs to GPs by communicating all specialist-to-specialist referrals that occur, for the GP to be fluent with the patient's status and be able to communicate any changes to the patient, if the need arises. The

themes and subthemes uncovered in the thesis supported this proposition; both GP and SMP cohorts reported that the GP can play an important role in the collaborative process through disseminating important information to the patient regarding their treatment and fielding any questions the patient may have about their specialist consultation.

Manca, Breault and Wishart (2011) described how trust was actioned in the GP–SMP relationship by defining the role of each player in the treatment process. The definition of each role in the process led to mutual empowerment, attention to fairness and justice, shared power relations and a sense of valuing one another. The specialists in the study identified that they could harness trust from the GP by increasing accessibility and appreciating the role they play in the referral process:

> There's no way we could admit all these patients without the family practice physicians…. And a thing I know the department has talked about is trying to make sure that all teams are equal as far as the workload. (p. 582)

It is well established that poor communication among collaborative partners can negatively affect the patient experience and create a situation where a medical error can occur; substantial research has illuminated the grim reality of delayed referral, inappropriate examinations, delayed diagnosis and poor patient outcomes in those diagnosed with cancer (Banks et al. 2014; Genden et al. 2006; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012; Goff et al. 2000).

Trabjerg et al. (2021) recently examined real-time collaboration in patient consultations via video link; the video link enabled patient, GP and oncologist to be involved in the same consultation. From the patient perspective, having the oncologist and the GP present was valuable because they were able to present their concerns in 95% of the consultations, and it helped them understand the role of oncologists and GPs in oncology care. The oncologists retrieved valuable knowledge about the GPs' role in the patient trajectory from two out of three consultations. Based on the dichotomisation of the responses, a total of 90% of the GPs found that the consultation could give a more coherent course for the patient (Trabjerg et al. 2021). The presence of all three parties in the consultation eliminated the weakness of delayed communication in the collaborative process; however, in real situations consultation delays could present in trying to synchronise GP and oncologist diaries for an appointment. It is important to note that a limiting factor of

this approach was that technology fails in 11% of consultations, and sound and picture were unsatisfactory 20% of the time.

To help with chronic and complex disease management, the need for closer interprofessional cooperation, as noted by Trabjerg et al. (2021), has never been greater. Most health system reforms involve GP–specialist–nurse collaboration and acknowledge the underutilisation of GPs and nurses in the care of chronically ill patients. The reforms are usually designed to shift care from the secondary sector to the primary sector. These should enable specialists to free up time for management of more acute problems in the secondary sector (Piterman & Koritsas 2005). Some participants in the thesis reported that patients should be referred back to GPs to perform tasks such as removal of stitches after surgery and that GPs should be informed about surgery results as soon as possible so they can further manage the patient. This result accords with the Piterman & Koritsas findings about freeing up the SMP's time for management of more acute problems.

6.3.4.2 Impact of Communication on Collaboration

Collaborative success in oncological care is a group of medical professionals working together to improve the outcome for the patient and provide a positive experience for the patient and carer. A SET-informed view would expect the GP to refer to a specialist if the specialist will collaborate with them throughout the treatment process; for the GP to be involved in the collaborative process after the referral, they rely on communication from the specialist. Communication is crucial throughout the diagnosis and referral process to ensure that there is accountability in treatment and that 'the patient doesn't fall through the cracks' through missed appointments, missed testing and missed treatment (Pearson et al. 1999). An RMT-informed view would highlight the trust the GP has in the SMP to communicate all treatment process aspects because as the primary referrer and the party with the initial relationship with the patient, the GP still has accountability to communicate the process to the patient should the patient not understand it (Pearson et al. 1999).

Holge-Hazelton and Christensen (2009) explored the experiences of GPs in the cancer care of young adults, who are particularly vulnerable since they often are marginalised (p. 326). This is particularly true when their treatment in specialist oncology is concluded in an abrupt manner, without ongoing support to continue with normal life; there may be

accompanying but unacknowledged symptoms of depression as a result of the marginalisation. At that point in time, general practice would be the best place for continuing support. Three aspects highlighted by the authors for responding to the needs of young adults require GPs to:

1. adopt a consultative role, which helps with two-way communication between the young adult and the GP;
2. accept responsibility for long-term continuity of care; and
3. implement a holistic approach to care that considers physical, psychosocial, cultural and existential dimensions.

As Holge-Hazelton and Christensen (2009) mentioned, using GPs for providing collaborative care to at-risk groups could be a powerful tool. GPs are often wired into the families of cancer patients, and through their collaborative work in other areas, such as mental health, can work with the patient, the family and other health professionals to help the patient with their wellness needs beyond the explicit cancer care context. Some participants in the GP cohort in the present thesis emphasised that the originating referrers have an existing relationship with the patients and that through this relationship trust has already been built. In Holge-Hazelton and Christensen's model of care, GPs can be utilised for ongoing care beyond the cancer care treatment, is consistent with GPs' views and experiences in this thesis.

6.4 Significance of Professional Exchange Drivers as They Relate to Clinical Judgement and Decision-Making during Referral Practices / Processes

6.4.1 GP-to-Specialist Referral

6.4.1.1 Linking GP Referral Practice and Survival

The nature of referral of oncology patients may significantly influence treatment outcomes; a considerable amount of research portrays the dangers of delayed referral, inappropriate examinations, deferred diagnosis, and poor patient outcomes in those diagnosed with cancer (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). Themes and

subthemes uncovered in the thesis findings outlined the reasons of referring doctors and their patients for choosing an oncologist. These themes included access to timely treatment, identifying the correct specialty and communication to reduce error.

6.4.1.1.1 Access to Timely Treatment

A delay in treatment may lead to medical error; the thesis findings highlighted factors such as seasonal holidays, geographical locations, cultural preferences and a busy SMP schedule as factors that affect the patient's ability to obtain a timely appointment.

A study in the Canadian context by Langley, Minkin and Till (1997) asserted that access to timely treatment may vary owing to differences in access to resources, which can lead to a style of practice with a local focus. Physicians located in tertiary care areas, who had the highest rates of referral, indicated that their geographic area increased their referral numbers, while for physicians in rural areas with generally low rates of referral, geographic location and style of practice were factors that decreased referral (Langley, Minkin & Till 1997). This is congruent with the results of the present research that accessibility because of geographical location could be a barrier for treatment.

In a large study to explore barriers in referral practices ($n = 1,566$ GPs and $n = 2,144$ SMPs), Kwon et al. (2014) found that in the US context, accessibility to treatment existed beyond the themes of availability-due-to-time-constraints, seasonal staff shortages and geographical restrictions. The most frequently reported barriers were health fund provider network restrictions and pre-authorisation payments. The lack of surgical subspecialists and excessive patient travel time were the least reported barriers. Patients' inability to pay (cost) and the lack of surgical subspecialists were also flagged as important barriers. Greater access to medical records was associated with lower levels of reported barriers (Kwon et al. 2014).

Australia's 'National Strategic Framework for Rural and Remote Health' endorsed by the Standing Council of Health on 11 November 2011, and reported on by Tracey et al. (2016), has stated that the goal of cancer care is to ensure that rural patients have increased access to diagnostic testing, coordinated care, MDT review, patient accommodation and appropriate medical oncology and radiotherapy services locally. To achieve this goal, the federal government has dedicated AU$1.3 billion not only to building two comprehensive cancer centres in Melbourne and Sydney but also to enhancing or building 10 regional

cancer centres. These developments should greatly improve cancer diagnosis in rural and remote areas and some aspects of cancer treatment, but they will not eliminate the need for some patients to travel for specialised surgical assessment and surgery (Tracey et al. 2016, p. 330).

6.4.1.1.2 Open Referral: Referring to a Specialty

The *Health Insurance Regulations Act* 2007 requires a practitioner to 'consider the need for the referral', and then provide the SMP all information pertinent to the patient's diagnosis. The referral must be given in writing, dated and signed by the referring practitioner, unless in an emergency. However, the regulations make note of referrals being addressed to a 'specialist or consultant physician'; the legislation is clear that the referee does not need to be named, making an open referral legal (*Health Insurance Regulation Act* 2007; *Health Insurance Regulations* 1975; *Health Insurers Act* 1973).

An open referral is currently the mode of practice in pathology (*Health Insurance Regulations [Pathology Services]* 2018); this successful implementation of policy favours the patient by providing both choice and ease of access. This policy is congruent with the results reported in Chapter 5 on the importance of providing patients with a list of options to provide both choice and fast accessibility to an SMP consultation.

As indicated in Chapter 5, the open referral could provide a faster means to an SMP consultation; however, it is essential to ensure there is continuity of care for the patient, and that processes are in place for the patient to be sent back to the referring doctor for ongoing management after referred services (Royal Australian College of General Practitioners 2019).

6.4.1.1.3 Identifying the Correct Specialty

Difficulty in navigating the correct specialty to refer the patient to may increase time to treatment. The thesis uncovered themes suggesting that referring complex patient issues, with multiple clinical presentations, can make it difficult for the referrer to prioritise the medical issue to refer first. Understanding the specialist and subspecialist field can be frustrating without appropriate education in the field. Sullivan (2012) said that the specialist and subspecialist areas have nearly doubled, and if referrers lack

interprofessional relationships to help navigate this field, then they are at risk of referring to the wrong specialist.

Participants from both the GP and SMP groups identified that navigating the speciality and subspecialty fields can be onerous. They also identified that an incorrect referral could lead to a chain reaction of delays, beginning with consultation and followed by diagnosis and treatment. This finding is in line with those of Sullivan (2012). However, participants in this thesis also identified that increasing GP education in oncology could improve the accuracy of the referral process, as could SMP provision of small group training and talks to GP groups, to both inform GPs of their existence and promote their practice.

6.4.1.1.4 Communication to Reduce Error

Communication to reduce error was a strong theme identified in the thesis. Bodenheimer's (2008) research on the US healthcare system uncovered areas of communication in the referral process that placed the patient at risk. Referrals from GPs to specialists often include insufficient information, and consultation reports from specialists back to PCPs are often late and inadequate. This lack of reciprocity in the communication exchange between referrers and referees can cause treatment delay and testing repetition. Further, when patients are hospitalised, their GPs may not be notified at the time of discharge, and discharge summaries may contain insufficient information or never reach the primary care practice at all (Bodenheimer 2008).

Bodenheimer's (2008) findings are congruent with the results of this thesis. The respondents outlined the importance of providing clear and concise communication in order to prevent medical errors arising from delayed diagnosis and treatment and the replication of testing. Comprehensive medical records that provide a systematic history of treatment and medication changes, are presented legibly and document all consultations and all phases of diagnosis and treatment can provide treatment fluidity and reduce medical mistakes.

Pearson et al.'s (1999) findings are also congruent with the findings of this thesis; the authors discussed how communication is crucial throughout the diagnosis and referral process to ensure accountability in treatment. Accountability through all levels of treatment can prevent medical errors by ensuring that 'the patient doesn't fall through the

cracks' through missed appointments, missed testing and missed treatment. However, as regards complete transparency in communication and the inclusion of the patient; oncologists believe that the patient should not have access to their notes since it could reduce information integrity. This view is despite the fact that the patients' ability to access their provider's clinical notes (OpenNotes) has been well received and has led to greater transparency in health systems (Alpert et al. 2019).

Section 4.3.3 of the Australian Medical Council: Good Medical Practice (2009) states that when referring, good medical practice involves 'Always communicating sufficient information about the patient and the treatment they need to enable the continuing of care'.

Trabjerg et al. (2021) explored a novel approach using video-link technology for a three-way consultation with oncologist, patient and GP. Having all three parties in one consultation meant that important aspects of treatment could be communicated in real time.

6.4.2 Factors Influencing GP Referral Practice

The referral in the Australian medical setting is always initiated by the GP. The patient cannot access a specialist directly without first consulting with a GP, even if the patient knows which specialist they wish to see and have been so advised that they are correct with their choice. The GP serves as a hub in the referral process between patients and specialists. The system is designed this way so that a well-trained, board-certified medical professional first assesses the medical condition and establishes whether it does in fact require specialist attention. If it does, the GP will then decide the stream of medicine best suited to the patient. Although GPs may have a working knowledge enabling them to diagnose and treat most problems that they encounter, they cannot be expected to do so for all conditions. Their reliance on specialists for expert content knowledge as well as technical and craft expertise makes the referral process essential (Piterman & Koritsas 2005).

In the Australian healthcare system that recognises the GP as the gatekeeper, letters of referral to a specialist or consultant are essential if the patient is to claim rebate for the specialist consultation under the *Health Insurance Act* 1973. Under this Act, registered specialists are not permitted to practise as GPs or to charge GP item numbers. Referrals

from GPs to specialists are valid for 12 months unless specified 'indefinite referral' (Piterman & Koritsas 2005).

Chapter 2 explored the factors influencing GPs' referral decisions. Newton, Hayes and Hutchinson (1991) viewed referral as a type of social action best understood by interpreting the meanings and motives of those involved:

> When a patient is referred to see a consultant this means that a doctor …has come to define a set of symptoms together with other information in a particular way. Each referral decision may depend on the way in which unique constellation of factors are interpreted. Studying referral, therefore, requires that investigators get as close to the interactional processes through which it is constituted (p. 309).

Referral pathways in oncology begin with the initial GP referral, but because of the complex nature of oncology diagnosis, other factors, such as the location of the cancer, its size and its aggressiveness, must be assessed by a specialist in oncology. Once an oncologist receives the referral, they may refer the patients to other specialists if needed.

The decision in the choice of referral by the GP can be influenced or impeded by a number of factors. The thesis employed RMT and SET to help identify how/whether aspects such as accessibility, clinical expertise, trust, patient experience and location influenced or impeded their decision in the referral process.

6.4.2.1 Factors Driving or Impeding Referrals

The choice to refer is based on medical as well as non-medical reasons, and in both cases, is driven by a need to obtain answers that are beyond the ability of the referrer to provide. The medical reasons for referral are straightforward: The patient presents with a serious medical condition that requires a specialist's view. The non-medical reasons for referral involve reasons such as trust, reciprocity, accessibility, and patient experience.

As cited in Chapter 2, Harris et al. (2016) explored aspects that influenced referral decisions around oncology patients to identify the likely systemic and other non-clinical factors influencing a GP's referral decision for cancer patients. They found that many non-clinical factors were likely to significantly influence referral decisions, such as gatekeeping responsibility, funding systems, access to special investigations, the fear of litigation and relationships with specialist colleagues.

In most cases the choice of specialist is left to the referring GP. According to Kinchen et al. (2004), the choice of specialist is influenced by a number of factors:

- The medical skill of the specialist and GP's previous experience with the specialist;
- the quality of the specialist's communication with the GP and the specialist's efforts to return the patient to the GP for continuity of care;
- geographic considerations or office location;
- hospital admission, which may determine the specialist for subsequent care; and
- patient requests: patients may obtain names of specialists from friends or relatives.

All five points raised by Kinchen et al. (2004) are consistent with the thesis study results: clinical expertise displayed through medical skill, accessibility through appointment timeliness, trust through previous experience with the specialist, quality communication, specialist efforts to return the patient to the primary physician for care via reciprocity and patient experience through patient–specialist rapport.

A survey of physicians in Canada by Langley, Minkin and Till (1997) examined non-medical factors that influence the referral practices of family physicians. The results revealed three factors affecting referral decisions: access to hospital facilities, remoteness from specialist care and relationship with specialists. In addition, the style of practice such as treatment policies, referee was an influencing factor on the decision to refer to a particular specialist, which could also be an indicator of patient experience. Non-medical factors, such as patient experience and relationship with the specialist, can both impede or promote the referral; as this thesis results show, interpersonal connection, communication, patient experience and accessibility were attributes that GP participants used to measure the worthiness of the specialist for referral.

Factors identified by Kwon et al. (2014) (restricted provider networks, preauthorisation requirements, a patient's inability to pay, excessive patient travel time and a lack of surgical subspecialists) were not all congruent with the findings of the present thesis. Preauthorisation requirements and restricted provider networks were not flagged by study participants; however, these factors could be indirectly added to the theme of accessibility. The cost of treatment, a lack of subspecialists and excessive patient travel

time were all congruent with the themes identified by Kwon et al. (2014) as impeding GP-to-specialist referrals.

6.4.2.1.1 Accessibility

Accessibility to timely treatment in oncology diagnosis is important; the degree of seriousness of the diagnosis is dependent on the location, size, and aggressiveness of the tumour. A retrospective study undertaken by Buccheri and Ferrigno (2004) emphasised that a late referral of lung cancer patients corresponded with advanced stage of disease, cough, increased weight loss, poor performance status and less effective therapy. An analysis of survival showed that expedient access to referral and providing an incidental diagnosis led to improved clinical outcomes. Time to treatment is accepted to be a critical aspect in determining treatment outcomes in aggressive cancers (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). This is consistent with the results of the thesis research, with GP respondents in this study becoming regularly very animated over their desire for timely SMP appointments for their patients with serious diagnoses.

Excessive patient travel time can impede accessibility to a specialist referral, as outlined by Kwon et al. (2014). This was in line with the viewpoints of some of the GP respondents in the thesis, who highlighted that accessibility to specialists and subspecialists with a diagnosis of rare tumour can be a challenge to the GP in the rural setting. Timeliness of treatment is the key reported challenge, and this can be critical to treatment outcomes in aggressive cancers (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012).

6.4.2.1.2 Clinical Expertise

The theme of clinical expertise as a reason for referral was very strong in this thesis result. The term clinical expertise branches all perceived skills related to a specialist's ability in dealing with a patient's clinical presentation. Clinical expertise can incorporate new techniques or strategies being employed by the specialist; the ability, knowledge and experience of the specialist in their particular field; and the GP's past experience of the specialist's success in terms of referred patients' treatment outcomes. Clinical outcome

is a strong indicator of clinical expertise. Glatzer et al. (2020) further defined that the clinical expertise of the referee can affect the process of treatment decision-making. Ideally, treatment strategy is based on high-level evidence and the ability to integrate the knowledge of current evidence into a clinical setting.

Clinical expertise is a strong motivator to refer to a specialist (Barnett, Song & Landers 2012; Glatzer et al. 2020; Kinchen et al. 2004; Walshe et al. 2008); the ability and knowledge of a specialist in resolving a patient's issue can garner trust from the referring physician and is generally a prime reason for referral. However, although clinical expertise is an essential skill, referring on this basis alone presents its own set of problems. Referral selection based solely on clinical expertise implies judging the ability of the surgeon based on their reputation. This has been shown to lead to referrals to surgeons with a high-volume patient load, thus, in turn, negatively influencing waiting times, and, ultimately, outcome (Katz et al. 2007).

However, despite this effect, having a system that prevents the GP from referring to a named specialist (a specialist with a strong reputation) may inhibit referrals (Harris, et al. 2016). As seen in the thesis result, the ability to refer to a specialist of choice based on the clinical need and the ability of the specialist to produce a positive outcome that addresses that need is a strong driver for referral. If this aspect of choice is taken away from GPs, then it may have a negative effect on the quantity and quality of referrals. The quality could be reduced because a high workload may cause GPs to refer onwards, in an attempt to reduce their own load of follow-up appointments.

6.4.2.1.3 Trust

Trust is a solid foundation of an interprofessional referral relationship; it is a prerequisite that encompasses other factors that may relate to the referral choice. Trust means that the referrer believes the referee will provide strong clinical expertise and good communication and take accountability for their role in the treatment process (Barnett, Song & Landon 2012). An RMT-informed view might suggest that the GP would usually want to experience a transference of trust to the specialist (as a positive relational factor). The patient has sought medical attention from the GP, and since the treatment is beyond the scope of the GP, the patient trusts the GP will have a network of trusted colleagues that can fill this void in knowledge.

In Chapter 2, it was established that there were no known data banks that GPs can use to help their decision process for referrals, and hence, they look to known entities that they trust through a shared background. As Anthony (2003) noted, in many managed healthcare systems: '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' (p. 2035). Thus, the 'trusted' network may not provide the best avenue for treatment and is therefore not necessarily in the patients' best interest.

If a specialist has many good attributes, but displays untrustworthiness, it is enough to dissolve the relationship and cease referrals (Goudge & Gilson 2005). In the beginning of a relationship, the GP has no guide other than word of mouth in referrals; in this instance, the GP will refer to a specialist who is unknown to the GP, but from this initial experience the seed of trust will grow. When dealing with new diseases and rare cancers, the GP will have to trust specialists and subspecialists based on their knowledge and unique skillset, and owing to the rarity of specialisations, the GP may have to maintain a relationship with them based on necessity rather than trust.

6.4.2.1.4 Communication

An important theme uncovered in the referral relationship is communication. The GPs who advocated its importance did so because they felt that it both positively and negatively affected the patients. RMT, which has relevance to interprofessional referral practice, is a useful lens through which to examine behaviour here, because communicative aspects are affective and instrumental to the commitment to the interprofessional relationship with the specialist, and also with the patient (Barnett, Song & Landon 2012; MacDonald et al. 2009). As the primary care provider of the patient, the GP needs a strong rapport with the patient and will often be the conduit between the patient and the specialist.

GPs are often dissatisfied with the communication they receive from specialists after the patient visit. Scott et al. (2004) summarised attributes GPs would like to see in the specialist's response as follows:

    i.   Specific answers to specific questions;

    ii.   Clearly stated diagnostic formulations;

iii. Detailed management regimen outlining anticipated benefits and risks of treatment(s) recommended;

iv. Clear comments on the possible effects of the disease or treatment on the patient's quality of life and functional capacity;

v. Contingency plans in the event of adverse events from (or failure of) first-choice treatment;

vi. Prognostic statements;

vii. Follow-up arrangements;

viii. Explanation of the reasoning behind the specialist's actions and recommendations;

ix. Medication lists;

x. Short turnaround time between the patient visit and receipt of the specialist letter; and

xi. Professional courtesy by including the name of the referring doctor as the person to whom the letter is addressed.

The thesis study suggested that communication via reports was important to GPs. They wanted to receive information about a patient's diagnosis, treatment strategy and any changes in medication. In addition, the respondents from the GP group felt that direct contact via a phone call from a specialist in emergency situations was an aspect of trust in the referral relationship. This finding is consistent with published research; Hespe (2010) reported that the main driver of referral was the communication that occurred alongside the referral, before, during and after the consultation. Hespe concluded that GPs will refer if they are assured of getting reports, fast advice and personal contact if required.

Hespe (2010) proposed five criteria that might guide GPs' decision-making in the referral process, five of which were related to communication by the SMP with the GP and staff. Given the depth of the review conducted in Chapter 2, it is important to compare these points against the findings of this thesis:

1. *Timely and relevant information provision back to the GP regarding the specialist's opinion following any consultation investigation or intervention.*

   Thesis study: The importance of timely feedback was echoed by the GP participants as an important aspect that underpins the theme of communication:

GP19: Quality of the letter communication, outlining of the management program, those sorts of things do matter.

2. *Interactions with the front desk staff/receptionist that includes both the GP interaction with the frontline phone service and the patient's experience with appointment making and attendances at the rooms.*

   Thesis study: The experience and professionalism of the specialist staff was reported by the GP respondents in this study as an important aspect of the patient experience in the referral process:

   > GP6: Yes, especially if it is a Professor or someone—the ones who help me at these times usually get more referrals for me. And here, it is very important the receptionist, there are some receptionists who are fairly accommodating. Some specialist's receptionist, this is the time you've got to do it and that's it. Yeah, get some time to work around, and you tell them that you are doctor such and such and they try and help you out somewhere. They are the face of the business.

3. *Willingness to communicate with the GP over the phone regarding potential referrals, difficulties with managing current patients under care and/or information about how to manage a patient who may or may not actually need to be referred.*

   Thesis study: The subtheme of accessibility recurred; the ability of the GP to contact the specialist via phone in times of emergency, or for advice, was an important factor that could both promote or impede the interprofessional relationship:

   > GP6: Yes, at times you do and you are on the phone basically begging, please someone.

4. *Willingness to educate the referrer regarding the management of gynaecological problems.*

   Thesis study: Educating the GP in exchange for referrals was located under the subtheme of reciprocity; it was not specific to gynaecological problems. The

specialist respondents identified that increasing the GPs' knowledge of oncology could expedite the referral pathway and reduce medical error:

> SMP16: I would say GP education for common cancers is critical.

> Interviewer: Ok. So, the purpose is?

> SMP16: Quick diagnosis, early diagnosis and early diagnosis multiple times and PSA is a classic. We would like to see this patient because PSA is now going up. Trouble is PSA has been abnormal for five years, of course, it is now going up. Or the second one is, I don't really vet my referrals. The girls know how to vet them. I just spend more my time investing in seeing the patient because it's my way of sort of approach; I work harder, probably not smarter than that who knows what do. I suppose you see a patient who's got a PSA of 1.14 because his median for his age was 0.8. I think not under-referring and, also over-referring.

> GP17 I want to learn from that, I just want a cursory education, I want someone to let me know what they've done, like a skin specialist, I don't want them to say to me that they prescribed an ointment to improve hydration in the skin, I want to know what he prescribed, I want to learn.

> Interviewer: So, if they don't do these things then obviously you stop referring to them.

> GP17: Yep, I refer to someone else, who will report back to me better and the patient will report back to me better.

5. *With increasing computerisation of GP practices, specialists who communicate with data files and emails that can be downloaded into patient files are preferred.*

Thesis study: Under the subtheme of 'communication' under the main theme of 'medical error', the respondents in the specialist group identified that poor communication in inappropriate form was a contributor to medical error:

> SMP12: Look, Ok, well if I'm talking, where I'm working at the moment—[location redacted], where I'm standing at the moment. I think one would have to be an improvement in our medical records.

> Interviewer: Okay so, what's wrong with the medical records?

> SMP12: A bit of a dog's breakfast how it's, what gets put in, what doesn't get put in, access to all the information—it's time-consuming. You're relying on, prescribing off chemotherapy, it's done handwritten and there are no electronic records, so that would have to be one of my biggest things that I think puts patients at risk.

Holge-Hazelton and Christensen (2009), in their study about GP experiences of cancer care of young adults, raised adequate follow-up as critical to longer-term success. In this clinical context, the specialist should communicate via a summary letter with the GP that their treatment has concluded, so that the GP can then provide a continuity of care to the patient and, if necessary, provide further referrals to other specialists to help the patient. This level of communication is essential for the GP to provide continual value to the patient and improve the patient's experience in the medical system.

6.4.2.1.5 Patient Experience

Patient experience is the interaction, from intake to discharge, between the patient and the specialist. It includes communication, empathy, examination, evaluation, diagnosis, prognosis and intervention. Although patient experience incorporates patient outcomes, it is a more encompassing theme that includes the aforementioned factors, not just the success of the treatment plan. Good patient management can foster trust from the GP for the specialist, because a positive patient experience will enable a patient to build rapport with the specialist and could translate to greater compliance with future appointments and treatment that can influence clinical outcomes.

Literature on the patient experience concurs with the thesis findings. The contributing factors of accessibility to timely treatment (Langley, Minkin & Till 1997) and the communication empathy and clinical skills of the attending physician (Bisschop et al. 2017; Kinchen et al. 2004) all lend to the patient experience. While all these attributes define the whole experience, the aspect of trust underpins them.

The trust in the specialist can change through reported negative attributes the specialist exhibits in referred patient consultations. Goudge and Gilson (2005) suggested we may trust people who are not trustworthy because we have too little knowledge of their behaviour or are misled by signals such as their reputation. Through patient feedback, the

GP is able to ascertain the consultation quality and the patient experience and decide whether to continue the interprofessional relationship.

Walshe et al. (2008) revealed that factors affecting GP perceptions of the SMP were a sense of autonomy, patient ownership, giving patients the choice, expertise in provision of specialist care, workload and relative positioning of palliative aspects. All of these can be seen to fall under the umbrella of patient experience and can be useful in the transition towards a more patient-centred approach of health care.

6.4.2.2 SMP's Perspective on Why GPs Refer to SMPs

The specialist's perception on why GPs refer patients to them could be an influencing factor for how they approach a patient and how they establish and maintain referral relationships with GPs. The thesis results showed that specialists believe trust is a key factor in the referral process and that this is nurtured through an established relationship. Aspects such as collaboration on patient treatment and effective communication on patient testing, results and outcomes; were all seen to be the builders of trusting relationships.

Trust is important to health systems because it underpins the cooperation throughout the system that is required for positive health outcomes (Loewy 2002). Trust is essential to positive interprofessional relationships that promote referrals (Hespe 2010). Barnett et al. (2011) explored differences in the reasons cited by GPs and specialists for referral. GPs were more likely to cite reasons relating to accessibility or physician communication, compared with medical or surgical specialists.

6.4.3 Specialist-to-Specialist Referral

In circumstances where the patient presents with an issue beyond the scope of their skillset, the specialist might need to refer to a different specialist, or a subspecialist for a more complete diagnosis or for collaborative management. GPs provide the initial referral to a specialist who, in their clinical judgement, could best treat the patient; if the patient requires extra care, then the specialist can refer to another specialist. Australian medical provider procedures and Australian Medicare regulations require that a patient be provided with a referral from a GP to a specialist, prior to the initial consultation by the specialist (Australian Medical Council 2009). This approach is adopted to direct the

patient to the correct field of specialty via a referral to ensure that the specialist has the requisite skill to further diagnose the patient and then determine the appropriate treatment pathway for the patient (Australian Medical Council 2009).

Referrals from one specialist to another are only valid for three months; this is designed to discourage cross-referral between specialists and acknowledges the need for the GP to be involved with, and informed about, all aspects of their patients' care (Piterman & Koritsas 2005).

As discussed earlier, Australia does not have a national database of specialists that GPs and specialists can use in referral selection as a reference for location, availability and price when choosing a specialist. Limited research has been conducted on the factors that specialists consider in their decision process when choosing referees for their patients. Owing to this lack of published data, little is known about the process through which a medical specialist chooses another SMP to further the patient's health. Ambiguity surrounds the factors that influence the choice of specialist providers, as well as the relationships that underpin referral, which are formed around these circumstances.

A symbiotic relationship exists between a specialist, referring GP and patient, such that each participant depends on the other. In the realm of specialist-to-specialist referral, the clinical diagnosis of the patient forms the basis of the field of specialty choice, but the specialist within that field will be chosen based on the referrer's network and history of dealings with that referee. Multiple professional service relationships of depth and importance are actioned and progressed as part of the oncology SMP care process. Reciprocity was shown in this thesis to be important. Other factors that affect referral practices are likely to include, but not be limited to, those relating to the patient, family, disease characteristics and community values.

The referral process outlined in Section 4.3 of Australian Medical Council: Good Medical Practice (2009) states, 'Referral usually involves the transfer (in part) of responsibility for the patient's care, usually for a defined time and for a particular purpose, such as care that is outside your expertise'.

This quotation indicates that the referral process should be a patient-centric approach that aims to benefit the patient. Referral is designed to fill a medical gap that the attending physician cannot, and the decision of the referrer to transfer the patient into the care of

another physician should be based on aspects that can enhance the patient experience, such as clinical expertise and accessibility to an appointment. The AHPRA (2014) Code of Conduct for registered health practitioners further defines the ethical process of referral as:

> involving one practitioner sending a patient or client to obtain an opinion or treatment from another practitioner. Referral usually involves the transfer (in part) of responsibility for the care of the patient or client, usually for a defined time and a particular purpose, such as care that is outside the referring practitioner's expertise or scope of practice (Section 6.3, p. 16)

> Good practice involves:

> > Taking reasonable steps to ensure that any person to whom a practitioner delegates, refers or hands over has the qualifications and/or experience and/or knowledge and/or skills to provide the care required; and
> >
> > Always communicating sufficient information about the patient or client and the treatment needed to enable the continuing care of the patient or client and the treatment needed to enable the continuing care of the patient or client. (2013)

Building on the referral process outlined in Section 4.3 of Australian Medical Council: Good Medical Practice (2009), AHPRA (2013) highlighted the importance of communication in the referral relationship. As the thesis results show, the importance of communication is echoed through all the themes descriptive of GP and SMP perspectives about the referral process: Communication is an essential component within interprofessional referral relationships; strong and prompt communication fosters collaboration in the treatment process and communication can reduce medical error via avoiding repetition of diagnostic testing and treatment, thus preventing delays to treatment.

The referral processes outlined in Section 4.3 of Australian Medical Council: Good Medical Practice (2009) and AHPRA (2014) do not promote reciprocity as an underpin to referral. Reciprocity is not a patient-centric practice but more of a business decision to grow the specialist network in order to expand SMP practices. Eisenberger et al. (2001) explored how employee-perceived organisational support was positively associated with employees' felt obligation towards the organisation's welfare and to help attain

organisational goals. They found that employee sense of obligation was a mediating factor in perceived organisational support, affective commitment, organisational spontaneity, and job performance; the relationship between perceived organisational support and felt obligation increased with employees' acceptance of reciprocity as a norm in the organisational context. The authors stated that the findings support the existence of reciprocity-based obligations in employer–employee relationships. In the context of this thesis, although participants were not in employer–employee relationships, reciprocity-based obligations do appear to be at play. The thesis study findings do not support the conclusion that these obligations yield negative outcomes, although it remains the case that this may be so.

According to Barnett et al. (2011), the choice of a referring physician for a given clinical problem, may have cascading effects. However, research on reasons for referral to a specific specialist is scant. Barnett et al. examined motives behind the choices of referral among both GP and specialist physicians, and, in particular, why the referrer chose a specific colleague to refer to. Results revealed that GPs mostly referred to colleagues within their professional network, whereas medical and surgical specialists referred patients to known colleagues less often. After excluding clinical skill as a gauge, patient experiences, communication and accessibility ranked prominently among GPs. Specialists referred based on collegial relationships, which incorporated shared workspace and patient rapport with the specialist. This study findings are in line with the thesis results, which uncovered that specialist-to-specialist referral practices depended on clinical expertise, trust, accessibility, clinical need for a particular specialty/subspecialty, patient experience and reciprocity. A poignant response from an SMP participant captures some of this complexity:

> SMP11: One is your relationship with that specialty, that specialist, full stop; is it someone you talk to every day, every other day and you know you can pick up the phone and will answer. The second one is your trust, and that trust may come from professional outcomes, it may come from their research or their reputation. I think thirdly is vice versa, is it someone that reciprocates, is it someone that sends you patients? And therefore, it's a symbiotic relationship.

Although literature on specialist-to-specialist referral practices is limited, there are guidelines set to govern professional standards in the referral process, as in Section 4.3

of Australian Medical Council: Good Medical Practice (2009) and AHPRA (2014). It is very clear that referral needs to be for the betterment of the patient and that self-interest in the referral process, or any aspect of medicine, is directly against the ethics as stated in Medical Professionalism in the New Millennium: A Physician Charter:

> Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession. (ABIM, 2004)

As with GP-to-specialist referral, specialist-to-specialist referral significantly affects patient outcomes. There is limited research in this area, and this thesis sought to breathe knowledge into this subject. Barnett et al.'s (2011) study was the first to explore the reasons for referral to specialists by GPs and specialists, and this thesis has built on this knowledge. This research concurs with the recommendation by Barnett et al. for a broader scope of research in terms of physician populations and study contexts.

6.4.4 Referral and the Role of the Patient

6.4.4.1 Patients' Choice of Referral

The role of the patient in the referral process is a factor explored in this thesis; it is important to understand how referral is influenced by the patient's choice, and the factors that affect a patient's decision to request a specialist. The patient's viewpoint is an important consideration for the attending physician when deciding on a referee because the patient's trust and treatment experience can be a factor in treatment compliance and patient experience. As cited in Chapter 2, Heritage and Maynard (2006) discussed the different types of doctor–patient-relationships. They asserted that if the relationship is based on mutuality, the power of each participant is broadly balanced, the agenda for the visit is negotiated, the patient's values are explored, and the physician's role is that of an advisor in relation to the patient's goals and decisions. When the relationship is paternalistic, the physician's power outweighs that of the patient, and the physician

controls the agenda, goals, and outcomes in the doctor–patient relationship. Under a paternalistic approach, a biomedical and guardianship approach is adopted, whereby the physician determines the best interests of the patient without explicit consultation, assuming these to be in congruence with those of the patient.

Glatzer et al. (2020) recently highlighted that patient preferences in medical decision-making help treatment selection, especially when no clear treatment preference exists based on prevailing evidence. Even though SDM is an admirable goal and routine medical decision-making is moving towards achieving this goal, this model has several limitations since it is exposed to a variety of biases. This is especially evident in the setting of poor evidence where oncologists are more comfortable with the paternalistic model, as described by Heritage and Maynard (2006).

The paternalistic model sees physicians exert control over information and decision-making, and the patient may simply comply with what the physician recommends. This approach affects the decision-making process and the outcome, leading to the under-treatment of elderly women with breast or ovarian cancer (Glatzer et al. 2020). In Engelhardt et al.'s (2020) study, SDM is not a variable of a patient's trust in the oncologist; it seems that in this study, the participants were comfortable with the paternalistic model.

The issue of patient participation in decision-making in Germany has been intensively debated with respect to both legal requirements and clinical practice. Patients' rights were stressed by the enactment of a patients' rights act ('*Patientenrechtegesetz*') in 2013. Training programs on SDM have been initiated, and the German government endorses the issue of patient participation by funding research programs in this subject area (Härter et al. 2011, cited in Sulloch et al. 2013).

Stacey et al. (2010) highlighted how SDM can help foster PCC and it is particularly relevant given the increasing number of healthcare choices. SDM aims to achieve healthcare choices that are agreed upon by patients and their practitioners; these findings are congruent with more recent research by Niranjan et al. (2019). However, SDM is not routinely implemented in clinical practice and effective interventions to facilitate SDM are not being used. The reluctance to build a productive SDM platform is evident by the unwillingness to adopt changes by the GPs and SMPs alike; this is illuminated by Glatzer

et al.'s (2020) research, where similar barriers to SDM in oncology remains a current issue.

The thesis research demonstrated there is strong interest among both GPs and SMPs to improve patient and health outcomes by building affective healthcare teams through interprofessional education and achieving interprofessional collaboration. Interprofessional collaboration was demonstrated in the thesis result through acknowledgement by many participants of the importance of the MDT, and the strong support of the GP's role in disseminating referrals and in their being a bridge of communication between patient and specialist. The referral pathway was recognised by participants as being improved by interprofessional education events, such as those at which an SMP delivers education about their speciality to a small group of GPs.

The term 'interprofessional' is defined as a cohesive practice between professionals from different disciplines to provide a collaborative means of meeting the needs of the client/family (Stacey et al. 2010). The key elements of interprofessional collaboration identified in systematic reviews conducted by Stacey et al, (2010) include having two or more health professionals from different disciplines, a common goal, collaborative relationships, integrated and cohesive care, symmetry of power, shared knowledge, interactions over time, a common understanding of each other's role, interdependency among health professionals and a supportive organisational environment. Therefore, if SDM, a core ethical imperative of PCC, is to be moved into mainstream clinical practice, then it would be worthwhile to establish conceptual models that acknowledge the principles of both SDM and interprofessional collaboration (Stacey et al. 2010). Unfortunately, current interprofessional collaborative practice conceptual models and evidence reviews neither indicate how SDM principles including patients' preferences are woven into interprofessional collaboration nor describe the effect of interprofessional collaboration on SDM (Stacey et al. 2010; Glatzer et al. 2020).

Adapting an early study of Emanuel and Emanuel (1992) on the medical interview, Heritage and Maynard (2006) proposed a framework to assess the medical visit:

> Who determines as to who sets the goals of the visit? The patient, the physician or both through negotiation?

Whether the patient's values, as assumed by the physician, are jointly explored or unexamined? and

What is the functional role of the physician? Is it as guardian, advisor or consultant?

In the thesis research, GPs were asked during the semi-structured interview about the role a patient's choice plays in the referral decision. Nearly all the respondents agreed that the patient's choice for referral is to be respected. Among these, about half believed the patient has absolute discretion and the other half indicated that they will refer to the specialist of the patient's choosing as long as the attending physician agrees with the selection. A small minority did not agree that a patient has a choice, but they did indicate that they will still refer to a specialist not of the GP's choosing on the basis of convenience of location. Notably, the GP respondents that agreed that the patient has the final choice would object if they considered the patient's choice of specialist incorrect on clinical grounds, meaning that the specialist would have to be from the correct specialisation or subspecialisation to address the patient's disease.

This thesis examined the mitigating factors related to the patient's involvement in the choice of referral. When examined against the three-factor framework set by Heritage and Maynard (2006), it was found:

The goals of the consultation regarding referral are mostly set by both the patient and GP; the patient has a choice but is often guided by the GP when necessary.

The patient's values are mostly considered in the referral process by the GP.

The functional role of the GP is to mostly advise the patient on their referral decision. If the patient chooses the wrong specialty, for instance, it is the GP's role to advise the correct medical pathway.

Within-patient factors shown to influence the role of the patient in the referral process were, culture, sex and language barriers. Although language barriers fall under the theme of culture; these can be based on the ability to understand English and medical jargon; both aspects are barriers in understanding the diagnosis and treatment, as well as the ability to make an informed choice (Sulloch et al. 2013).

6.4.4.2 Cultural Issues in Referring

Australia is a multicultural society, and hence, it must be recognised that a patient's culture must be considered in the referral decision. According to the census in 2016, of the 6,163,667 people born overseas residing in Australia, 18% arrived since 2012 (Australian Bureau of Statistics 2016). In Australia, 300 languages are spoken, and 21% of Australians speak a language other than English at home (Australian Bureau of Statistics 2016). This is a very diverse demographic, and since cancer does not discriminate between sex, race or creed, the language barrier, which may create comprehension limitations, must be considered when choosing the correct specialist.

Analysis of the thesis results clearly revealed that the majority of the participants considered culture and/or sex to some degree in their choice of referral. The headings of 'moderate importance' and 'not in this area' (see Figure 6.1) are interesting because the GP is ignoring culture as a reason for referral, although Australia is widely recognised as a multicultural country. Some GPs appear to be taking a paternalistic approach as discussed by Heritage and Maynard (2006), which differs from most participants who took a mutuality approach in their referral decision, where the patient had an equal say in referral choice.

The paternalistic approach of the GP of not considering patients' culture could reduce compliance rates, by way of the patient not comprehending the specialist instructions and diagnosis and not asking questions if they do not understand directions (Sulloch et al. 2013). Given the diversity of Australian society, it is promising that the thesis findings suggest that a good proportion of referral decisions are based on a mutuality approach, considering the implications of culture and sex, and by providing a specialist who the patient understands and feels comfortable conversing with. Such diversity-based sensitivities can promote faster diagnosis and treatment times and reduce medical error (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012).
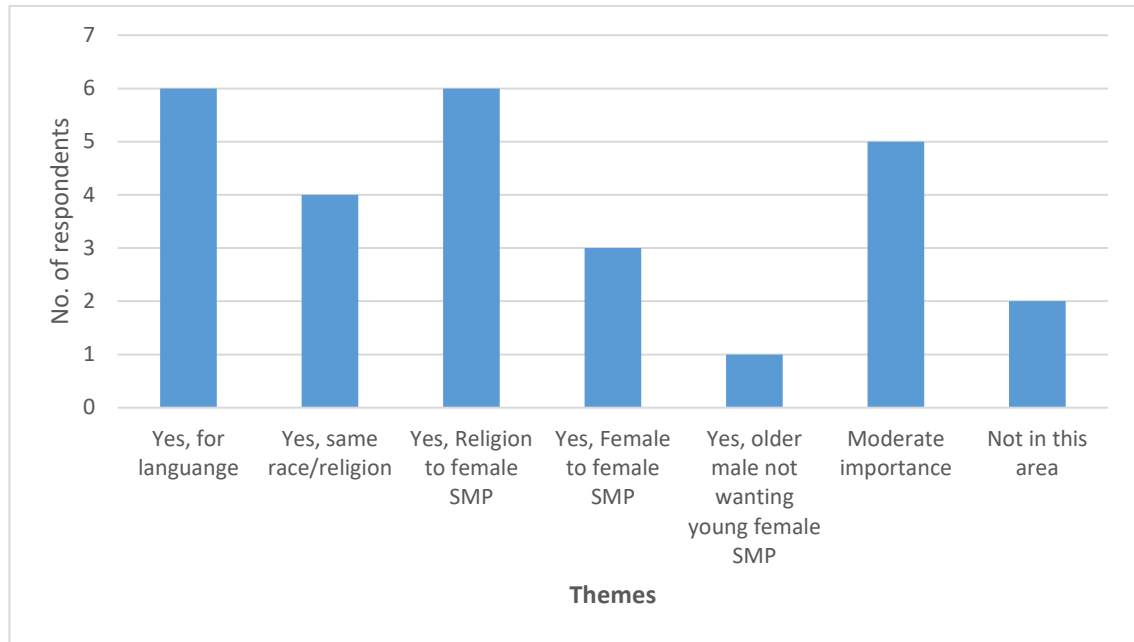
Figure 6.1: Culture as Determining Factor in Referring to SMPs

High patient understanding of the consultation and the implications of the diagnosis, treatment and/or change in treatment may significantly influence the patient's health. That is, 'Effective communication is essential in the delivery of quality patient care and building patient-doctor relationships based on compassion and shared respect' (Teutsch, 2003, p. 1115). When communication is multifaceted and multidimensional, opportunities for educating patients about disease evaluation, diagnosis, prognosis, and care can arise and be acted on (Suurmonf et al. 2017; Teutsch 2003). However, the business model of medical practice can sacrifice patient–doctor communication. This results from limited time, a focus on technology and the culture of medicalisation.

Sulloch et al. (2013) conducted an observational study in oncology in which they observed physicians on ward duties in a hospital, an outpatient clinic, and a world conference on tumours. They examined the role of the patient in oncology treatment. Physicians were shown to influence patients' perceptions of their disease and knowledge of treatment options by the language they used and by the amount of information they transmitted to the patients. Observations in the outpatient clinic showed that essential aspects of treatment, such as alternative therapies or dosages, were not brought into the doctor–patient conversation, but rather, perceived as subjects of medical expertise (Sulloch et al. 2013). Although this study did not examine the patients' choice in referral, it did highlight existing language barriers and the ability of the patient to ask questions in consultations about their health (Sulloch et al. 2013; Suwrmond et al. 2017). This is in

line with the findings of the present thesis, which shows language around medical jargon as an influencing factor in providing a positive or negative patient experience.

6.4.4.3 Choices Based on Sex

The choice of specialist can go beyond the skillset and likeability of the specialist; it should also include the perspective of the patient and their willingness to communicate with the specialist. As the thesis result showed, the desire of some female patients to see a female specialist can be strong and it extends beyond the bounds of religion. A GP or SMP who takes a mutuality approach to the consultation will discuss the needs of the patient and make a referral based on those needs (Heritage & Maynard 2006). One participant reported that they would not refer an older male patient to a young female specialist; although this may not be a popular response, it is still an example of a mutuality approach because the referring doctor has taken into consideration the needs of the patient when choosing a specialist.

Janssen and Lagro-Janssen (2012) reviewed studies on women seeking gynaecological or obstetrical care and physician's gender. They focused on patient preferences, differences in communication style and patient satisfaction. The review found that most patients preferred a female rather than a male gynaecologist–obstetrician, a result which was partly explained by the more patient-centred communication style used by the female physician. This is congruent with a more mutualistic approach as described by Heritage and Maynard (2006), in which the patient and the consulting physician discuss the options, agree on outcomes and plan a course of action. Patient satisfaction increased when gynaecologists–obstetricians used a patient-centred communication style (Janssen and Lagro-Janssen 2012).

Franks and Bertakis (2004) examined the relationship between physician and patient gender using data from the US National Ambulatory Medical Care Surveys. The results highlighted that female physicians were more likely to see female patients, had longer consultations and were more likely to perform female prevention procedures and make some follow-up appointments and referrals. The thesis research participants highlighted the importance of referring a female patient to a female specialist if available and when requested.

Female physicians were more likely to check patients' blood pressure, but there were no significant differences in other non-gender-specific prevention procedures. Among encounters without breast or pelvic examinations, visit length was not related to physician gender, but consultations were longer in female physician with female patient visits than in mixed gender visits (Franks & Bertakis 2004). Thesis research participants recognised and confirmed the need to refer based on gender where appropriate.

6.5 Implications for High-value Service Provision in Australia's Private Specialist Medical Sector

6.5.1 Medical Professionalism: Professional Lens in Medical Practice

Owing to the stringent laws around medical advertising and the limitations on what an advertisement can claim (AHPRA 2014), medical professionals must create other avenues to attract patients. GPs rely on word-of-mouth marketing as their primary driver to build their practice. However, specialists cannot attract patients directly, and hence they must pursue other means to increase value in their service and create a competitive advantage.

This thesis examined the competitive advantage in specialists' practice; Three themes were tied to the view that competitive advantage was being accrued:

1. providing a good patient experience through good patient management;
2. relying on their clinical expertise to provide a good therapeutic outcome; and
3. providing good accessibility for timely treatment.

Research cited in Chapter 2 showed that staff attitudes, behaviours, service level orientation and, more recently, engagement level, are likely to influence the customer satisfaction level (Grönroos 1990; Johnson & Grayson 2000; Kim, McCahon & Miller 2003; Kim, Leong & Lee 2005; Teng & Barrows 2009). This is congruent with the thesis results showing that some SMPs reported an emphasis on providing excellence at all levels in their practice from the specialist right down to the receptionist.

Specialists seeking differentiation to surpass their competitors should create a service-oriented climate by selecting highly engaged employees (O'Connor & Shewchuk 1995) who strive to satisfy consumers (Grönroos 1990; Hennig-Thurau 2004; Heskett, Sasser

& Schlesinger 1997). One SMP participant in the thesis expressed the belief that their competitive advantage was accrued via their accessibility, timely provision of quality care and a more patient-oriented approach as well as their provision of a personalised patient experience.

Specialists who pursue service-oriented business strategies are likely to build long-lasting relationships, enhance consumer commitment (Homburg, Hoyer & Fassnacht 2002), create competitive advantage (Teng & Barrows 2009) and positively influence their financial performance (Homburg, Hoyer & Fassnacht 2002; Kohli & Jaworski 1990; Lytle & Timmerman 2006; Narver & Slater 1990). A specialist relies on referrals for business, and by providing good service to GPs, their main source of referral, they can increase their practice. One GP participant stated that service orientation comes from the top down; this participant expects expedited help from specialists in times of emergency, but in general referrals, expects accommodating service from the support staff and reception.

Trust within a health system may be influenced by professional norms and power dynamics between nurses, doctors and others in a healthcare organisation and may shape attitudes and practices towards patients (Foot 2005). Trust also plays a critical role in public–private health partnerships (Jones & Barry 2011) since it addresses the problem of information asymmetry and diminishes the transaction costs associated with extensive external monitoring (Bloom, Standing & Lloyd 2008). Having a trusting and trusted health system can then contribute to fostering wider social value and social order (Gilson 2003).

This thesis explores the managerial implications of reduced accessibility and its implication to medical error and service quality. The effect of reduced accessibility to consultations through poor referral decision(s) and practice(s) can affect the patient experience in oncology treatment.

Oncologist burnout can contribute to medical error; Australia has 1.4 medical oncologists per 100,000 head of population, compared with 3.5 in the US (Blinman et al. 2012). This small representation of the population coupled with a projected cancer incidence of 150,000 cases and just under 50,000 deaths (Australian Institute of Health and Welfare 2018) can have a managerial influence in relation to maintaining staff to treat patients

through oncologist overwork and burnout. The impact on the patient translates to diminished accessibility, poor service, and a negative experience. This thesis reported that both GPs and SMPs observed that a positive patient experience was in many respects synonymous with ease of accessibility and quality service that provides both value and satisfaction to the patient.

Murali et al.'s (2018) study in the US context described the personal and professional consequences of burnout as profound. As demand for oncologists continues to grow, burnout has the potential to exacerbate projected workforce shortages through a concerted reduction in time dedicated to patient care and overall work hours or through early retirement (Murali et al. 2018). This perpetuates a vicious cycle because increasing demands in the context of decreasing resources will propagate workplace tension. The annual US productivity loss attributable to burnout is substantial, as is the cost of replacing a physician who retires early or leaves the profession. Australia may face a similar situation, given the country's low number of oncologists—1.4 medical oncologists per 100,000 head of population, compared with 3.5 in the US (Blinman et al. 2012; Franco et al. 2020; Murali et al. 2018;)

6.5.1.1 Value v. Satisfaction: Aspects of a Practice that Enhance a Patient's Experience

The aspects of a specialist consultation that enhance patient satisfaction are an important facet to measure when examining HVC. Palmer Kelly et al. (2020) explored HVC provision in the US context through the experiences of cancer patients and their caregiver/family members as regards their relationship with their oncologist, healthcare team and the hospital environment. Three major themes that emerged around the patient–oncologist relationship included:

1. choosing a physician and healthcare location;
2. relationship with the physician, healthcare team and hospital environment; and
3. patient engagement and decision-making.

Subthemes highlighted the importance of the flexible communication behaviours and trustworthiness of the oncologist and the impact of other healthcare team members. Patients also reported the desire to be engaged in making treatment-related decisions and to include the caregiver/spouse in all stages of cancer care (Palmer Kelly et al. 2020). These findings are similar to the thesis results in which the following themes associated

with HVC emerged: patient experience, clinical outcomes, accessibility, cost and interpersonal connectedness of the specialist. Participants perceived the following as aspects of the practice that provide value to the patient: better patient experience, improved clinical outcomes, greater accessibility, and affordable treatment. These findings support the view that the importance of the specialist in providing value to the patient is key to building a positive reputation for the practice to attract further patients. The themes reported in this Thesis about value for the SMP and value for the patient are quite similar, and an inference can be drawn that working on multiple points of satisfaction can build value for the patient (Palmer Kelly et al. 2020).

There is currently a significant lack of research that seeks to identify contributing factors to business growth within a service environment, such as specialist medical care. Perhaps this is due in part to the particular nature of the healthcare industry in which the usual marketing and business strategies are not applicable. This prohibition of direct advertising to the public is imposed by the regulations and legislation, such as the *Health Act* 1954 and the *Health Administration Act* 1982 (NSW), as well as the specialists' respective accrediting college/body. Providing HVC to attract patients is the only means of advertising at the disposal of SMPs; this highlights the importance of providing a value-based patient experience to garner loyalty that could foster repeat business and promote word-of-mouth referral.

According to Zeithaml (2000), service plays a critical role in retaining customers. Providing a service at a reasonable cost is an aspect of practice that can attract patients and can be viewed as a degree of value for money and therefore a satisfying experience; but this can be replicated or under-cut by other specialists and is not a lasting model. However, providing consistently good service is a distinct competitive advantage since it is harder to replicate and therefore is likely to be the cementing force, both in patient relationships and referral relationships.

Keating et al. (2004) conducted a survey of patients referred to specialist physicians. They highlighted the importance of the specialist's listening skills, knowledge, and the ability to impart knowledge; the follow-up on treatment, the identification of changing symptoms and the prescription of a possible course of action; and the inclusion of the patient in decision-making. The numerous components of exchange flagged in the survey

results not only provided satisfaction to the patient, but also added value through a trusting, transparent relationship.

Trust is an important component in a relationship; it provides value to the patient through peace of mind, and for the specialist, it provides a loyal patient who will return for follow-up consultations In Chapter 2, the positive relationship between patient loyalty and frequency of patient visits was discussed (Choi et al. 2004). Patient loyalty is a result of providing a valued service through positive patient experiences, which leads to repeated consultations and increased referrals. A practice that provides value to a patient leads to profitability as well as to building a sustainable patient base that will compel patients to choose the same provider again (Ruyter, Wetzels & Bloemer 1998; Sardana 2003), but also to the development of relationship engagement with the referrer.

6.5.1.2 Culture of Dependence on the GP Referral

The role of the GP as a gatekeeper in the medical system refers to their control over the initial referral of the patient to the specialist and their power over patient dispersal. The thesis research explored both the popularity and effectiveness of the gatekeeper system through the lens of the specialist. The results highlighted that all specialists agreed with the gatekeeper model; however, the degree to which they approved differed to a minor extent. Participants believed that the system works well because the patient should not have direct access to the specialist and that the GP's role as gatekeeper prevents chaos in the system and can create continuity of care and greater collaboration. However, one participant noted that they agree with the system, but a limitation is the knowledge of the GP and its likely effect on correct referrals.

GPs and specialists in Australia have been involved in Medicare-regulated 'shared care' for more than 30 years. The Health Insurance Commission hallows the role of the GP as the gatekeeper to the health system and requires patients to see a GP in order to be referred to a specialist. However, the regulatory requirements may affect quality of care. For example, if specialists are not obliged to communicate with GPs and a single practitioner is not identified as responsible for coordination of care, patients may move from one specialist to another for different ailments (Piterman & Koritsas 2005).

Hiom (2015) discussed healthcare systems throughout Europe and the variations in the extent to which GPs are gatekeepers. While GPs in Sweden have no gatekeeping role, in

Switzerland, a third of the patients choose a health insurance model that uses GPs as gatekeepers. Croatia and Slovenia require their GPs to be gatekeepers within their public health systems, but private patients can see specialists without a GP referral. As is the case in Australia, in Spain and the UK, GPs have a gatekeeping role for all patients. The countries with the gatekeeper system have a significantly lower one-year relative cancer survival rate than systems without gatekeeper functions (Hiom 2015).

Khare et al. (2021) examined cancer referral pathways in the Canadian health system. They compared lung cancer patients ($n = 50$) who were referred by GPs ($n = 34$) to those that presented at emergency departments ($n = 16$) and were referred through to oncologists via this route. The results showed that lung cancer patients who were referred through their GP took twice as long to receive a referral to an oncologist than the group that went through the emergency department. Owing to this delay, the GP group also presented with a more advanced stage of cancer than their emergency department counterparts (Khare et al. 2021). In this instance, it is evident that the GP cohort were inferior to the emergency department referral group; this could be due to the lack of education in oncology, which this thesis has identified as a weakness in the oncology gatekeeper referral system.

Green, Atkin and Macleod (2015) found that GP participants valued their gatekeeper role and perceived that the GP's skill was to distinguish those patients in need of further investigation or referral from those who could be managed within primary care. The ability to perform this role adequately was perceived to be dependent on the quality of the GP/patient relationship and the GP's role as patient advocate. GPs often felt that the bureaucracy of the medical system was limiting; this included the guidelines and the 2-week-wait (2WW) urgent referral routes available for potential cancer symptoms in England. Although GPs valued 2WW, they also highlighted its limitations when symptoms do not meet guideline criteria, and referral criteria then acted as a barrier. In these cases, GPs had to foster strategies that leverage relationships with specialists to bypass the system and obtain the necessary appointments. The GP respondents in the present thesis reported that similarly to their GP counterparts in the Green, Atkin and Macleod (2015) study, they also use interprofessional relationships with SMPs to fast-track an appointment for a patient in times of emergency.

The potential diagnosis of cancer was a concern for GPs because these consultations absorbed considerable time. Inherent uncertainties in cancer symptom recognition and referral decisions in primary care were also factors that needed to be overcome; the skill required in the management of risk and uncertainty has been noted as an aspect of practice that increases patient consultation times (Cook et al. 2014; O'Riordan et al. 2011; Round et al. 2013). A weakness in the GP's knowledge can be a limitation in the gatekeeper system and often increases non-productive time spent with patients. This thesis did not directly examine SMPs non-productive time with patients, but indirectly reported on this aspect as a result of incorrect referrals due to GP knowledge gaps in oncology specialties and subspecialties, as well as in knowing when best to time referring cases where early intervention can make a difference.

6.5.2 Non-competing System of Medicine for Better Collaboration

Some participants in this thesis opined that creating a non-competing system of medicine between public and private systems would ultimately provide HVC and that the focus should be on providing the best outcomes for patients. A recent retrospective cohort study in Victoria (Weerakoon et al. 2015) had tested this view, and it found that patients with very low-risk or low-risk prostate cancer were more likely to be placed on active surveillance if managed in a private institution than in a public hospital. Active surveillance refers to the monitoring of the non-acute stage of the disease, and the fact that the private system was more likely to monitor low-risk cases indicates their propensity towards preventive medicine. This approach by the private system could be construed as providing better service to patient and could be a by-product of a better resourced, better-managed system. Such views were expressed by the thesis research participants. Reasons for the apparent underuse of active surveillance in the public system might relate to the culture, structure and the organisational and financial constraints of public hospitals compared with private facilities in Victoria, where treating the more acute stage of the diseases is regarded as a better use of funding (Weerakoon et al. 2015). This explanation is congruent with the thesis results about participants reporting that the private sector can be more efficient than their public counterparts owing to the financial constraints of the public system, which ultimately results in limiting HVC to patients.

In Chapter 3, the trust of the patient in a medical institution about receiving quality care was examined. Ward et al. (2015) highlighted the blind trust the patient has in the public

system, given that they have no say in the doctors who treat them. The patients in this study understood the failings in the underfunded public system but ultimately trusted the doctors' training and forgave any shortcomings, given that the doctors were doing the best they could in an imperfect system. This acceptance and defence of the failings of the public system do not equate to HVC; public patients, who are often in the public system due largely to personal financial restrictions and for their own intrapersonal comfort, often find ways to trust the public system doctors. Ward et al. concluded that the lack of competition for patients between public and private hospitals does not force doctors to assess and improve their quality.

The contrasting views of the quality of service between doctors and patients emerge from two very different viewpoints; the participants in this thesis work within the Australian medical system and have first-hand knowledge of the strengths and weaknesses of the competing systems; the patients are those diagnosed with cancer and can therefore have a vulnerability behind their quality assessment. As shown by Ward et al. (2015), patients want to believe they are receiving the best treatment from a doctor not of their choosing in a system that they understand is underfunded.

The participants in this thesis regularly asserted that a non-competing system should focus on the best outcome for the patient; however, the reality is that the systems do compete since the public system is underfunded and actively recruits private patients to boost revenue. Some SMP participants opined that in this situation, two patients may be lying in adjacent beds, but one could be paying private fees and the other could be receiving free treatments, which is an unfair situation for the private patient. According to Weerakoon et al. (2015), the private patient in the public system is likely receiving lower-quality treatment than they would in a private facility. However, this assertion is likely to hold in only some diagnostic contexts.

The thesis result emphasised a widespread view among both GPs and SMPs that the competing systems could and should work collaboratively, in that some private systems do not have the same level of facilities as public hospitals and therefore rely on the public system to fulfil the medical needs that the private system lacks. Conversely, the efficiently run private system could take excess patients from the overburdened public system in times of emergency.

6.5.3 Medical Error: Impact on Delay to Treatment

Medical error can result from delay to diagnosis and to treatment. An aspect that this thesis discovered from the specialist cohort of participants is that the delay can begin with incorrect referrals. According to many of them, providing GPs quality education in oncology is a sound preventive measure to reduce medical error. The specialist participants stated that GPs do not see many oncology patients, and in the cases of rare tumours, the GPs might only see a couple of examples in their whole career.

The results of a brainstorming exercise among European GP research experts (Harris, et al. 2016) highlighted the poor rate of survival outcomes for cancer patients in the UK and the wide variation across European countries, leading to high mortality. Poor one-year survival rates are generally taken to be a gauge of a more advanced stage of disease at the time of diagnosis. For those patients that survive at least a year after their initial cancer diagnosis, there is less national variation. Although overall cancer survival trends are improving in Europe, there is little narrowing in the differences between European countries. International variations in cancer outcomes are related to differences in stage at diagnosis. This may be due to both differences in diagnostic delay and GP awareness of symptoms. Clearly, the need to achieve a timelier diagnosis warrants priority.

In a national, population-based modelling study, Maringe et al. (2020) predicted the impact of delay to diagnosis and treatment as a result of COVID-19 lockdowns. This study is in line with this thesis in that it postulates that delay to diagnosis and treatment is associated with poor outcomes in patients with an oncology diagnosis. Maringe et al. (2020) obtained information on adults in the UK with lung, colon and rectum cancers, oesophageal and gastro-oesophageal junction cancer and breast cancer from the National Cancer Registration Service. They created a conceptual framework that assumed that the incidence of each of the four tumour types of interest would remain relatively stable year on year based on trends in previous years (2010–2018), and that the ongoing COVID-19 pandemic and UK lockdown will mean patients are more likely to delay presentation. The researchers estimated the subsequent impact on survival by reallocating patients from screening and non-urgent routine referral pathways (from GPs and secondary care) to urgent pathways—namely, 2WW referral routes and presentation at an emergency department. Both of these urgent pathways are associated with a later stage of diagnosis and enabled the researchers to estimate the impact of diagnostic delay on stage migration

and survival outcome (Maringe et al. 2020). They based their analysis on three sets of predictions according to possible changes in referral patterns:

Scenario A: The researchers projected survival outcomes for patients by transferring those who are expected to be diagnosed through screening and routine referral pathways (GP or secondary care) to 2WW and emergency presentation pathways, from 16 March 2020.

Scenario B: Largely the same as scenario A, but they simulated the effect of an 80% decrease in 2WW referrals from 16 March, which has already been observed during the lockdown period, and presumed that this reduction will continue (due to COVID-19-related concerns) for a period of up to three months. Emergency presentations are assumed to continue at their usual rate. Therefore, they reallocated the backlog of patients in months 4–12 to 2WW pathways and emergency presentations.

Scenario C: It builds on scenario B, but the researchers simulated the effect of 2WW referrals continuing to be reduced beyond the first 3-month period by 25% for a further 3-month period, until month six after introduction of physical distancing measures. Under this scenario, emergency presentations are assumed to continue at the usual rate. Therefore, they reallocated the backlog of patients in months 7–12 to 2WW pathways and emergency presentations.

The researchers projected the impact of delay in diagnosis for the 12-month period from 16 March 2020 to 15 March 2021. Across all scenarios, the researchers estimated an absolute decrease in cancer survival ranging between 1.0–1.1% (breast, all scenarios) and 6.1–6.3% (oesophageal) at one year after diagnosis, and between 3.5% (lung, scenario A) and 6.4% (colorectal, scenario C) at five years after diagnosis (Maringe et al. 2020).

The researchers estimated rates for the scenarios compared with the pre-pandemic period: a 2.1–6.6% increase in the number of deaths due to breast cancer up to year 1, a 6.8–9.1% increase up to year 3 and a 7.9–9.6% increase up to year 5. For colorectal cancer across scenarios A–C, the researchers estimated an 18.2–20.3% increase in deaths due to cancer up to year 1, a 16.1–17.6% increase up to year 3 and a 15.3–16.6% increase up to year 5. For lung cancer across scenarios, the researchers estimated a 6.0–7.7% increase in the number of deaths due to cancer up to year 1, a 5.1–5.8% increase up to year 3 and a 4.8–5.3% increase up to year 5. For oesophageal cancer, the researchers estimated a 9.3–

10.3% increase in deaths due to cancer up to year 1, a 6.4–6.7% increase up to year 3 and a 5.8–6.0% increase up to year 5 (Maringe et al. 2020).

The plateau in additional deaths due to cancer over the 5-year period for lung and oesophageal cancer reflects relatively higher proportions of early cancer deaths at year 1 due to more advanced stage at presentation in the scenarios. In the pre-pandemic period, some of these patients would have been expected to die after year 1 as a result of less advanced disease at presentation compared with the pandemic scenarios. Overall, in comparison with the pre-pandemic period, the estimated number of additional deaths attributable to these four cancers at five years is between 3,291 and 3,621 deaths across the scenarios due to delays in cancer diagnosis (Maringe et al. 2020).

The information provided by the Maringe et al. (2020) prediction study on the potential outcomes for oncology patients due to delayed treatment has illuminated the same dangers this thesis hypothesises about: poor prognosis for cancer patients that is created by incorrect and late referrals causing treatment delays.

6.5.4 Forms: Need for Comprehensive Referral Forms

The need for comprehensive referral forms when referring a patient was a strong theme in the thesis result in that most of the GP respondents agreed that referral forms need to be complete and comprehensive. A comprehensive referral form should have a patient's current medical diagnosis, a complete medical history, and present and past medications. However, a minority of participants felt time was a limitation for GPs in completing a complex referral, and for specialists, in reviewing information not directly relevant to the current diagnosis.

Harris et al. (2016) noted that the expectation that the GP will write a detailed, comprehensive referral letter may discourage the GP from doing so owing to time restraints of the consultation. In Sweden, where a typical GP appointment is 30 minutes, patients have more time to mention symptoms that concern them and the GP has more time to consider whether investigation or referral is needed, compared with those in many other countries. Strict time restraints through short consultation times could negatively affect referral quality; with a high workload, GPs may be more likely to refer unnecessarily on cases to reduce follow-up appointments. This reason for referral possibly creates an unnecessary burden on a specialist's workload and therefore reduces

their accessibility, potentially creating delay for patients with appropriate clinical need; it has been noted throughout this thesis that delay to treatment is a form of medical error that can affect treatment outcomes.

Piterman and Koritsas (2005) researched the effectiveness of the referral letter in conveying information and found that specialists are generally dissatisfied with the information provided. Specialists often complain that they do not receive enough information to adequately address the problem and that referral letters from GPs lack information about the reason for consultation, socio-psychological factors or follow-up plans. Specialists also express concern regarding the absence of information about clinical findings, test results and prior treatment details (Ghandi et al. 2000).

Bodenheimer (2008) identified the need to improve referral forms in the context of coordinated care centres, discovering that some medical practices adopted referral agreements between PCPs and specialty practices that specify the responsibilities of each party. Referral agreements outline the clinical conditions that are best managed within primary care and the conditions that are best referred; specify the studies to be performed before specialty referral; and compel the specialist to see the patient promptly, answer the questions posed by primary care and report back to primary care in a timely fashion. Although referral agreements are a step beyond a complete and comprehensive referral form, they are of the same type in that they create a requirement for complete information so that decisions can be made without delay. Referral agreements have a greater requirement of communication and accessibility than comprehensive referral forms, which ensures greater accountability for all the parties in the collaborative treatment team. More systematic study is needed to rigorously evaluate the merit of these innovations (Bodenheimer 2008).

An earlier 1993 study by Fertig et al. examined the referral practices of Cambridge GPs in the UK. Their conclusion differs from those of later studies in this area (Bodenheimer 2008; Harris, et al. 2016) in that it concluded that the variation in referral rates among GPs could not be explained by inappropriate referrals. In such a scenario, application of referral guidelines would be unlikely to reduce the number of patients referred to hospital.

A varying body of work in this area (Bodenheimer 2008; Fertig et al. 1993; Harris, et al. 2016; Piterman & Koritsas 2005; Westerman et al. 1990) has highlighted the need for a

standardised referral form in order to provide complete and relevant information to the referee, so that clinical decisions are based on all the facts. Of note, these studies that consider what is essentially the same point (i.e. the need for standardised referral documentation) range from 1990 until the near present. This indicates that little has changed in 30 years (since the 1990s) and is congruent with the thesis result that most respondents agreed that a comprehensive referral form was necessary when sending a patient to a specialist.

6.6 Perspectives on Sector-wide Changes Needed to Deliver High-value Care

6.6.1 Bringing About Sector-wide Change: Overcoming Challenges

6.6.1.1 Cost of Unnecessary Testing and Treatment

Reducing unnecessary treatments of patients should be a priority in providing HVC (Millensen & Berensen, 2017). The thesis results indicated that some participants identified the need for sector-wide change through determining unnecessary practices and investigations, ending treatment when it is no longer beneficial and communicating effectively within the collaborative team to avoid repeating medical testing.

Over-diagnosis is a relatively common phenomenon that entails diagnosing 'diseases' that do not necessarily decrease a patient's lifespan or quality of life, with rates as high as 30% for breast cancer screening alone. This has resulted from the greater use of increasingly sensitive diagnostic and screening tests, generous disease definitions and more testing in patients with low to very low pre-test probability of disease (Moynihan, Doust & Henry 2012; Scott, 2014).

Moynihan, Doust and Henry (2012) examined the impact of over-diagnosis on the healthy population. Over-diagnosis is often a result of over-screening (diagnostic tests). Diagnostic scanning of the abdomen, pelvis, chest, head and neck can reveal incidental findings in up to 40% of individuals being tested for other reasons. Some of these tumours are malignant, but most are benign. The authors claimed that a very small number of people will benefit from early detection on an incidental malignant tumour, whereas others will suffer the anxiety and side effects from the treatment of an abnormality that may have never harmed them. The authors cited a 2007 systematic review in the *Lancet*

Oncology, which found that the proportion of over-diagnosis of invasive breast cancer among women in their fifties ranged from 1.7% to 56%; an Australian study estimated that the rate was at least 30%, while a Norwegian study calculated it as 15–25%. A 2009 systematic review in the *BMJ* concluded that up to 33% of all screening-detected cancers may be over-diagnosed (Moynihan, Doust & Henry 2012).

Over-diagnosis is being addressed at policy level. The US National Institute of Health has been performing a dispassionate assessment of evidence to narrow disease definitions, as has been seen with tentative proposals to raise thresholds for hypertension, which could de-medicalise 100 million people (Moynihan, Doust & Henry 2012). Similarly, Millensen and Berensen (2017) explored the overuse of chemotherapy and reported on the lack of transparency of oncologists in communicating that in end-stage cancers, chemotherapy is unlikely to be curative.

Apart from the emotional aspect and family influences that drive over-testing as reported in this thesis, a key driver in over-diagnosis is the technology itself and the businesses that benefit from said technology. These industries that profit from over-testing have wide-reaching influence in the medical community through financial ties with professional and patient groups, research foundations, disease awareness campaigns and medical education; most importantly, they are members of panels that write disease definitions and treatment thresholds (Moynihan, Doust & Henry 2012).

Schnipper et al. (2015) suggested that the adoption of newer, more expensive diagnostic and therapeutic interventions in oncology may not be well supported by medical evidence and would raise costs without improving outcomes. Coupled with, or even driving, some of these rising costs are sometimes unrealistic patient and family expectations that lead clinicians to offer or recommend some of these services, despite the lack of supporting evidence of utility or benefit (Millensen & Berensen 2017; Schnipper et al. 2015). The thesis results were strongly supportive of a medical view that in order to provide HVC, SMPs need to practice evidence-based medicine and to resist the pressure placed on them by patients and family to explore expensive, experimental medicine.

Similar to the stresses of cancer treatment, financial stress resulting from out-of-pocket treatment expenses can also reduce quality of life. Patients experiencing high out-of-pocket costs have reported reducing their spending on food and clothing, reducing the

frequency of taking prescribed medications, avoiding recommended procedures, and skipping physician appointments to save money. These unintended consequences risk an increase in health disparities, which runs counter to some of the key goals of healthcare reform (Millensen & Berensen 2017; Schnipper et al. 2015).

Owing to the financial burden placed on patients, they specifically want financial information about treatment alternatives along with information about medical effectiveness and treatment toxicity. However, they often do not receive it. Patients with cancer are often surprised by, and unprepared for, the high out-of-pocket costs of treatments. They also overestimate the benefits of treatments that sometimes extend life by only weeks or months or not at all (Schnipper et al. 2015). Treatment cost recurred as a subtheme in the thesis that highlighted that to overcome the challenges of providing HVC, there needs to be affordable treatment for patients.

Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience (ABIM 2004, p. 2). The thesis results indicated that the subtheme of practising only evidence-based medicine was strong; this position was put forth by respondents as a means to protect patients from medical error and promote HVC.

6.6.1.2 Using Evidence-based Practice

Evidence-based practice is often understood to be a decision-assisting mechanism that emphasises the provision of treatments that have been proven to be effective through rigorous testing in randomised clinical trials. Evidence-based medicine is often referred to as the gold standard of medicine and should form the basis of clinical reasoning (Kienle & Kiene 2010). However, in the case of patients in an advanced stage of cancers where survival is diminished and quality of life is limited, the consulting physician may feel pressure from the patient and/or the patient's family to seek treatment that is not evidence based. In this case, the ability to discern the clinical efficacy and safety of a drug or treatment can be difficult, and thus, the specialist needs to follow the practice standards of the Royal Australian College of General Practitioners: 'in the absence of well-

conducted clinical trials or other higher order evidence, the opinion of consensus panels of peers is an accepted level of evidence and may be the best available evidence at that time' (Margolis 2018, p. 325).

Practising evidence-based medicine in oncology was discussed by participants in the thesis, in relation to the use of experimental medicine, or medicine with a low percentage of success in oncology patients. Significant numbers of participants identified this theme as important for both the patient and the medical industry. From the patient's perspective non-evidence-based medicine could subject them to unnecessary side effects and costs and decrease their quality of life. The lack of proper clinical testing through randomised clinical trials means the medicine will not be listed on the Pharmaceutical Benefits Scheme, and therefore, the price will be set by the manufacturer.

In 2012, the American Society of Clinical Oncology responded to the Choosing Wisely Campaign of the American Board of Internal Medicine Foundation and identified specific instances of overuse of non-evidence-based medicines in the delivery of cancer care (Schnipper et al. 2015). The Society used a deliberative consensus process to identify five common clinical practices that are not supported by high-level evidence. A second list of five was developed using the same process and submitted to the Choosing Wisely Campaign in 2013. The Society amplified the evidence basis for both top-five lists in two publications and is now developing measures to evaluate the use of these practices as part of its Quality Oncology Practice Initiative. These exercises have provided opportunities to develop a rigorous but flexible approach to assessing efficacy across diagnostic and treatment domains (Schnipper et al. 2015).

Evidence-based care respects the values and preferences of the person (Sackett et al. 2000). Through a collaborative process, persons affected by cancer develop preferences for both a method of decision-making and for particular care options. The process of informed consent establishes a shared decision for a reasonable course of action. Care decisions and actions occur within the context of regulations, professional standards and legal requirements, as well as within the context of particular clinical settings, available resources and political jurisdictions, and in relation to society. Health professionals advocate for improvements in practice in accordance with best research evidence and the definition of evidence-based care (Principle 6, Canadian Association of Psychological Oncology 2010).

6.6.1.3 Providing Education for GPs

The thesis study results highlighted the need for greater education for GPs. This was perceived to be able to enhance the patient experience through better referral pathways and to identify which treatments different specialists provide by providing an intimate knowledge of their facilities and capabilities. Referring to the correct specialist in the first instance is an important factor in reducing time to treatment. The role of the GP in the continuity of care of the patient is important, and with a more complete understanding of oncology, they can be a better advocate for the patient (Green, Atkin & Macleod 2015).

Holge-Hazelton and Christensen (2009) examined the role of GPs in treating young adults with cancer. The GPs tended to use everyday language in their communication with patients; the experiences were that the patients disappear, they are seldom involved and that they lack knowledge. The authors concluded that although the GPs have few experiences with young adult cancer patients, they have a unique role in general primary cancer care if they develop their vocabulary, relate more to relevant theory, and develop a clear vision of the content of the professional aspects of their work. In such a scenario, the case for GP education can be made directly, and it is congruent with the thesis results that located a widely agreed view that the GP can play a collaborative role in the oncology process through disseminating treatment information to patients in a language they understand.

GPs often need reassurance that they are not missing an important condition or that their management of the condition is appropriate, particularly when treating chronic and complex diseases and multiple comorbidities. Referral to specialists for reassurance or to obtain a second opinion is common (Lee et al. 1983; Piterman & Konsitas 2005). Increased education may provide GPs with more confidence in their decision-making, making them less likely to refer based on lack of understanding. Many of the thesis participants (GPs and SMPs) asserted that a stronger emphasis on educating GPs could streamline the referral process via improved knowledge of specialties and subspecialties, as well as via correctly identifying the urgency of the referral so as not to under-refer urgent cases and over-refer palliative cases.

The thesis results highlighted that GPs wanted education from specialists, and they welcomed them as guest speakers at their informal meetings, as a means to both learn

from them and develop a referral relationship with them. This was in line with Marshall et al.'s (1998) finding about a mismatch between what the GPs wanted from specialists in educational terms, and what the specialists were providing. GPs wanted to learn information that was directly applicable to their clinical work and to use referrals as two-way learning opportunities; however, they were not sufficiently explicit about their learning needs. Specialists preferred to concentrate on new developments in their subject and would benefit from learning different ways of teaching. The participants were willing to learn from each other.

6.7 Chapter Summary

Chapter 6 sought to explore and, where appropriate, link extant research findings to the thematic areas that were discovered and reported on in Chapter 5. Respect, collegiality, and reputation were noted as key determinants of interprofessional relationship commencement. These factors are predictable by both SET- and RMT-informed views of the interprofessional relationship.

Trust was fundamentally important as the strongest contributor to the durability of an interprofessional referral relationship. This is predictable by SET and widely found in the extant literature. Trust's key role as a maintainer of exchange relationships raises a vital problematic—the more trusted the SMPs, the longer their waitlist/wait time is likely to be. Hence, paradoxically, the less likely they may be to generate an optimal treatment outcome for referred patients (since the timing of treatment commencement is key to cancer outcome).

Communication was shown to be important here, since good communication pathways were discussed by the thesis participants (and in the wider literature) as potentially ameliorative of wait-related dilemmas. Collaboration and MDT involvement were also shown to be important, as was the prizing of accessibility by referrers as vital to their referral decisions.

A balance can therefore be proposed, between trust as an interpersonal maintaining influence, and accessibility as an extra-personal and pragmatic influence, which may outweigh the influence of trust on decisions to refer.

Patient experience was shown to be key to relationship durability, because regardless of trust or perception of clinical expertise, patient feedback to GPs about their experience with SMPs was highly predictive of ongoing referral behaviour. Patient-centric conceptions of care are ascendent in healthcare at present, and it is encouraging to locate strong patient-centred informed practice among referrers. This role for patient-centredness as a driver of relationship maintenance was not as strongly found in the context of SMP–SMP referral relationships, where 'tit for tat' referring in the pecuniary interest of practitioners (irrespective of patient-specific factors) remained a commonplace phenomenon among thesis respondents. Such material reciprocity can be predicted by a SET-informed view of this relationship, although in contrast to this, the reciprocal exchange for the GP is non-pecuniary in nature and revolves around the prospect of gaining informational access to an expert. These findings are novel to the very small body of existing literature concerning both the SMP–SMP and GP–SMP relationships.

This thesis explored clinical judgement and decision-making factors associated with referral practice and found significant gaps in the current Australian scene. GPs and SMPs both reported that GP referrals would benefit from greater GP knowledge. An incorrect referral wastes everyone's time, and it would appear that this is not rare in the Australian space. Better GP education has been proposed already in the literature, and the thesis result supports such a strategic aim.

Further, the introduction of standardisation in relation to documented communication around referral was strongly emphasised by participants and by published commentators dating to the early 1990s. Turning to the wider operational environment within which practice occurs, HVC was widely held to be unachievable in the absence of positive patient experience and outcome. The thesis participants often expressed a wish for a system that did not promote competition between public and private sectors, in favour of a non-competing system that focuses on the best outcome for the patient. Nevertheless, few held 'revolutionary' in favour of 'evolutionary' views, which accommodated change and improvement over time.

Chapter 7: Conclusion

7.1 Overview

This thesis explored the dynamics and characteristics of social exchange and professional relationship drivers in GP and specialist referral practices and how they operate in an ethically bound, high-value service environment. The oncology context is a valuable context to explore these aspects of the Australian clinical medicine environment, as the stakes for patients are usually very high, and ethical, patient-centred practices are on the minds of both GPs and SMPs as they seek to deal effectively with the fate of each of their patients. Two major socio-psychological theories—SET and RMT—have been blended and a conceptual framework developed within the operational context of medical professionalism, which was understood to represent a contract between the medical profession and society as a whole. This theoretical approach allowed the thesis to frame an inquiry method that described the drivers of professional-to-professional relationships and their influence on referral patterns.

This thesis has put forward a sustainable approach to professional-to-professional social exchange relationships between medical professionals that describes improved referral patterns that have implications for best patient outcomes in the field of oncology. Through a better understanding of the determinants of professional exchange that underpin referral relationships between specialists in the field of oncology, and between GPs and specialists, the thesis has paved the way for improved clinical referral pathways by describing ways to improve patient accessibility and promote an enhanced patient experience. These improvements aim to create reductions in overload on SMPs, by optimising 'best fit' patient referral practices, and to achieve best patient outcomes in terms of both treatment and survival. The thesis findings highlighted changes in practices and approaches that can reduce clinical risks by fostering a collaborative and mutually reinforcing service orientation approach between GP and SMP, and between SMPs.

7.2 Drivers of Professional Exchange Relationships that Determine Referral Practices

Drivers of professional exchange relationships that determine referral practices start with the original meeting between players and the formation of the relationship. GPs and SMPs view building and maintaining relationships as an essential aspect of their mission to help their patients. Interprofessional exchange relationships are an important element for SMPs to obtain patients; since patients cannot contact them directly for a consultation, they need referrals from GPs and other SMPs to maintain their practice and having a strong interprofessional referral network that yields a steady pipeline for referrals offers them pecuniary security. GPs are not reliant on their network to obtain patients; their network provides a treatment avenue for their patients and a communication avenue for them that centres on treatment and referral advice/information.

Interprofessional medical relationships can be seen to reflect the respect they have garnered throughout their career. The strength of a GP's network can influence referrals and help patients jump the bureaucratic queue in times of emergency, offering great benefit to the patient. However, the system is less than perfect if it promotes reciprocity as a means of patient advancement, rather than referral based on urgency of medical need (Green, Atkin, & Macleod, 2015).

Barriers around SMP accessibility, SMP costs and their own oncological knowledge can hinder the GP in the referral process. GPs have strategies to overcome some of the barriers, by leveraging their network to obtain advice on referral pathways, to obtain timely appointments when an SMP would otherwise be fully booked and to have the SMP make provision to see their patient at a cheaper rate. Although this situation promotes an exchange relationship that could be viewed as a quid pro quo, the GP utilises their network to get what they feel is the best outcome for their patient.

The reliance on interprofessional networks for SMP practice growth and referral exchange is a model that may not always benefit the patient. The patient's health and prospects for better health are at the whim of the strength of their GP's and/or SMP's interprofessional network. A better system would involve the maintenance and use of a national database that lists all available oncologists that a referrer could access via a quick search; this would mean that a referrer could select an oncologist that fits the patient's

requirements about location, price and, most importantly, accessibility to a timely appointment. The national oncology database model would promote a shift from a reliance on interprofessional networks that benefit physicians to a model that focuses on best outcomes for the patient. A weakness in the latter model which might be predictable by SET, is the potential loss of ability of the GP to contact SMPs for advice (since the formal reciprocal benefit would now have evaporated), but this may be remedied by improved ongoing GP education in oncology referral.

7.3 Factors Underpinning Lasting Professional Exchange Relationships

7.3.1 Trust, Collaboration and Reciprocity

A SET- and RMT-informed view would predict that trust, reciprocity, and collaboration would be key factors that underpin lasting professional exchange relationships in the thesis context. This was found to be so. Trust was established by all participants as an essential component of all interprofessional relationships. It was held that without trust a relationship will dissolve. The role of trust is a cornerstone to the formation and maintenance of relationships between physician and patient, and referrer and referee, and is an essential component in any collaborative approach to patient care.

Trust was seen as unequivocally the most important aspect of the interprofessional relationship and one on which the relationship hinges. Trust begins with the patient's trust of their GP; the patient entrusts their health to the GP's ability to heal them or to use their network to find them someone who can. Then, the GP relies on the SMP to provide a positive patient experience and outcome. A 'transference' of trust can be seen to occur here. An exchange relationship then begins, where the GP requires communication from the specialist to continue servicing the patient's needs. This is how a GP maintains their role in patient treatment collaboration, and over time, the SMP requires the GP to continue referring patients to them.

The role of trust from the SMP perspective has two components: establishing and maintaining trust from a GP and establishing and maintaining trust in the SMP-to-SMP interprofessional relationship. Specialists felt that obtaining trust from a GP was centred on:

1. providing a positive patient outcome through clinical expertise;

2. providing a positive patient experience through quality service delivery;

3. providing accessibility to timely patient appointments; and

4. being available to answer GP's questions around medical conditions pertaining to their specialty.

Trust in an SMP-to-SMP interprofessional relationship was built upon mutual respect. This respect was largely measured according to quality communication, accessibility to consultations and, importantly, as an exchange of a referral for a referral. An SMP would feel disrespected if there was no reciprocity in referrals, and this would damage the trust within the relationship; subsequently, this could cause the interprofessional referral relationship to dissolve. The link between reciprocity and trust in the SMP-to-SMP relationship is not mutually exclusive; by and large, one cannot occur without the other, and they are interdependent.

Owing to the vastness in range and type of cancer presentations, numerous oncology specialists are required to address the varying components. The thesis has highlighted the importance of collaboration between the GP and the specialist team and the crucial role of communication in this collaboration. Poor communication in the collaborative process tended to be linked to weaknesses in the practice of medicine, such as repetitive testing and delayed responses and reporting. These are major practice deficits, which have been linked to treatment delay and negative patient experience/outcome. The role of communication in the collaborative process begins with the referral letter; the thesis determined that this is a weakness in the referral process. The routinised use of a comprehensive referral form is an area that needs further exploration. Calnan and Rowe (2006) noted that patient-perceived risk and uncertainty resulting from the lack of information is potentially related to the patients' perceptions of competence and intentions of the practitioners on whom they are dependent. In essence, poor communication practice erodes the patient's trust in the process. Practice/process deficits around communication, collaboration and delay have by and large not been the subject of improvement-targeting practice/process-oriented research. Future research agenda-setting is clearly warranted here.

Collaboration requires an interprofessional referral relationship, which begins with the initial referral from the GP. Referral is an expression of social exchange, and within an exchange relationship, a degree of reciprocity and trust is needed. Reciprocity and trust

have a symbiotic relationship in medicine; trust without the expectation of reciprocity is self-destructive (Evans & Krueger 2009). The thesis examined how reciprocity affected referral patterns, collaboration and the patient. Reciprocity in referral among SMPs can influence a patient's outcome since when the referral choice is not based on accessibility, but instead is seen as an exchange opportunity, this can result in treatment delay (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). The thesis highlighted that this as an area that needs further research.

7.4 Significance of Professional Exchange Drivers as They Relate to Clinical Judgement and Decision-making during Referral Practices / Processes

Referral processes and practices within oncology require improvement. The thesis explored the interprofessional relationships that surround the process of referral, the decision process when choosing a specialist for referral and the Australian gatekeeper referral system. Study participants expressed strong support for the gatekeeper system, but GP and SMP participants both felt that it could be improved in the oncology context if there was a greater focus on education for GPs, to help them streamline the process with more accurate referrals. As discussed above, decisions around referrals need to be refocused from quid pro quo exchange arrangements to patient-centric approaches that prize timely contact with SMP, and SMP accessibility. However, this shift remains a difficult prospect, without a national referral database for oncology to aid the referrer to quickly access and find an available specialist. Improvement-targeting research agenda-setting is needed around SMP access processes. The potential for database-based solutions is one such area, which should be pursued in the health services research space.

A patient-centric change to the referral processes could include adopting a system through which referrals are made to a specialisation in oncology rather than to an individual oncologist. This open referral would be provided by the GP or SMP, and the patient would be given a shop list of potential SMPs ideally sourced from a national database who meet the patient's need-based criteria, such as regarding location, price and accessibility. The introduction of the open referral would reduce time to treatment by eliminating the need

for the patient to go back to the referring doctor for a second referral letter should the initial SMP be too busy; the patient would simply go to the next recommended name on the list until they obtain a timely appointment from an available SMP.

The open-referral system would be best implemented alongside the national referral database. Potential limitations to this system are an erosion of the interprofessional relationship and the positive patient experiences that benefit from this relationship, since SMPs will not be guaranteed the referral as they would be where the referral relationship is exclusively theirs, as at present. The thesis posits that there would be limited disruption to the interprofessional relationship because the referrer would still need to provide SMP recommendations to the patient, which would therefore continue to affect their business in the way it does currently. The interprofessional relationship would be further strengthened by the need for continuity of care as outlined by the Royal Australian College of General Practitioners (2019); once the referred services are concluded, the patient would be sent back to referrer for ongoing management.

The issue of specialist accessibility and availability is a difficult hurdle for the referrer (Langley, Minkin & Till 1997). This is further complicated when there are geographical restrictions, and financial limitations that the patient places on the referrer. Tracey et al. (2016) highlighted Australia's $1.3 billion National Strategic Framework for Rural and Remote Health, which aims to reduce the burden of location on the patient. The stated goal for cancer care is to ensure that rural patients have increased access to diagnostic testing, coordinated care, MDT review, patient accommodation and appropriate medical oncology and radiotherapy services locally. While lofty, this goal is in line with the thesis research findings about the need for greater accessibility for rural patients. Such goal setting could be further enhanced by the development of a national referral database for the referrer to access, to help their patient obtain timely consultation.

Communication came up repeatedly in the thesis results; it was intertwined with the themes of trust, reciprocity, and collaboration. GPs relied heavily on communication for effective involvement in the collaborative team. Communication often represented the 'GP side' of the reciprocal exchange, which occurred around referral to an SMP. By referring, they expected in exchange, quality, and timely communication. Poor communication could promote distrust and therefore destroy an interprofessional referral relationship. From the SMP perspective, they relied heavily on quality communication

from GPs through comprehensive referral letters, to prevent repetition of any testing performed, to make a sound diagnostic decision and to commence treatment. Poor SMP-to-SMP communication was an impediment in this interprofessional referral relationship. It was shown to influence other factors in the relationship, such as accessibility, collaboration, trust and interpersonal connection.

A recommendation arising from the thesis is that communication processes should be improved between GPs and SMPs, and between SMPs. It is also recommended that the use of comprehensive referral forms be routinised when GPs refer to SMPs. Further research of an improvement-targeting process/practice nature should be conducted around GP–SMP and SMP–SMP communication processes.

7.4.1 Referral: Improve the Process

7.4.1.1 National Referral Database to Improve Accessibility to Treatment

To address treatment delays as a result of imperfect referral practices, the formation of a national referral database is proposed. This database would list all oncologists by specialty and location. It would provide a referrer searchable access to the SMP who would ideally address the patient need—in terms of diagnosis, location, and affordability. This proposal is patient-centric, and SMPs may not see direct benefits to current business models, which prize practice growth above all else. The thesis reported that SMPs obtain future referrals through interprofessional relationship development and are dependent upon the provision of value to patients and their GPs, through excellent service. The proffering of a quality treatment experience builds patient satisfaction and helps maintain their competitive advantage. If SMPs were receiving referrals through a national referral database, as proposed by the thesis, a component of their interprofessional relationships may be eroded. Such a move would demote the importance of reciprocity in the referral relationship and might affect their communication with GPs negatively. The thesis reported that GPs relied on communication to be active in the collaborative process, and they experience communication as a reciprocal exchange for referrals with SMPs. With reduced communication from SMPs, a prevalent outcome is diminished; namely, GP collaboration in the oncology treatment process.

The aforementioned negative aspects of the proposed referral database could be offset by other findings of the thesis, such as the generalised contemporary trend in favour of

improved communication between SMPs and GPs and greater collaboration (inclusive of the MDT development) in the oncology treatment process. It should be emphasised that a national referral database would not diminish the number of cancer patients but would simply aim to distribute them more equitably so that patients could be better positioned as regards accessibility to available SMPs. Under the proposed concept, if high levels of service and quality communication are not maintained by SMPs, then the GP can hold them accountable by not choosing them for referral from the national referral database. This approach would ensure that the aspects of competitive advantage still hold relevance to the SMP practice. The national referral database proposal is aimed at pairing patients with available oncologists to reduce wait times and improve patient accessibility. While this idea is novel, it is supported by the thesis findings.

Accessibility to appointments was repeatedly emphasised by GP participants in the thesis, since slow access to an SMP consultation can indirectly cause treatment delay, which can affect treatment outcomes. Extensive literature has highlighted the grim reality of delayed referral, inappropriate examinations, delayed diagnosis, and poor patient outcomes among those diagnosed with cancer (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). The referrer must be able to have the means to provide reasonable SMP access to prevent treatment delay. As argued above, access to a national referral database may remedy this delay, but this aspect would need to be tested with further research.

Introducing a referral system that benefits the patient by providing an open referral to an appropriate oncological specialisation, rather than to a specific oncologist, could improve accessibility. This thesis posits that best practice would be to introduce this system alongside the national referral database, so that patients could be provided a list of SMPs obtained from the database to eliminate the need for the patient to go back to the referring doctor for a second referral, should the initial referred SMP be too busy. This thesis proposed that this approach would increase accessibility and reduce time to treatment but has also identified its potential to fracture the interprofessional referral relationship owing to the diminished exclusivity of referral. However, the foundations of interprofessional relationships of collaboration, trust, communication, and reciprocity will still need to be maintained as the SMP will still need to be included on the referral list in order to maintain a competitive advantage.

Accessibility also refers to geographical locations; the patient may not have access to private transportation and may be too unwell to use public transport and therefore may rely on a support network for transportation to consultations and treatment. If the SMP within the referral network is out of the geographical proximity of the patient, then the referrer will need to provide an alternative that can reasonably meet the needs of the patient. Alternatives could be sought via a national oncology referral database.

Study participants indicated that the ability to obtain an appointment for the patient often required the referrer to leverage an existing network. If the SMP within their network is unavailable for unforeseen reasons, then there needs to be a viable alternative, and it is proposed that a national oncology referral database could address this limitation.

7.4.1.2 Financial Accessibility to Treatment

Patients with an oncology diagnosis may be limited by finances. According to Schnipper et al. (2015), patients desire financial information about their treatment alternatives along with information about clinical effectiveness and treatment toxicity. However, they often do not receive it. This was articulated and clarified in this thesis when SMP participants identified that the high cost of treatment was a barrier to providing HVC, and in order to provide HVC, treatment expenses need to be reduced. In fact, patients with cancer are often surprised by and unprepared for the high out-of-pocket costs of treatments. Depending on the specific diagnosis of the patient, some will be forced to have extended time off work, and without an income they may be required to rely on family support (Schnipper et al. 2015). A national referral database could help the referrer identify SMPs that bulk-bill or are within the price range of the oncology patient.

7.5 Implications of Results for High-value Service Provision in Australia's Private Specialist Medical Sector

Service provision in the private medical sector needs to focus on providing HVC that focuses on service to maintain a competitive advantage (O'Connor & Shewchuk 1995). SMPs seeking differentiation to surpass their competitors need to create a service-oriented climate by selecting highly engaged employees (O'Connor & Shewchuk 1995) who strive to satisfy consumers (Grönroos 1990; Hennig-Thurau 2004; Heskett, Sasser & Schlesinger 1997). Such views are congruent with the results of the thesis research,

where participants reported that their competitive advantage was tied to their accessibility, timely provision of quality care and a more patient-oriented approach as well as their provision of a personalised patient experience. It is recommended that referrals be made primarily on the basis of service quality. It has been established that staff attitudes, behaviours, service orientation level and engagement level are likely to influence the customer satisfaction level (Grönroos 1990; Kim, McCahon & Miller 2003; Kim, Leong & Lee 2005; Teng & Barrows 2009).

The service-oriented approach in which SMPs rely on referrals to build their patient base is highlighted further in the SMP–GP relationship. The initial referral must come from a GP, and through this, the SMP can provide a service-oriented approach by providing a positive patient experience resulting in positive patient feedback to the GP; quality and timely communication on patient outcomes and progress; and accessibility for the GP to both advice and timely consultations. However, turning to the SMP–SMP referral relationship, the thesis uncovered a contrast to the service-oriented approach whereby an exchange relationship existed on a referral-for-referral basis that had no basis in patient service quality, but was of a pecuniary nature alone. This finding is predictable by SET in the sense that exchange remains primary to the relationship, it is less predictable by RMT in the sense that the character of such relations may lack communicative and collaborative veracity. It is though not predictable by the doctrine of medical professionalism, which might demand a stronger emphasis on patient outcomes.

7.5.1 Current Specialist-to-Specialist Referral Patterns and Competitive Advantage

SMP-to-SMP referral can hinge on the referrer's existing network and be governed by a quid pro quo approach. The thesis results uncovered the theme of reciprocity as a means of referral exchange among SMPs. This can clearly affect the patient if it is not congruent with the patient's geographical accessibility or not within their financial means. If the referral provided by the SMP has an extensive waitlist, it affects time to treatment and, depending on the diagnosis, may have a negative treatment outcome (Banks et al. 2014; Genden et al. 2006; Goff et al. 2000; Gomez et al. 2010; Gulliford 2012; Hamilton 2012; Hollows, McAndrew & Perini 2000; Kwon et al. 2015; Macleod et al. 2009; Mitchell et al. 2008; Olson et al. 2012). It is asserted that referrals should be made for the betterment of the patient, and processes and outcomes could be improved if there was a national referral database for the specialist to use.

The thesis result highlighted the importance of adding value to the patient throughout the treatment process by providing a positive treatment experience through good service, warm and friendly staff, accessibility to timely consultations and exposure to strong clinical expertise communicated to the patient in a language they understand. The value of a positive treatment to the patient cannot be overestimated. A positive experience fosters trust from the patient and builds loyalty, which translates to perceptions of a high-value service that will drive further positive relationships (Choi et al. 2004; Ruyter, Wetzels & Bloemer 1998; Sardana 2003).

It remains the case that a positive treatment experience can substantially affect the competitive advantage and financial viability of an SMP's practice. If an SMP focuses on this aspect of practice expansion and provides referrals that benefit the patient rather than referrals characterised by reciprocal exchange with other SMPs, mutually beneficial outcomes for both patient and specialist can be generated. However, to confirm these findings, further research is warranted.

7.5.2 Non-competing Medicine Systems

The current framework in Australian medicine incorporates competing systems of medicine. The public system is large and has the facilities to treat the whole range of oncological problems; however, it struggles with funding, overcrowding and quality management, and it lacks the ability to provide HVC to patients (Weerakoon et al. 2015). Many study participants expressed the hope that public systems will seek avenues to improve funding by competing with private hospitals for private patients as a means to fund new systems to improve the provision of HVC. The thesis results showed that SMP participants believe private hospitals have excellent service and provide HVC, and that the patient has the means to choose their own doctor; however, they lack the ability to offer all services, and hence, there are instances where a private patient will have to go to a public hospital for treatment.

From the patient perspective, the service and experience are superior in a private setting, since it allows patients to choose their own doctor and doctors engage in treatment at early stages with a preventive medicine mindset (Weerakoon et al. 2015). In the public setting, the patient may not have the choice of doctor and the service may be inferior to the private system, but according to Ward et al. (2015), patients have faith in the public

system and might have a 'blind' trust in their doctors. It seems reasonable to assert that the medical system could benefit from a non-competing system of medicine and a collaboration at system level with a patient-centric focus and that this may improve both patient experience and outcome. Further research is needed to explore this view.

7.6 A Conceptual Framework to Bring Sector-wide Change in Healthcare Context

7.6.1 Improve Patient Experience and Outcomes: Evidence-based Medicine, Medical Error and Referral Process

Research participants identified that the patient experience can be improved by understanding and changing processes and practices that constitute medical error. It was postulated that the incidence of medical error can be reduced by streamlining the referral process and by practising evidence-based medicine. Practising evidence-based medicine in oncology was discussed by thesis research participants in relation to the use of experimental medicine, or medicine with a low percentage of success in oncology patients. When evidence-based medicine has been unsuccessful in advanced-stage cancers, physicians feel pressure from patients and their support network to try experimental medicine.

The adoption of newer, more expensive diagnostic and therapeutic interventions in oncology may not be well supported by medical evidence, thereby raising costs without improving outcomes. Coupled with, or even driving, some of these rising costs are unrealistic patient and family expectations that lead clinicians to offer or recommend some of these services, despite the lack of supporting evidence of utility or benefit (Schnipper et al. 2015).

Given that the medicine is 'experimental', and provides risk without proven benefit, it is proposed that the evidence-based approach be supported; more evidence should be sought on the prescription and usage of experimental medicine, and any such usage should hold sound medical reasoning that will be accountable to the appropriate governing body. Although evidence-based medicine is an important identifier of medical error, the thesis participants also highlighted the need for streamlining the referral process through improved education for GPs, providing a comprehensive referral with all relevant medical

information and adopting a transparent, expedient communication platform between referee and referrer.

7.6.1.1 Referral Education for GPs

As a measure to develop the referral process in oncology, this thesis recommends focusing on improving the GP's knowledge base in oncology. This viewpoint was formulated through the thesis results and is reinforced by supporting literature (Green, Atkin & Macleod 2015; Holge-Hazelton and Christensen 2009).

The thesis results highlighted that greater education for GPs could enhance the patient experience through helping the GP to choose better referral pathways and identify correct specialties and subspecialties to refer to. Having an intimate understanding of the expertise and training of the SMP, coupled with an in-depth knowledge of the equipment and capabilities of the referee's facility, should help the GP cultivate a more informed decision. Referring to the correct SMP in the first instance is an important factor in reducing time to treatment. The role of the GP in the continuity of care of the patient is fundamentally important; with a more complete understanding of oncology, they can be a better advocate for the patient (Green, Atkin & Macleod 2015).

An increase in education may provide GPs with more confidence in their decisions regarding oncology patients, and therefore, their referrals will be based on clinical need, and not result from a lack of understanding (Lee et al. 1983; Piterman & Konsitas 2005). Such a development would reduce unnecessary specialist consultations, improve accessibility and, ultimately, improve patient experience and outcome. However, since the required nature and breadth of education was not adequately described by thesis participants, it is recommended that more in-depth research be conducted to identify the scope of education required to enhance the oncological knowledge of GPs.

7.6.1.2 Standardised Referral Form for Australian Setting

Medical error can likely be reduced with an improved referral process; accessibility to treatment can be improved by reducing delays that are synonymous with poor and/or incomplete information pertaining to the patient's condition and treatment history in the initial referral. If an SMP does not have all the information at their disposal to make clinical decisions on diagnosis or treatment strategy, they may be forced into a delay by

chasing missing information from the referrer, or waste time and resources on duplicating testing.

A routinely utilised and comprehensive referral form for oncology patients is necessary to ensure all pertinent information is provided to ensure the referee can make an informed decision with complete information. It is anticipated that a complete referral form can expedite time to treatment by eliminating back-and-forth communication between SMP and GP, chasing omitted information. Thesis participants postulated that the referral form should provide a complete case history, current medications and test results, and some suggested that psychosocial information should also be included. On a practical note, some in the GP cohort claimed that there was not enough time allocated in a consultation to include this necessary information. Thus, the issues around consultation times not providing enough time for referrers to complete the form will need to be addressed in further studies to improve compliance.

Noting that SMPs want a detailed referral letter from GPs, with all pertinent information (Piterman & Koritsas 2005); however, according to Westerman et al. (1990), GPs are frustrated that SMPs do not answer referral letters and in some cases do not read them. To determine the effectiveness of a comprehensive referral letter, and the optimal content of such a letter, would need to also be tested in a research project.

7.6.1.3 Improved Communication through Collaboration to Reduce Duplicate Testing and Unnecessary Treatment

Quality and timely communication among the collaborative team is essential to prevent duplicate testing. The process starts with the original referral from the GP, which should include patient history, current medication, and diagnostic test results. If the SMP possesses the results from testing, there is little reason to replicate this. Then, the onus is on the SMP to provide thorough communication about all diagnostic testing and medication changes to the original referring GP and any other involved SMPs.

A collaboration is successful if each medical professional performs their given role with a patient-centric focus and then promptly communicates action or inaction to the other medical professionals involved so that accountability can be placed on each phase of treatment to ensure that clinical competence is displayed, and a positive treatment experience is delivered to the patient (Pearson et al. 1999). It is proposed here that Pearson

et al. (1999) is correct. Communication through all phases of treatment prompts accountability. Further, it is asserted that additional research should be conducted on improving SMP-involved communication processes.

7.7 Summary: Research Recommendations and Limitations

Through the conceptual frameworks of SET and RMT, viewed through the Medical Professionalism lens, trust in the context of interprofessional referral relationships in oncology was explored and explained in the thesis. The role of trust was established by participants as a cornerstone to the formation and maintenance of relationships between physician and patient, and referrer and referee, and an essential component in any collaborative approach to patient care. Trust needs to be reciprocal in nature but can be measured in different ways: SMPs saw reciprocal exchange of referrals as a measure of trust, whereas GPs viewed inclusion in the collaborative process as trust.

It is recommended that interprofessional relationships be built upon service quality that promotes a positive patient experience, which would involve all contributors working in collaboration for the betterment of the patient. Prompt and thorough communication should be practised throughout the collaborative process on the basis of the patient's needs rather than simply as a means of exchange for future referrals. The thesis concludes that referrals should be patient-centric and not based solely on reciprocity, and an open-referral system should be adopted, so that the referral is made to an oncological specialisation rather than an individual SMP.

This thesis proposes the adoption of a national database that lists available oncologists for referral. It recommends listing oncologists by speciality/subspecialty, location, price, and bulk-billing status. This recommendation is based on the findings in the thesis and the literature reviewed about a weakness in the referral system(s) between GP and SMP, and among SMPs, that creates a chain reaction of delays from consultation through to diagnosis and, ultimately, to treatment. The thesis postulates that delay to treatment constitutes medical error, which can be remedied through improved accessibility to timely SMP consultations.

It was identified that medical error could be further reduced through providing education in oncology for GPs, to eliminate mistakes in referral and streamline the process; practising evidence-based medicine; using a standardised referral form so the SMP has a

complete picture of the patient's history; and improving communication practices to eliminate repetition in testing and treatment.

As enunciated in this thesis, the existing body of knowledge, as it pertains to the topic areas under investigation, does not seek to describe, or explain, the interprofessional relationship. Using SET, RMT and the doctrine of medical professionalism, a description and explanations for behaviours and practices, which are influenced and/or guided by theoretical informants, was put forward.

The research conducted sought to bring a theoretical understanding and thus, postulated a new way to interpret the actions and the interprofessional relationships that exist in medicine, particularly in the life-threatening complex world of oncology. This theoretical framework was presented in Figure 3.4, which was subsequently brought together within the broad canvas of medical professionalism, in Figure 3.5, to develop a socio-medical model conceptual framework, which incorporates the major domains and dimensions of both SET and RMT. These were tested and the findings reported together with recommendations for future research.

SET and RMT proved to be informative of GP and SMP referral behaviours as indicated by the participants' responses during the interviews. This is where the character of the exchange between referring GP and SMP was identified to be bound up in the 'currency' of ongoing GP referral for the SMP, who balanced this GP behaviour with the reciprocal provision of communicative accessibility in relation to cases – an identifiably scarce resource for GPs. Conversely, though SMP to SMP referral was also exchange-bound, in this scenario, a medical professionalism-inspired view might find some SMPs ethically wanting, as such referrals did not always appear to occur based on patient-related factors, but instead occurred on a 'tit for tat' basis. In the relational aspects of referral behaviours, RMT was reasonably predictive.

In professional and operational terms, this thesis study located some inherently sub-optimal characteristics of the current GP-SMP referral relationship. The relationship appeared to be heavily influenced by reciprocity and the potential for mutual advantage, but when waiting times are factored in (in the sense that popular SMPs attract higher waiting times and hence poorer ultimate patient outcomes), any benevolent reciprocities at play between GP and SMP are dwarfed in importance when compared to the proven

impacts of rapid access to SMP assessment on ultimate patient outcomes. Numerous potential practice-based research questions should now be explored and ultimately tested. The potential for the development of a national referral database, the introduction of open referral practices and the revision of the existing referral form process are three areas which stand out as being of potential utility. Positive cancer patient outcomes are prized in our society, yet we appear to have so far paid little attention to process around access to expert care. Such a situation demands further exploration, process innovation, feasibility study and development, process intervention testing and ultimately sustained long term improvement.

7.7.1 Limitations and Opportunities for Further Research

The qualitative design disallows the possibility of generalising the results of the research to all GPs and SMPs. Moreover, the design is not longitudinal, and hence, no sense of changes in attitude/opinion/experience over time can be discerned from the thesis. However, given the paucity of extant research in this area, it was felt that a descriptive 'snapshot' design was needed most, to gain an accurate sense of where things stand now.

It also remains the case that the sampling frame was limited to NSW GPs ($n = 20$) and SMPs ($n = 20$). However, the sample size facilitated data saturation at $n = 40$ (Francis et al. 2010; Townsend 2013), and the rigour applied to sampling within this frame, and to data collection, helped in yielding results that offer insights not previously described in the literature. These could be further explored in the future using quantitative and mixed-methods research designs. Suggested research directions arising from the investigation conducted in the thesis are outlined at the end of this section.

Some study participants were known to the thesis author, and it is acknowledged that hence some of these participants may have responded more positively, and/or negatively. Nevertheless, the credibility of qualitative research across many contexts relies to some extent upon the depth and character of the relationship between researcher and participant (Botsford, Clarke & Gibb 2012).

Themes and subthemes developed through qualitative semi-structured interviewing and the subsequent analysis of the transcripts using the methodological framework of SET and RMT and the professional lens of medicine were compared and contrasted against both current and seminal literature. While this methodological framework benefitted the

discovery of themes and subthemes, it did not allow testing the themes and nor did it provide the means to test the validity of recommendations put forth in the thesis about the need for a national referral database, improvements in GP education in oncology and the formation of a comprehensive referral form.

The recommendation of a national referral database is a novel, promising idea; however, a limitation of the research is that the operational mechanics of the idea were not fully canvassed with study participants. A similar limitation applies to the thesis findings regarding the need for better GP education, where scope-, accessibility-and acceptability-related factors need explication. In addition, the contents of the proposed comprehensive referral form need to be articulated.

A further limiting factor of the national referral database is its application in a rural and/or regional setting where the chronic shortage of SMPs leaves GPs and other SMPs with little option in their referral choices; in this context, the thesis accepts that a national referral database may not improve accessibility or reduce consumer costs in these environments. Further, due to the chronic shortage of SMPs in the rural setting, the findings regarding competitive advantage associated with quality service would not be as applicable to the growth of a rural oncology practice.

The process of an 'open' referral currently exists for diagnostics such as radiology and pathology (*Health Insurance Regulations [Pathology Services]* 2018). However, it is not encouraged by the law or in practice in the case of therapeutics. This thesis acknowledges that the adoption of such a policy will need to be designed and tested in conjunction with specialist oncologists and GPs, and thus, warrants further research in the therapeutic and oncological context. The open-referral system should be established with protocols in place that ensure continuity of care is maintained and that all relevant medical information pertaining to the patient is shared among the collaborative team, for a smooth transition for the patient from referrer to referee and then back to referrer for ongoing care (Royal Australian College of General Practitioners 2019). Research should be conducted to test the validity and success of adopting this policy; further, a longitudinal study using a mixed method approach (Neuman, 2006) should also be conducted to measure the ongoing and long-term success.

As to the comprehensive referral form, the thesis identified time as a potential limiting factor in providing it for GP use; some participants identified that patient consultations in the Australian medical setting may be too short to complete such a task. Time restrictions are further exacerbated in the rural and regional medical setting because of the shortage of GPs and SMPs; however, while this thesis recognises time as a limitation, it also asserts the necessity of such a form, because mistakes performed under time pressure in a limited market are only going to increase time to consultation, diagnosis and, ultimately, treatment, which this thesis has postulated constitutes a form of medical error.

This thesis recommends that areas identified be formally explored via practice-oriented research, in terms of content, feasibility and ultimately, effectiveness. Thus, further research is now needed to:

1. establish a workable functional model for the national database concept, test its viability through mixed-methods research (Neuman, 2006) and explore its impact on referral practice;

2. establish a functional model for open referral, used mixed-methods research (Neuman, 2006) to test its viability and impact in terms of improved accessibility and reduced time to treatment and ascertain its potential impact on continuity of care;

3. establish content/scope and other key operational factors through a mixed-method approach (Neuman, 2006) for an enhanced education program for GPs to improve their understanding of cancer and the precision of their referral practices; and

4. establish content and design for a new comprehensive referral form using through a mixed-method approach (Neuman, 2006), and then test its validity through quantitative methods. Moreover, since the thesis findings suggest that such a form, alongside improved communication, could eliminate repetitive testing, it is recommended that mixed-method longitudinal research be conducted to determine whether the form has had an impact on the incidence of repetitive testing.

Appendices

Appendix 1: Evidence—Section 5.1

Results Section	Evidence
5.1.2.1 Communication	GP7
	"Number one, communication and more important than anything is the seriousness or otherwise is better communicated by one on one with a phone call. And just to outline whatever's involved and then with a simple report. I always know the way they communicate with letters - without a flowery letter. For example, the infamous discharge summary from the hospital is a bane of my existence with all these acronyms half of which I've never heard of, but I have to talk to, you know, to one of the younger newly qualified doctors - what does this mean? Yeah and the way in which it's formulated I had a go at the health insurance group, well North Shore, not a go at them, but I contacted one of the blokes I know and said I don't like bad discharge summaries. It's 6 pages of gobbledygook and I can't find what I was looking for"
	GP 12
	"GP12: Not communicating.
	Interviewer: Anything else?
	GP12: No not really.
	Interviewer: Earlier on you spoke about a doctor who didn't take your calls…
	GP12: Yes. Yeah. Well, you could add that [SMP not taking GP call to discuss a patient].
	Interviewer:
	Anything else in that regard? [18:00
	GP12: Well I guess on that note; like sometimes a specialist might give advice over the phone and then say you know I recommend you do this and this and I'll see them in a few days' time, if it's

Results Section	Evidence
	something urgent, more urgent ,doesn't need to go to hospital, that you feel you need to do something immediately and you're not quite sure what to do and if you speak to a specialist they give advice over the phone and they might follow up and see the patient in a few days' time. That's very helpful.
	Interviewer: So effectively if it's urgent and they don't give you the advice and support then that would impede it?
	GP12: Yeah that would be detrimental.
	GP17
	…So I like good language skills, so that's probably important. Availability, the apparent willingness of the specialist to talk to me, because I want to feel like I'm a doctor as well in the eyes of the specialist so you want to feel a little bit special. It's all communication, it all comes down to communication and a little bit of effort, minimal effort, but on the specialist part."
5.1.2.1 Patient experience	GP16
	"Yes, we are looking at feedback, both to me and to my patient. If my patient's happy with the feedback they get from their specialist."
	GP16
	"I must say, with all these referrals, I'm more likely to refer to a specialty if the patients like them than if I like them. So it will always come back, are the patients happy with this specialist and I never not refer to them, that's always the number one."
	GP17
	"I wrote down, I want to know that the specialist is putting my patient ahead of their own interests, so in other words they are tailoring treatment to the patients rather than to their own little whims. Like some guys do robotic prostate

Results Section	Evidence
	surgery, they want to do robotic prostate surgery on everyone, I get irritated by that I want to have the patient being treated honestly, because that patient is going to report back to me, and the people pick when the specialist is really interested in them and honest and they'll come back to me and that reflects on me, because I've sent them to someone they look up to and admire and feel is really interested in them."
5.1.2.1 Collaboration	GP6:
	"I think it's quite important because simple reason we are common goalies for the benefit, be it cure or control of the disease for the patient. So at times the specialist may ask us to do certain investigation, some blood tests or whatever needs to be done in the case. Also putting faith in us he hasn't taken the patient all to himself."
	GP13
	"Well you can. I suppose it's just a matter of how would I say: The rapport between specialists and GP is important because it allows a proper communication of management of patients.
	And there is no sort of misunderstanding of what the specialist needs you to do or what the specialist wants the patients to do. I think it is important, very important and if the specialist, let's put it this way: if the specialist is able to come down from the high horse and communicate with the GP and the patient that would be the perfect choice."
5.1.2.1 Trust	GP14
	"GP14: It's sort of difficult to answer that. You know, I sort of turn round and go for you know, are they good doctors? Are they decent people? You know are they;
	Interviewer: How do you classify them as good doctors?

Results Section	Evidence
	GP14: Well I think its knowledge and skill. But also the way they treat patients and their clinical decisions, you know that sort of thing. There's some people, you'd probably hear it
	GP1
	"Lack of availability."
	GP2
	"Time. Sinking [syncing] of time."
5.1.2.1 Accessibility	GP1
	"Most important is communication: Advice about patients referred, written communication and also others ability to talk to us when we need to talk to them in case I ring up and they're happy to take my call and then give me directions and for sure he will be the next one the patient will rather happy to connect me to take call and assist with diagnosis and also the availability of appointments because they either really booked-up for six months, then forget it just pretty important the patient can't get in. Yeah so, availability to talk to us: Happy to take call and assist me with the diagnosis especially when you've got urgent cases especially when you do have a list of things. Yeah, you know, you have your list of favourites."
5.1.2.2 Trust	SMP 5
	"Yes, disagreements in management plan - not necessarily once, but maybe if it happens two or three times"
	SMP2
	"SMP2: Ah, yeah, lack of response I guess is one of them. That's not the major one I think if they don't look after the patient, if I send them one of my patients I would hope that they would treat them with the same kind of respect that I do, *Interviewer: Ok, to look after a patient in the same way;*

Results Section	Evidence
	SMP2: And in the same manner that I do. So, I'm looking, I suppose for the care component and so that's why if they are rude or abrupt that's not what I would be looking for. I can understand because they're obviously translates all the way across."
5.1.2.2 Collaboration	SMP4:
	"Well I think they expect that you'll be accessible and available to see their patients when they want you to. My expectation is that get all necessary information for that consultation so I'm not chasing up bits of paper and I guess importantly that they've told the patient whether referring to me, as a person to me, because they've got cancer."
5.1.2.2 Accessibility	SMP1
	"Yes. A few people. So, someone, he's my first and final patient, who perforated his bowel and after he went to see [name redacted] the colorectal surgeon. So I've got him and the text messages and we've been back and forth on the phone and through texts looking out for him. So it depends on the level of urgency. Some people, a phone call, that some issues will be a phone call issue where people have to be up to speed. Others it's more of that I guess if it's a routine follow up and things are stable and you can wait for the letter to go out. And I'm always, you have to be mindful of who's doing what to whom. So I'm, so in that case that's been operated on what we share."
	SMP8
	"They're approachable and available. I mean my best interpersonal relationships are with those where I can just pick up the phone and give them a call when I've got someone with me and I can talk to them. Clinical skill. So, good clinical skills and the patients will be happy with that particular doctor."

Results Section	Evidence
5.1.2.2 Reciprocity	SMP7
	"It needs to be about the patient, not about the doctor. It's very rare that you have a contact with a colleague, another specialist, which doesn't go well or it's not favourable."
	SMP5
	"SMP5: That's an interesting one because there are expectations that we now have the expectations that I started with sort of the two different things. I started with the concept that any personal or professional relationship was a friendship type thing. *Interviewer….but now?* SMP5: But now, I think that there's a lot more to the business communication aspect of maintaining a working relationship of cross referral
	SMP4: Oh, now that would cause me some concern as to, you know, why am I bothering with you if your not referring anybody to me."
	Interviewer: So you therefore are looking for things relating to the reciprocity between you, in that you know look, I'm sending you my patients you should rightly send me some patients;
	SMP4: Yes, you'd expect that relationship if it was good enough to go one direction, it should be good enough to go back the other direction, if that's appropriate. *Interviewer: So if I refer a patient, I expect them to be referred back;*
	SMP4: Or at least a discussion as to why they should not be referred back because it might be there outside my expertise;
	Interviewer: Or a discussion and agreement as to why not coming back to me for review. Okay, what about in the referral outright. So you're referring patients to a breast surgeon but that breast surgeon you know you've been referring to them and they either don't refer or they stop referring to you; not

Results Section	Evidence
	your own patients but, say they refer all their patients to another oncologist. Would that lead to a breakdown in your relationship?
	SMP4: No not necessarily. I think over time you, well I'm seeing that the patients are being referred by the younger surgeons to the younger oncologists. Some of the people that used to refer to me all the time are now retired. So that's an expectation just with getting older I think.
	Interviewer: But if you're referring to a surgeon constantly and that surgeon never refers a single patient to you;
5.1.2.2 Interpersonal issues	SMP4 "My expectation, if I refer a patient to a surgeon knowing that they need to have surgery I would expect that patient to be referred back to me. So that would certainly cause a break down in our relationship, or a strain in the relationship." SMP14 "Difference of opinion and likely the way it is communicated. One feeling, the other is not fulfilling their role within the team." SMP 9 "Rudeness and arrogance are the two culprits, as professionals if you are unhelpful in patient care …non-patient care; as professionals you need to be helpful and courteous."
5.1.2.2 Unethical behaviour	SMP17 "SMP17: Ehhm, obviously when there are these conflict of interest and difference in opinion. *Interviewer: Interesting then let me just ask you some more about the conflict of interest. What do you mean by conflict of interest? Are you talking about when the patient when the doctor is putting their*

Results Section	Evidence
	needs ahead of the patients or??? What do you mean by conflict?
	SMP17: Yeah, actually for one particular patient there would be more than one management, in some situations like that.
	Interviewer: Okay. So when there are alternative clinical protocols available?
	SMP17: Yes.
	Interviewer: So alternative clinical protocols are available for the patient's care, and the doctor pushes for their own …
	SMP17: View and technique
	Interviewer: Versus something else which might be better for the patient?
	SMP17: Yep.
	Interviewer: And you said when there is a difference…
	SMP17: Of opinion about patient care."
	SMP8
	"SMP8: Competition. Just interpersonal issues.
	Interviewer: OK, name some?
	SMP8: Say for example if the person / the other specialist said something derogatory about you or either to the patient or to someone else. And if you were concerned about their clinical judgment or professionalism.
	Interviewer: What do you mean by professionalism?
	SMP8: Like the way they've spoken to you or a lack of respect. If they are not contactable as well, so if they are consistently not available."
5.1.2.2 Communication	SMP13
	"SMP13: A lot of it does relate to a lack of communication or a lack of respect for communication. So in medicine that's very much a hierarchical structure and you know the varying people who have traditionally been further down the food chain and often they're a bit put out by that and by the same token those at the

Results Section	Evidence
	top of the food chain need to be respectful of those who are a little bit further down.
	Interviewer: So respectful of everyone up and down the chain;
	SMP13: Yes that's right. Everybody has something to bring.
	Interviewer: Something to offer the relationship;"

Appendix 2: Evidence—Section 5.2

Results Section	Evidence
5.2.1.1 Trust	GP4
	"GP4: 100 percent, if you can't trust the guy you're not going to use them. Well the person I should say shouldn't I.
	Interviewer: Ok, I accept that; if you can't trust you can't use. Ok, in terms of, you know, thinking about this trust and saying it is important; what are the elements that would lead you to trust? So when you talk about the role of trust, what are the things that, you know, how do you know you can trust somebody? What do they do for you to trust them?
	GP4: Ok, they've got the ability, the skill, they are nice to you, they will contact you, some surgeons will contact you after the operation and say; yes, I thought this is going to be a terrible operation; it's turned out all right.
	Interviewer: Give you honest feedback?
	GP4: Honest feedback; so it gets back to, yeah, the quality of their work."
5.2.1.2 Trust	SMP 14
	"Trust plays a big role because how you care for the patient will reflect on their reputations."
	SMP 11
	"element of trust that the GP or someone who you may not know has referred to you in the belief that they have heard about you or they know your reputation, and I think that, in its own right infers trust because they're handing over a patient, So I think that should be sort of taken as flattery more than anything else. And clearly they trust you that you're going do the best for the person they're handing over."
	SMP 20
	"well, if you, if you, after your period of care, you send the patient back, well, I

Results Section	Evidence
	think it's important to trust that they would come back and say, "Well, okay, everything is okay," or if there's a problem that the patient gets referred back. So there is some trust that I require as well, and you also have a trust - you also want to trust them that they would support what you, what you say because - and again that mutual trust comes out"
	SMP 3
	"SMP 3: We're building trust;
	Interviewer: Ok, build trust; and how do you do that? What would this trust mean to you?
	SMP 3: By that I mean. I trust that we are on the same page in the patient journey. We are supporting each other's opinions, are respectful of each other's opinions.
	Interviewer: In agreement on clinical matters;
	SMP 3: That we will also provide information that would assist each other in;
	Interviewer: Provide information that would assist each other
	SMP 3: For the purposes of looking after the patient as best we can for the patients benefit, we have a have a shared common goal, providing information to help each other achieve the same goal."
5.2.2.1 Communication	GP14
	"A reasonable time, you know, I acknowledge you know I turn around and say to people all they'll write me a letter and probably get it a week or so after you've seen them maybe two weeks, I'm happy with that. And you know, if there was something urgent send us a fax or give us a ring and most guys do that."
	SMP 4
	"I think personal communication; nothing improves your image amongst GP's, and all specialists, more than a quick phone

Results Section	Evidence
	call to bring them up to speed. Particularly if there's a change in what's happening to the patient, a quick phone call could make all the difference in the relationship."
5.2.2.1 Collaboration	GP7
	"I think reciprocity is really, the specialist, really making the patient feel comfortable that he's following up from the GP's referral and not to denigrate the GP. I mean you know how many referrals, are unnecessary? You don't know. And send the patient back to GP for further follow up."
	GP4
	"It's all about communication, yes, because you're the one who's going to be managing the person you're the one who's going to have to; ok, the big things you've got to do with the GP with the patient is explaining what the hell's going on because they'll go see the specialists then they come back and say what the hell was that all lot about, what am I doing, what have I got, what's going to happen, right. So half the time you're explaining to them what is wrong and what's going on even though they've seen the specialist because they say, the specialist didn't tell me anything. I mean it's like the patients who go"
	SMP 6
	"Probably you choose the one that you are most comfortable and work most frequently with, and some of the motivation for that's likely to be around familiarity, it's going to be around confidence that what you need to be done will be done; and there's probably going to be a reciprocal element in here as well, in other words investing in this relationship."

Results Section	Evidence
5.2.2.1 Respect	GP 4
	"Yeah, I mean, obviously don't want to have them pinch the patient but it's not going to really happen because the patient, as I said, the patient comes back nine times out of ten and says please explain what's happening, what have I got. They will ring, they will write, nobody sends an e-mail to me….. I've had nobody actually turn up here other than a couple touting for business. What else is there?"
5.2.2.2 The role reciprocity in the specialist to specialist relationship	SMP 8
	"So if I have someone who refers patients to me I'm more likely to refer patients to them definitely. So it is it is quite interesting concept actually because you could argue that that then narrows your scope of referrers"
	SMP9
	"SMP: Provide the expert opinion; reciprocity e.g. Gastroenterologists refer to us, I refer back to them for patients who need their service."
5.2.3.1. Inter- professional collaboration	SMP 7
	"Ok, I think culture comes with mutual respect and mutual respect comes with experience of having dealt with patients collaboratively in the past. If there are structured environment in which that can occur in the multidisciplinary team meetings obviously. The MDT is an example of where there is a structured collaborative exercise, but most of my collaboration with colleagues is based upon a long history of knowing how they think how they like to do things and what works and what has worked in the past in terms of patients that we have shared and an understanding of the limitations of my clinical discipline and how that has to link in with other clinical disciplines. Surgery and radiotherapy is a classic example and understanding of treatment processes, modalities, side effects and

Results Section	Evidence
	outcomes outside of my own discipline, facilitates that process as well"
	GP19
	"GP19: I think communication probably is the word that comes to my mind, I mean if communication on one side or the other is lacking that's really going to influence whether I want to refer and also the quality of care and the outcome
	Interviewer: So communication is something that you look at to ensure there is good collaboration between you and the specialist?
	GP 19: Yeah, anecdotally if we know a patient has been seen, we have referred a patient to a specialist and has been seen regularly and I haven't received a letter or in my referral letter made a specific query or comment e.g.; what are your views about surgery for this condition and I haven't received a letter back or the letter does not answer that question, I'm feeling that's poor communication. Very conscious that this should work both ways and we often communicate very poorly with specialists too."
	GP9
	"GP9: I can remember referring to a surgeon whose expertise was in melanoma. I had done a biopsy and the biopsy had come back as melanoma, so I mean again, I've got on the phone rang him saw him expeditiously and then he went and had a look at the pathology himself, and he got back to me very quickly and said in fact this is not a melanoma. And so I was very happy with that sort of result and this young fellow he was a young man of about 18
	Interviewer: So he looked up the pathology himself?
	GP 9: He did. He went and had a looked at the slides and then they don't and there.

Results Section	Evidence
	Interviewer: I mean that's really going the extra mile isn't it.
	Gp9: Yeah that's excellent yeah and he did it straight away so that I wasn't left red-faced if the patient came in you know. I am aware and we can celebrate together that it wasn't.
5.2.3.1 Impact on communication on clinical trials	SMP8
	"SMP8: Good communication. Prompt communication. So not getting a letter four weeks and then they've already had to see them and they don't know you told them. But, you know I think direct contact I think direct contact in things like multidisciplinary meetings. Phone calls
	Interviewer: What else?
	SMP 8: I guess departmental meetings, grand rounds all of those sort of hospital based education activities."

Appendix 3: Evidence—Section 5.3

Results Section	Evidence
5.3.1.2 Accessibility to timely treatment	GP6
	"GP6: Yes, at times you do and you are on the phone basically begging, please someone. The last one is a lady who fell in the shopping centre and fractured jaw. Eventually one of the professors saw her quickly.
	Interviewer: When they do that,, does that then endear you, say to that specialist, who yes, I will see them?
	GP6: Yes, especially if it is a Professor or someone- the ones, who help me at these times, usually get more referrals for me. And here it is very important the receptionist, there are some receptionists who are fairly accommodating. Some specialist's receptionist, this is the time you've got to do it and that's it. Yeah get some time to work around and you tell them that you are doctor such and such and they try and help you out somewhere. They are the face of the business."
	GP7
	"GP7: It can do, occasionally, and you just get the feel for it? The answer is yes. The culture does, may well in this day and age, with greater immigration that may come into it.
	Interviewer: So can do, particularly for certain backgrounds.
	GP7: Yeah.
	Interviewer: Okay.
	GP7: Never more so than in the western suburbs, you know, compared to here."
	GP7
	"I think proximity of service. Now in the city and the Suburban areas is very important because of the increasing traffic is very difficult. We have a lot of complaints. The patients have indeed, you and I complain about sitting in the traffic for hours and that I think t for the country people, well there's a big one.

Results Section	Evidence
	Must be hell because they have to chase up things that we don't relay need to chase up because we are close by"
5.3.1.3 Identifying the correct speciality	GP 10 "Essentially just getting the right subspecialist SMP for a given clinical problem."
5.3.1.5 Inter-personal connection	GP 11 Your personal relationship, with that particular specialist, like if you didn't get on you'd be disinclined GP4 Well ok, lets say he sent a letter back to me, abusing me, saying I was a dick head because I missed this or missed that; well that could go down like a lead balloon. Abusive feedback.
5.3.1.6 Location	GP 12 "Location is a factor; and for some patients that's more important than others." GP 8 "Ok, so, I mean for us it is often people being local, it's the convenient factor." GP11 Waiting times. *Interviewer: Yep. Waiting times can be a problem obviously -* And then probably patient dissatisfaction with the group that you have available to you locally
5.3.1.7 Patient experience	GP 13 "how they managed to patients; and then how they manage their patients. Really. That's the next step, which is the most important you know patients are really astute. They would come back and say I wouldn't waste my time seeing that guy again."
5.3.1.8 Trust	GP14 "You don't want to necessarily judge people I am a GP, but if you think that

Results Section	Evidence
	the clinical skills or judgment are waning or deficient"
	GP9
	Look I suppose there was just thinking of an experience that wasn't so good. It wasn't enough to trust at all but I had a patient who I'd been treating for a while who I knew had
5.3.2.1 Trust	SMP6
	"SMP6: Well I mean the GP has acknowledged that it's a specialty that they are in need of. It is a clinical analysis for the needs of the patient.
	Interviewer: Anything else.
	SMP6: Similar things to what we're talking about before, we look after their patient well and the next one will come your way."
5.3.2.2 Referral through established networks	SMP2
	"For me personally, probably experience, I think, I don't know, maybe reputation, and maybe because they've already have a history of referring me patients and seeing what the outcome is."
5.3.2.3 Clinical expertise	SMP6
	"Well I mean the GP has acknowledged that it's a specialty that they are in need of. It is a clinical analysis for the needs of the patient."
5.3.2.4 Communication	SMP3
	"Probably it's a number of things; Prior experience with shared patient care, previous referrals, ease of referral, communication in response to the referral and an ongoing relationship with the referrer in the shared care of the patient.
	So you are keeping them informed, you are keeping them a part of the care, you're not just saying thanks very much is my business."

Results Section	Evidence
5.3.2.5 Collaboration	SMP5
	"SMP5: There is an expectation of trust in maintaining the general practitioner in the circle of management
	Interviewer: And how might you do that?
	SMP5: Other than the letters it's also a question of discussing with the GP. Asking for their advice in terms of which specialists they prefer their patient to be cross-referred for care by another specialist.

Appendix 4: Evidence—Section 5.3.3

Results Section	Evidence
5.3.3.2 Clinical expertise	SMP19 "I think the problem is normally tailored towards the expertise of SMP to attend to the clinical problem" SMP9 "Perhaps their expertise - procedure related; Then we want someone whom we trust will do the procedure well, eg. Dr [Name removed] for brain tumour; the ease of access, do not want to delay the patient being seen; need to balance between "A" and "B"" SMP6 "Yes, and it's really an internal measure of confidence that I'm across this particular problem. If my perception is that we need another expert, somebody else could likely do better than me to deal with this particular problem, then let's get that person involved, and that's a pretty poorly explanation…"
5.3.3.2 Accessibility	SMP2 "So availability, I'm more likely refer someone who has available timely you know slots. Someone I have met or know, in preference to someone I don't know and their reputation I suppose. Yeah"
5.3.3.2 Trust through existing relationship	SMP12 "So I would certainly be thinking about the radiotherapy in my multidisciplinary group. So the one I have relationships with that would probably be the biggest one." SMP 7 "SMP7: My experience of having done it in the past…..that is, my past prior experience, and patient feedback based upon that. *Interviewer" Anything else?*

Results Section	Evidence
	SMP7: Availability and maintaining a good and sort of longstanding professional relationship."
5.3.3.2 Clinical need/specific specialty	SMP 2
	"SMP2: Urgency of the clinical situation.
	Interviewer: Well presumably the first thing would be the clinical need?
	SMP2: Yeah clinical.
	Interviewer: So the clinical need would determine the speciality.
	SMP2: Yes.
	Interviewer: And sub speciality.
	SMP2: Yeah.
	Interviewer: Urgency.
	SMP2: Yeah."
5.3.3.2 Patient experience	SMP15
	"SMP 15: First thing - if they are qualified, if it's the right professional.
	Interviewer: Okay, so essentially clinical factors?
	SMP 15: Yeah.
	Interviewer: Okay, now you've made that decision on clinical factors and you found that there are three qualified specialists. How do you then select from one of those three? [07:05]
	SMP 15: So, it's about access. So, if the person is in the centre and I have access and communication with.
	Interviewer: Access to that SMP?
	SMP 15: Yes.
	Interviewer: What else?
	SMP 15: And also waitlist, how quickly they can see patients.
	Interviewer: What else.
	SMP 15: And also my previous interactions and if you had a good experience; and the patients' feedback."
5.3.3.3 Communication	SMP 19
	"One of the biggest challenges is once you have an established relationship a lot of the doctors will start to use you as their personal specialist and whenever they

Results Section	Evidence
	have a problem they want to talk to you like immediately, and the difficulty to get them to understand that they're not the only doctor that's referring to you, there's about 40 doctors who think the same way and that you have to let them understand that each patient is going to be treated in the same way, they are going to be triaged in the same way and the miss-fact that they are calling up does not necessarily mean that you are going to give that patient preference and that happens quite quickly the moment they start to trust you the moment you start having a relationship with them"
5.3.3.3 Disagreement in treatment	SMP6 "SMP6: And there is another one Tony, which thankfully is not all that common, but I think I'll express this: When a patient is referred and the situation that I'm presented with, makes me say why on earth did you do that? And why on earth am I in this position now of having to treat? Because you stay away you disagree with what was done for you. So you think you would have done something quite different. This is not because of an evolving medical practice. *Interviewer: So, its clinical disagreement as to what is in the patient's best interests? Would it be fair to say that you lose confidence and you lose trust when that happens?* SMP6: It doesn't fill you with confidence or trust. And depending on egregious the error is, it might present you with an opportunity to deal with it and teach them. In my experience, you can say to some of those people: We'll do this, but next time what about … you know what I would suggest you do in this instance. You know it's usually crumbly old neck patient that's had an operation that I didn't think that really needed."

Appendix 5: Evidence—Section 5.3.4

Results Section	Evidence
5.3.4.1 The patient's choice in referral	GP14
	"So you often may find that they want to nominate somebody, I think yeah sometimes they choose a specialist and you go ah so-and-so is really good but you know this person is a real worrier and he or she doesn't necessarily if they are worrier they don't work well with that, but so-and-so is a really softer person they'll be really good for them. So, I guess sometimes trying to match personalities may play a role and then yeah I guess finances plays a role as well like if there are a pensioner and all of that. Even if they're in a health fund they don't have a lot. You may turn around and send them to someone who also has a public hospital appointment and that if things are difficult, they can go through the public hospital system sort of thing."
	GP8
	"Some do, they'll want to go somewhere see a particular person for a variety of reasons. I think that I have a role in probably exploring what the reasons are. If it's not my standard referral then I wouldn't necessarily deny the patient but I would probably actually want to know why they want to do that, had they really thought about all the ramifications. For instance sometimes people want to go and see a surgeon that they saw on TV and are doing a procedure in Sydney or something like that you know... and they haven't really thought it through. I would still work and guide the patient as to the most appropriate SMP for their specific condition. Yeah and then they might say my daughter lives down there and she'll look after me after the operation or something, well that makes perfect sense."

Results Section	Evidence
5.3.4.2 Same sex specialist	GP15 "Yes, definitely yes. So I got, for example, some Muslim family, I know ladies do not like to go to male gynaecologist, I understand that from that culture so I give them choices to go to a female gynaecologist." GP 16 "Yes it would be, I mean in certain cultures where the females won't see a male doctor and therefore finding a female specialist in that field is important." GP17 "Yeah, I think of similar age group, not vitally important but you certainly don't want an old man going to a young girl, it doesn't seem to work"
5.3.4.2 Referring to the same culture/background as the patient	GP7 "GP7: It can do, occasionally, and you just get the feel for it? The answer is yes. The culture does, may well in this day and age, with greater immigration that may come into it. *Interviewer: So can do, particularly for certain backgrounds.* GP7: Yeah. *Interviewer: Okay.* GP7: Never more so than in the western suburbs, you know, compared to here." GP14 "But, you know there are people who… but I will often send Greeks to Greek practitioners because Greeks seem to worry a lot more."

Appendix 6: Evidence—Section 5.4

Results Section	Evidence
5.4.1.1 Patient experience	GP 19
	"the things that they will judge is the friendliness, the communication skills of that specialist and they will also judge the entire practice so the front desk, the friendliness of the receptionist"
5.4.2.1 Patient experience	GP6
	"I think a very understanding, especially with empathy. And explaining things in clear terms and may have to use diagrams or may have to use an old Chinese proverb a little picture is worth a million words."
	GP2
	"Listening to the patient's, respecting the patient's wishes, what their goals are with their expectations and a comprehensive check on health.
5.4.2.2 Clinical expertise	GP10
	"More specialised knowledge and information they receive about their particular problem"
	GP16
	"GP16: The best value for a patient is a good outcome.
	Interviewer: Anything else?
	GP16: Well the patient is only going to a specialist to get an outcome."
5.4.2.4 Costs	*Interviewer: Compared to the way they've been treated.*
	GP14: Yeah, yeah. So I think people are willing to pay a cost, but under the same circumstances. I don't know whether you can quote me…but people feel medical treatment is in need. "I need this I need this." "Why should I pay or pay a lot for it." "I need this." So therefore they don't want to pay something. The doctors who make a lot of money, they're the ones

Results Section	Evidence
	who provide it Patient: I want it, I want it, I want it!
	Doctor: "Oh you need a hair transplant? That'll be a thousand dollars."
	Patient: "I want it, I want it, I want it!"
	Doctor: "For you I'll make a special deal. Don't tell anyone. 750."
	Patient: "You're great! Fantastic!"
	Patient: "I want it, I want it" – charge such and such…
	Doctor: "I'll give it to you for 750 but don't tell anybody!"
	He's really good! Yeah. You understand what I mean?
	Interviewer: Yeah. Yeah
	GP14: So unfortunately, very often we're dealing with what people as a need. So, if it's a need they don't necessarily feel that they have to be paying big bucks for it.
5.4.3.1. A non-competing system of medicine	SMP2
	"I think instead of having GP's isolated, you know Medicare Locals and then specialist practice quite separate, If you had big group practices which included GPs and specialists in the one roof, I think that would end up with much better care for patients, for all the reasons that you've alluded to because you develop better relationships, you develop better trust and so the patients are going to benefit as a result of that"
	SMP3
	"Well I think if we look at the previous question that you said that the public and private I think we can expect, well we can create a system that can provide for all, non-competing systems would be good, in a greater interdependency between systems that are in public and private so that we recognize the strengths of each. In terms of overcoming clinical trials"

Results Section	Evidence
5.4.4.1 Provide GPs education to understand cancer better and enhance the referral process	SMP16 "SMP16: I would say GP education for common cancers is critical. *Interviewer: Ok. So the purpose is?* SMP16: Quick diagnosis, early diagnosis and early diagnosis multiple times and PSA is a classic. We would like to see this patient because PSA is now going up. Trouble is PSA has been abnormal for five years, of course it is now going up. Or the second one is, I don't really vet my referrals. The girls know how to vet them. I just spend more my time investing in seeing the patient because it's my way of sort of approach I work harder, probably not smarter than that who knows what do. I suppose you see a patient who's got a PSA of 1.14 because his median for his age was 0.8. I think not under-referring and also over referring;" SMP9 "Urgency of referral. Education is important so that oncologist practitioners understand what in our view require urgent referral; generally metastatic cancers is not urgent because it is not curative and only palliative, whereas others such as testicular cancer is to be prioritised, they are curable with timely referral
5.4.4.1 Improve efficiency of systems to prevent mistakes	SMP3 "Audit; ability to audit. How do you know you've done a bad thing if you haven't looked at what you've done? Benchmarking audit essentially is what it is, and therefore re-establishing many standards all time, and as such we need to have structures in place to give you the ability to do that in a timely fashion that identify errors before they have led to major consequences and where you can review your practice and say are we doing as well as we want to. What about checks and measures. I guess that comes

Results Section	Evidence
	out infrastructure support doesn't it, appropriate infrastructure."
	SMP7
	"I think a failure to refer patients when appropriate is more like it should lead to adverse outcomes and consult with specialists. I think the clinical pathways, following evidence based medicine are very important to minimise errors. And when you stray from a clinical pathway, that needs to be flagged and often those flags will need to result in a referral and cross collaboration."
5.4.4.1 Good documentation and communication	SMP19
	"Communication: It's all about communication. Medical error happens when appropriate information is not available and that goes from Pathology services, radiology services, referring doctor services; so it's all about proper communication and Proper documentation and continuity of communication"
	SMP14
	"Communication and documentation; this is the biggest risk to my practice. Being able to collate all of the relevant diagnostic and clinical assessments to enable me to reach an early conclusion as to the diagnosis and factor in all the co-morbidities for treatment."
5.4.4.2 Communication	GP8
	"I'm not sure if this is the biggest one but one that is probably really relatively easily changed and resolved would be just to make sure that our referral letters contain accurate and up-to-date information, particularly in respect to what medications patients are taking. That's a really big one.

Results Section	Evidence
	GP16
	"Generally once we have made a diagnoses of the serious illness that may need an oncology referral, we would chase that to be made fairly urgently. So what's urgently is within days to weeks, not weeks to months. You can't expect people to be seen the same day but generally most of the cases, when we ring up if I get a lung cancer here a specialist will generally see them within a week. So generally from a GP point of view, if anything we are finding things earlier these days because we are investigating more secondly we go out of our way in general practice to try and get a referral and make that as quick as possible so we would never send a patient here with a referral for them to make it themselves. All our oncology referrals are made by us because that way we know it's done and our staff can get them in quicker than what the patient might. What often might happen, if the staff can't get a patient in as quick as I would like, they would let me know and then I would ring to make sure they get in within a time frame that I think is appropriate; I think that is important for the GP to manage that, I don't think that it's good enough for a GP to do a referral that needs urgent care for the patient to make that referral."
5.4.4.2 Education	GP14
	"Talking about delaying diagnosis. How often is it more - I don't have the statistics. You guys might have the statistics of how many times people have had symptoms for a year or two years and didn't come to the doctor. So therefore, if that is the major thing, then it's probably an education, patient education thing."
	GP4
	"GP4: Making sure that they have a comprehensive referral; a comprehensive referral from the GP to the special so that nothing was missed.

Results Section	Evidence
	Interviewer: Anything else?
	GP4: Then it gets back to making sure the staff are properly trained and the staff don't give out the wrong medicine, I mean there's plenty of things, surveys showing the RNs give out the wrong medicines, this sort of stuff. So it's again training and upskilling of the staff."
5.4.5.1 The GP's perspective on the need for referral forms to be comprehensive and complete	GP15 "GP15: Probably when the patient has seen one GP, because he knows his patient, if any changes he can detect it very early. I don't know is this what you mean? *Interviewer: Yeah so early detection and therefore quick referral? Is there anything that you would do in the referral letter or form or something that makes it so that every GP is doing the same thing?* GP15: For cancer patients, especially cancer patients? *Interviewer: Yes, especially cancer patients.*"
5.4.5.1 The GP's perspective on the need for referral forms to be comprehensive and complete	GP14 "I think … referral forms… I'd probably be a little bit of a devil's advocate here. You've got specialists who are doing a… who often have complex things. I think, you now to plough through two pages of information and then turn around and then he's going to take a history and do examination and all of that I was brought up and if you're going to write a letter or something brevity is probably the better thing. What's the problem? How you can help? And then probably a list of medications and probably relevant past history that might be important! So, my feeling is in most communication if you could brevity is important so that you get the message across that… I would also say that probably goes against the current concept."

Results Section	Evidence
	GP13
	"Yeah it should be, however, in real life, it's never easy to do that, the time restrictions, or…it's mainly time. I mean half of us handwrite notes and half of us you know use the full computer. And when you use a full computer you spit out all that stuff, which specialist has to run through. Which is not all collaborated in a nice manner"

Appendix 7: Evidence—Section 5.5

Results Section	Evidence
5.5.1.2 Accessibility	GP9 "Gee… ehmm there's always the human factor there. As you progress toward change was key facilities excellence. I think manpower is the most important thing. I mean. We have a lot of facilities sometimes and we just don't have the manpower. You build another building and who's going to man that and I think manpower is probably the most important thing. So providing you've got enough nurses and doctors. Yeah of course"
5.5.1.2 Communication	GP8 *Interviewer: Do you see that as a bad thing?* GP8: I don't see that as a bad thing necessarily but what probably happens is that, well, let's worry about faxes because you never know if they have arrived and I think there's the potential for important information to slip down the cracks, literally you know. So I think if you're going to use a fax as a sort of means of communication you need really to know that the fax has arrived and that it is acted upon. And I'm not sure if that should really be the general practices responsibility or the specialist's responsibility." GP9 "GP9: If he does not have protocols in place. That can be, so you get uniform treatment in situations. So you can refer for those protocols and the ones generally thought-out beforehand. *Interviewer: All right. What else could you do? What about things like clear referral pathways? [40:48]* GP9: Yes I agree. Yeah. Well I suppose I was thinking that was part of the protocol when you went from there to there and you followed that"

5.5.1.2 Education	GP6 "Excellent up to date knowledge, excellence and giving good patient outcomes" GP1 "Provide education: Build trust by education, SMP about the role of the GP, and GP about what SMP does and developments in their field so that we can archive that collaboration."
5.5.1.2 Reducing unnecessary testing and treatments	GP17 "GP17: Number one knowing when to stop chemotherapy, that's a real problem, you sometime feel as though people get a bit overdone. High value care is so hard for us to value, what high value care is but as you say, there's monstrous waste even in general practice. One of my doctors in the practice is continually looking for these CA1, what is it, all these different markers of cancer in patients that don't have cancer but she's trying to diagnose it with all these CA129 and all these things, she's got a list of them, so in other words, doing tests when there's no treatment going to be done is not worthwhile, if you've got a demented patient who's going to start chemo so us seeing high value care is so hard for us to decide what is high value care. *Interviewer: Well, I mean, as you have just rightly said its doing tests that are not indicated.* GP17: Yes, not indicated and useless, yes good wording." GP19 "Firstly, I think these are very good goals and I agree with it. I think there is a lot of wastage in general practice and in hospital care so those objectives would involve identifying wasteful practices, wasteful investigations, and rewarding quality and best practice management and care, and that's at a general practice and a specialist level"

5.5.2.1 Reducing unnecessary testing and treatments	SMP10 "I think everything; there are several tests we do as routine which are completely unnecessary and the best way to determine that is to say, if I was on a desert island with this patient what would help me treat this patient. Do I need 50 tests to do it or do I need half a dozen tests to do exactly the same thing that I would end up doing at the end; and we are conditioned to do a whole stack of investigations that may or may not be contributory to their management. I don't believe that's necessarily the case for treatment but it's difficult to make an umbrella statement about that."
5.5.2.1 Prioritising evidenced based medicine	SMP8 "SMP8: So I guess you know, an example of that is giving a third and fourth and fifth line chemotherapy that have likely response rates of less than 10 percent. *Interviewer: But some would argue that even low response rates is still a chance for life or longevity, so how do you how would you respond to that?* SMP8: I think it's saying you know look if the first three lines of chemotherapy haven't worked, the chance of a fourth and fifth line chemotherapy working are negligible. *Interviewer: But if there is still any positive chance?* SMP8: But then you can talk about quality of life and you know. If you're asking me what I think will maximum high value cancer care, it's about those at ASCO, sort of statements to say these are the things that we should not be doing in our practice. *Interviewer: So, it's really all about not treating patients unnecessarily?* SMP8: Yeah basically what we're doing is evidence-based."
5.5.2.1 Improving referral pathways	SMP2 "I think early referral to specialists who best manage cancer is the best way.

	There are lots of people with fingers in pies and cancer patients and so the question is which doctors are the best place to offer that, and although I don't think medical oncologist is necessarily the best, they're probably the most qualified either that or the radiation oncologist I think, because their specialist training is in cancer care."
5.5.2.1 Addressing accessibility	SMP4 "SMP4: I guess by having a mix of highly qualified consultants at the top who cover the full range of tumours and well recognised, hopefully internationally; *Interviewer: So a mix of highly qualified specialist medical providers covering all specialties or sub-specialties who are internationally recognised; Interviewer: what are the challenges in doing that?* SMP4: I think having a high quality private facility amongst it would work. *Interviewer: And I guess the challenge that one would need to overcome is the ability to develop such a facility.* SMP4: Yes;"

Appendix 8: Tables

Table A8.1 Participant Demographics

Demographics	SMP Participants (*n* = 20)	GP Participants (*n* = 20)
Male	14	16
Female	6	4
Age Group (years)		
20–35	3	
36–55	15	4
56–65	2	10
66–75		5
>75		1
Years in practice		
0–5	36	
6–10	4	2
11–15	2	
16–20	4	1
>20	4	17

Table A8.2: Total Number of Patients

Data Groups	SMP (*n* = 20)	GP (*n* = 20)
Number of new referral patients per month		
>20	4	
20–40	9	
40–60	3	
60–80	3	
80–100		
100–150	1	
150–200		
200–250		
250–300		
300–350		
350–400		
>400		
Number of follow-up referral patients per month		
>20		
20–40	1	
40–60	1	
60–80	2	
80–100	5	
100–150	4	
150–200	3	
200–250	2	
250–300	1	
300–350	1	
350–400		
>400		

Total number of patients		
>20		
20–40		
40–60	1	
60–80	1	1
80–100	2	1
100–150	6	
150–200	4	
250–300	1	
250–300	3	2
300–350	1	
350–400		
>400	1	16

Table A8.3: Sources of Referral

Data Groups	SMP (*n* = 20)	GP (*n* = 20)
Number of new referral patients per month		
>20	4	
20–40	9	
40–60	3	
60–80	3	
80–100		
100–150	1	
150–200		
200–250		
250–300		
300–350		
350–400		
>400		
Number of follow-up referral patients per month		
>20		
20–40	1	
40–60	1	
60–80	2	
80–100	5	
100–150	4	
150–200	3	
200–250	2	
250–300	1	
300–350	1	
350–400		
>400		

Total number of patients		
>20		
20–40		
40–60	1	
60–80	1	1
80–100	2	1
100–150	6	
150–200	4	
250–300	1	
250–300	3	2
300–350	1	
350–400		
>400	1	16

Table A8.4: GP Source of Patients

Source	No.
Patient referral word of mouth	19
Location walk-in	7
Referral from SMPs & GPs	5
Referral from complementary and alternative medicine practitioners	1
Advertising	8
Community engagement	3

Appendix 9: General Practitioner (GP) Interview Documents

UTS
UNIVERSITY OF TECHNOLOGY SYDNEY

INVITATION LETTER

Dear General Practitioner

My name is Tony Noun and I am a PhD student at the University of Technology, Sydney. I am conducting research into the role of interprofessional relationships and trust in determining referral practices between GPs and specialists, and between specialists, and its impact on patient outcomes in cancer care. I would appreciate and welcome your assistance in this regard.

Project Title: *Professional-to-professional exchange relationships and its impact on oncology referral patterns and patient outcomes.*

This research is for my doctoral studies in Health and my request to you to participate is because you are a practicing medical professional. Participation is voluntary and you are free to opt out at any time/phase of the research.

Participation involves you completing a consent form, providing basic demographic data and participating in an interview.

The duration of each interview is expected to be approximately 30-40 minutes. The interviews will be recorded for transcription purposes only. The results from these interviews may be used to design a semi-structured survey comprising scale-based measures and open-ended questions. The aim is to seek your views to help understand the emerging concepts in a theoretical context. Following completion of the research, a summary of the results will be shared with you.

I understand, as a General Practitioner, you are hard-pressed for time, but without your valuable input, this research cannot be progressed. You are under no obligation to participate in this research. **Attached herewith are potential dates for your consideration. If you are able to participate, please notify me of your preference by fax: 02-85569399 or email: tnoun@cancercare.com.au**

Thank you

Yours sincerely

Tony Noun

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 2478 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number (ETH17-1464). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

PARTICIPANT INFORMATION SHEET

Research Project Title: *Professional-to-professional exchange relationships and its impact on oncology referral patterns and patient outcomes.*

UTS HREC APPROVAL NUMBER ETH17-1464

WHO IS DOING THE RESEARCH?

My name is Tony Noun, a PhD student at UTS. My supervisors are:

- Dr Maruf Chowdhury (Maruf.Chowdhury@uts.edu.au) and

- A/Prof Greg Fairbrother (Greg.Fairbrother@health.nsw.gov.au)

WHAT IS THIS RESEARCH ABOUT?

This research aims to explore in-depth the role of interprofessional relationships and trust in determining referral practices between GPs and specialists, and between specialists, and its impact on patient outcomes in cancer care.

FUNDING

Not Applicable

WHY HAVE I BEEN ASKED?

You have been invited to participate in this study because you are a General Practitioner and an important stakeholder for the health and wellbeing of our community.

Your contact details were obtained from the public domain on practicing medical professionals, and from our hospital databases.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate you, I will ask you to answer questions as part of a semi-structured interview that will take approximately 30 to 40 minutes to complete. The interview will be audio recorded and transcribed. However, all information is treated as confidential, and data is de-identified.

ARE THERE ANY RISKS/INCONVENIENCE?

There are no risks involved, and the questions will not inconvenience you.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, it will not affect your relationship with the researchers or UTS. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason, by contacting Dr Maruf Chowdhury (Maruf.Chowdhury@uts.edu.au) or Tony Noun (tnoun@cancercare.com.au) / Ph: ▮▮▮▮ ▮▮▮▮▮▮.

If you withdraw from the study after the interview, the information you have provided will be used for data analysis. Both confidentiality and anonymity is guaranteed. All personal / demographic information shared will be coded during data entry.

CONFIDENTIALITY

By signing the consent form, you consent to the researcher collecting and using demographic information, and your answers to the interview questions and online survey, for the research project. All information you provide will be treated confidentially. Your information will only be used for the purpose of this research project.

We plan to discuss/publish the results in Conferences and in peer-reviewed journals.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think we can help you with, please contact me via telephone (▮▮▮▮▮▮▮▮▮); or by email to (tnoun@cancercare.com.au) or my supervisor, Dr Maruf Chowdhury by email: Maruf.Chowdhury@uts.edu.au

NOTE:
This study has been approved by the University of Technology Sydney Human Research Ethics Committee [UTS HREC]. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au], and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

PARTICIPANT CONSENT FORM

I, ……………………………………………………………………………………………….., volunteer to participate in the research entitled *"Professional-to-professional exchange relationships and its impact on oncology referral patterns and patient outcomes".*

Please tick the box that applies, sign and date and return to the researcher

I agree to take part in the doctoral project outlined above.	Yes		No	
I agree to be interviewed by the researcher.	Yes		No	
I agree to allow the interview to be audio taped.	Yes		No	
I agree to further interviews, if required.	Yes		No	
I agree to complete a questionnaire related to the research.	Yes		No	
I understand that my participation is voluntary and that I can cease participation at any time.	Yes		No	
I understand that my participation in this research will be treated with confidentiality.	Yes		No	
I understand that all information that may identify me, will be de-identified at the time of data analysis.	Yes		No	
I understand that no identifying information will be disclosed or published.	Yes		No	
I understand that all information gathered in this research will be kept secure and confidential for a period of seven years.	Yes		No	
I am aware that I can contact the researcher at any time with queries. His contact details have been provided to me.	Yes		No	
I understand that this research project has Human Research Ethics Committee approval	Yes		No	

Participant's Signature:_____ Date:___/___/___.

Interview Guide ~ General Practitioners

Being a GP

- When did you start practicing as a GP?

- What are some of the factors that led you to deciding to become a GP?

- How <u>do you</u> / <u>does your practice</u> get patients?

Inter-professional relationship/s

- How do you form professional relationships with other GPs and specialists?

- What factors determine the choice of these relationships?

Patient Referral

According to AHPRA, a referral involves the transfer of responsibility in part or whole for the care of a patient, such as care that is outside the referring practitioner's expertise or scope of practice.

- Once you decide that your patient needs to be referred to a specialist, what are the factors that determine the choice of the specialist? (Prompt: What alternatives present themselves to you?)

- What would stop you from referring a patient to a particular specialist?

Inter-professional collaboration

According to AHPRA, effective collaboration is identified as a fundamental aspect of good practice among medical practitioners. The care of patients is improved when there is mutual respect and clear communication… With this understanding

- In your professional experience, what is the role of inter-professional collaboration in determining the choice of specialist provider?

- Any specific experiences to share?

- What do you think if this statement by a researcher from the healthcare context:
  "Collaboration is more than simply placing people together and hoping they will be able to organically get along and make it happen, health care providers require more experiences that foster interprofessional socialisation and evolving team culture" *(Beales & colleagues 2011).*

- From your perspective, what factors enhance inter-professional collaboration?

- What factors impede inter-professional collaboration?

About trust and related variable

- In your professional experience, what is the role of trust in your relationship with the specialist provider/s?   Any specific experience you could share in the context of patient referral.

- Your views on the statement that referral forms from GPs to Specialists need to be comprehensive and complete?

- What about specific feedback about the patient you referred?

- Is it essential for specialists to have ongoing communication with GPs regarding the treatment facilities and procedures used?

- What would be the nature of the communication (formal … forms, feedback)?

- In your opinion what is the role of reciprocity in inter-professional relationships?

- Any specific narrative to share?

The patient's choice and referral practices

- What is the role of the patient in determining the choice of specialist?

- Does culture feature as a significant factor in determining choice of specialist provider?

- Have you faced challenges in the course of referring patients?

- A specific experience/s to share?

High-value care

- In your experience, what aspect/s of the specialist's practice brings about greatest patient **satisfaction**?

- And what aspect/s of the practice bring about greatest **value** for the patient?

- Despite the Australian Government's proposed cuts to health expenditure, and plans to shift costs to patients and clinicians, Australia's health expenditure as a proportion of GDP is close to the OECD average. The Australian Healthcare & Hospitals Association (2015) states:

  > *'Government funded and supported healthcare practices require a fundamental shift to maximise high-value care (HVC) and minimise no-and low-value interventions'.*

> ➢ *HVC helps physicians provide the best possible patient care, while simultaneously reducing unnecessary costs to the health care system (American College of Physicians 2012).*

> ➢ *HVC has a "triple aim": better care for individuals, better health for populations, and a lower cost per capita (Martin LA, Berwick D & Nolan T, 2013).*

- In your opinion, what factors will help maximise high value care for cancer patients?

- What challenges are there to providing high value care to cancer patients?

Medical Error

- *It has been shown that despite a heavily regulated health structure in developed countries such as the United States, United Kingdom, and Australia, medical error of patients in care, accounts for the third highest number of deaths.* Against this backdrop, and in the referral context, what would be one factor that you believe needs to be addressed to reduce risks to cancer patients caused by medical error?

Demographic Data ~ GP

Gender	Female ☐	Male ☐
Age	25-35 years	☐
	36-55 years	☐
	56-65 years	☐
	66-75 years	☐
	76 years and older	☐
Year graduated in Medicine		
Years in general practice	0-6 years	☐
	6-10 years	☐
	11-15 years	☐
	16-20 years	☐
	20 years or more	☐
# of referrals made	On average per month	
# Oncology referrals	On average per month	
Average # of patients consulted each month	<25 patients	
	26 - 50 patients	
	51 - 75 patients	
	76 - 100 patients	
	101 - 125 patients	
	126 - 150 patients	
	151 - 200 patients	
	201 - 300 patients	
	300 or more patients	

Thank you for your time, patience and willingness to share your professional experiences and expertise. I am truly grateful for your contribution to the research.

Appendix 10: Specialist Medical Provider (SMP) Interview Documents

UTS
UNIVERSITY OF TECHNOLOGY SYDNEY

INVITATION LETTER

Dear Specialist Medical Practitioner

My name is Tony Noun and I am a PhD student at the University of Technology, Sydney. I am conducting research into the role of interprofessional relationships and trust in determining referral practices between GPs and specialists, and between specialists, and its impact on patient outcomes in cancer care. I would welcome and appreciate your assistance in this regard.

Project Title: *Professional-to-professional exchange relationships and its impact on oncology referral patterns and patient outcomes*

This research is for my doctoral studies in Health and my request to you to participate is because you are a practicing medical professional. Participation is voluntary and you are free to opt out at any time/phase of the research.

Participation involves you completing a consent form, providing basic demographic data and participating in an interview.

The duration of each interview is expected to be approximately 30-40 minutes. The interviews will be recorded for transcription purposes only. The results from these interviews may be used to design a semi-structured survey comprising scale-based measures and open-ended questions. The aim is to seek your views to help understand the emerging concepts in a theoretical context. Following completion of the research, a summary of the results will be shared with you.

I understand, as a specialist, you are hard-pressed for time, however, without your valuable input, this research cannot be progressed. You are under no obligation to participate in this research. **Attached herewith are potential dates for your consideration. If you are able to participate, please notify me of your preference by fax: 02-85569399 or email: <u>tnoun@cancercare.com.au</u>**

Thank you

Yours sincerely

Tony Noun

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 2478 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number (ETH17-1464). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

PARTICIPANT INFORMATION SHEET

Research Project Title: *Professional-to-professional exchange relationships and its impact on oncology referral patterns and patient outcomes*

UTS HREC APPROVAL NUMBER ETH17-1464

WHO IS DOING THE RESEARCH?

My name is Tony Noun, a PhD student at UTS. My supervisors are:

- Dr Maruf Chowdhury (Maruf.Chowdhury@uts.edu.au) and

- A/Prof Greg Fairbrother (Greg.Fairbrother@health.nsw.gov.au)

WHAT IS THIS RESEARCH ABOUT?

This research aims to explore in-depth the role of interprofessional relationships and trust in determining referral practices between GPs and specialists, and between specialists, and its impact on patient outcomes in cancer care.

FUNDING

Not Applicable

WHY HAVE I BEEN ASKED?

You have been invited to participate in this study because you are a General Practitioner / Specialist, and an important stakeholder for the health and wellbeing of our community.

Your contact details were obtained from the public domain on practicing medical professionals, and from our hospital databases.

IF I SAY YES, WHAT WILL IT INVOLVE?

If you decide to participate you, I will ask you to answer questions as part of a semi-structured interview that will take approximately 30 to 40 minutes to complete. The interview will be audio recorded and transcribed. However, all information is treated as confidential and data is de-identified.

ARE THERE ANY RISKS/INCONVENIENCE?

There are no risks involved, and the questions will not inconvenience you.

DO I HAVE TO SAY YES?

Participation in this study is voluntary. It is completely up to you whether or not you decide to take part.

WHAT WILL HAPPEN IF I SAY NO?

If you decide not to participate, it will not affect your relationship with the researchers or UTS. If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason, by contacting Dr Maruf Chowdhury (Maruf.Chowdhury@uts.edu.au) or Tony Noun (tnoun@cancercare.com.au) / Ph: ▮▮▮ ▮▮▮▮▮▮.

If you withdraw from the study after Phase I, the information you have provided will be used for data analysis. Both confidentiality and anonymity is guaranteed for Phase I and Phase II. All personal / demographic information shared will be coded during data entry.

CONFIDENTIALITY

By signing the consent form, you consent to the researcher collecting and using demographic information, and your answers to the interview questions and online survey, for the research project. All information you provide will be treated confidentially. Your information will only be used for the purpose of this research project.

We plan to discuss/publish the results in Conferences and in peer-reviewed journals.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think we can help you with, please contact me via telephone (▮▮▮▮▮▮▮▮▮); or by email to (tnoun@cancercare.com.au) or my supervisor, Dr Maruf Chowdhury by email: Maruf.Chowdhury@uts.edu.au

NOTE:
This study has been approved by the University of Technology Sydney Human Research Ethics Committee [UTS HREC]. If you have any concerns or complaints about any aspect of the conduct of this research, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au], and quote the UTS HREC reference number. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

PARTICIPANT CONSENT FORM

I, …………………………………………………………………..……………………….., volunteer to participate in the research entitled *"Professional-to-professional exchange relationships and its impact on oncology referral patterns and patient outcomes"*.

Please tick the box that applies, sign and date and return to the researcher.

I agree to take part in the doctoral project outlined above.	Yes		No	
I agree to be interviewed by the researcher.	Yes		No	
I agree to allow the interview to be audio taped.	Yes		No	
I agree to further interviews, if required.	Yes		No	
I agree to complete a questionnaire related to the research.	Yes		No	
I understand that my participation is voluntary and that I can cease participation at any time.	Yes		No	
I understand that my participation in this research will be treated with confidentiality.	Yes		No	
I understand that any information that may identify me, will be de-identified at the time of data analysis.	Yes		No	
I understand that no identifying information will be disclosed or published.	Yes		No	
I understand that all information gathered in this research will be kept secure and confidential for a period of seven years.	Yes		No	
I am aware that I can contact the researcher at any time with queries. His contact details have been provided to me.	Yes		No	
I understand that this research project has Human Research Ethics Committee approval	Yes		No	

Participant's Signature:_____ Date:___/___/___.

Interview Guide ~ Specialist Medical Providers

Being a Specialist

- When did you start practicing as a Specialist?

- What are some of the factors that led you to deciding to become a Specialist?

The professional-to- professional relationship/s & inter-professional collaboration

- *According to AHPRA, effective collaboration is identified as a fundamental aspect of good practice among medical practitioners. The care of patients is improved when there is mutual respect and clear communication…* With this in mind, how do you form professional relationships with general practitioners and other specialists?

- A health care researcher noted that *"Collaboration is more than simply placing people together and hoping they will be able to organically get along and make it happen, health care providers require more experiences that foster interprofessional socialisation and evolving team culture" (Beales & colleagues 2011)* ~ What is your view about this?

- What in your opinion are the causes of a breakdown in professional exchange relationships?

Patient Referral

According to AHPRA, a referral involves the transfer of responsibility in part or whole for the care of a patient, such as care that is outside the referring practitioner's expertise or scope of practice.

- When you believe a patient needs a referral to another specialist, what are the factors that determine who you refer that patient to?

- What would stop you from referring a patient to a particular specialist?

- In your professional experience, what is the role of trust in your relationship with referring doctors (those that refer to you)?

- In your professional experience, what is the role of reciprocity in your relationship with referring doctors (those that refer to you)?

- What challenges (if any) have emerged in your relationship with referring doctors?

- As an (oncology) specialist, what are some of your most memorable experiences with referrers during the past year?

- *In the highly regulated Australian healthcare context, specialists are dependent on General Practitioners / other specialists for patient referral:* Therefore, if there is one factor that stands out in this established referral structure, as enabling best patient outcomes, what would that factor be?

- According to the Australian Healthcare & Hospitals Association (2015) *"The private sector plays an important role in maintaining a balanced system where people have a genuine choice. However there is no logic to a system that sees private hospitals contracted to treat public patients while public hospitals compete for private patients …"* What do you think of this statement? What is your view about this?

High-value Care

- In your experience, what aspect/s of the specialist's practice brings about greatest patient **satisfaction?**

- And what aspect/s of the practice bring about greatest **value** for the patient?

- Despite the Australian Government's proposed cuts to health expenditure, and plans to shift costs to patients and clinicians, Australia's health expenditure as a proportion of GDP is close to the OECD average. The Australian Healthcare & Hospitals Association (2015) states:

  - *'Government funded and supported healthcare practices require a fundamental shift to maximise high-value care (HVC) and minimise no-and low-value interventions'.*

  - *HVC helps physicians provide the best possible patient care, while simultaneously reducing unnecessary costs to the health care system (American College of Physicians 2012).*

  - *HVC has a "triple aim": better care for individuals, better health for populations, and a lower cost per capita (Martin LA, Berwick D & Nolan T, 2013).*

  In your opinion, what factors will help maximise high value care for cancer patients?

- What challenges are there to providing high value care to cancer patients?

Medical Error

- *It has been shown that despite a heavily regulated health structure in developed countries such as the United States, United Kingdom, and Australia, medical error of patients in care, accounts for the third highest number of deaths.* Against this backdrop, and in the referral context, what would be one factor that you believe needs to be addressed to reduce risks to cancer patients caused by medical error?

Demographic Data ~ Specialist

Gender	Female	☐	Male	☐
Age	25-35 years	☐		
	36-55 years	☐		
	56-65 years	☐		
	66-75 years	☐		
	76 years and older	☐		
Year graduated in medicine				
Professional qualifications				
Years in specialist practice	0-6 years	☐		
	6-10 years	☐		
	11-15 years	☐		
	16-20 years	☐		
	20 years or more	☐		
Average number of referrals Made to you each month	From GPs			
	From Specialists			
Average number of referrals You make to other specialists each month				
Average Number of Patients consulted Each month	New Patients:	☐		
	Follow-ups:	☐		
	Total:	☐		

Thank you for your time, patience and willingness to share your professional experiences and expertise. I am truly grateful for your contribution to the research.

Appendix 11: Research Design Plan

Date and Duration	Purpose	Process	Status
Consultation phase: pre-2014	To seek views from stakeholders about the relevance of the research to the health context and field of Specialist Medical Practice.	In interactions with medical professionals, meetings with Medical Advisory Councils and communication with government authorities, medical practitioners, specialists and community members, the proposed research was discussed over the course of many years.	Completed
Prepare a draft proposal for this doctoral study: 2014–2015	To progress the doctoral work.	Connecting with University and potential supervisors to further the doctoral study.	Completed
Designing the first study: 2015	To design interview schedules for GPs and SMPs.	Based on an understanding of the research context, published literature and the study methodology.	Completed
Ethics approval: 2015	To obtain ethics approval from the Human Research Ethics Committees of the participating hospitals and SCU.	Submission of the supervisor-approved research proposal, ethics application forms, draft version of the participant consent form, participant information sheet and interview schedules.	Ethics approval obtained from SCU and participating hospitals in NSW (ETH17-1464). November – December 2015
Data collection: 2016	Piloting the interview schedule and refining the questions.	Piloting the interview schedule with the participant groups: general practitioners and specialists.	Completed
UTS Ethics: 2017	To obtain ethics approval from the UTS	Submission of the supervisor-approved research proposal, ethics application forms:	Ethics approval

Date and Duration	Purpose	Process	Status
	Human Research Ethics Committee.	participant invitation, consent form, information sheet and interview schedules.	obtained from UTS HREC~ June 2017
Data collection 2017–2020	Complete field research component: interview GPs & SMPs.	Face-to-face and telephone	Completed
Data Analysis 2017–2020	Data analysis of qualitative interviews.	Interviews conducted, recorded, transcribed; data entered into NVivo analytics software.	Completed
Results 30.09.2020	Results To accomplish the aims of the research.	The results emerged with data collection and post the end of data collection. NVivo was used for data analyses.	Completed
Discussion 30.11.2020	To accomplish the aims of the research.	Undertake a comprehensive review of all work to date and compare and contrast, noting the differences and areas for further investigation.	Completed.
Conclusion & Recommendations 31.12.2020	To complete the research.	To revisit the research questions and ensure all are addressed, and that the findings are summarised in the context of the aims, literature review and data analysis.	Completed
Abstract 31.01.2021		Emerged from the aims, the conclusion and the recommendations.	Completed

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