GUIDELINES FOR EFFECTIVE INPATIENT CONSULTATION
Department of Medicine
University of Alabama at Birmingham
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In simple terms, a consult is a request made from one physician or provider to another physician or provider to give an opinion or advice on a specific patient. A consultation is usually sought when a physician or provider with primary responsibility for a patient recognizes conditions or situations that are beyond his or her training or expertise. An effective consult should always be performed with the patient’s best interest in mind and have a positive impact on the patient’s care. Open communication between the referring physician or provider and the consult provider is essential for effective consultation.

Guidelines for Referring Physicians/Providers Requesting Consultation
1. Ask a clear and specific question.
   - Don’t make the consultant guess what your question is. A vague question will likely result in a vague response;
   - Referring physicians/providers are encouraged to contact the consultant directly to clarify the question to be addressed;
   - If the referring physician/provider is interested in arranging a procedure (endoscopy, bronchoscopy, etc.), he or she should make that request clear to the consultant;
   - A request for a consult should be placed in IMPACT and/or documented in the medical record.

2. Establish the degree of urgency.
   - The referring physician/provider must decide if the consult should be seen emergently (immediately), urgently (same day), or routinely (within 24-48 hours). Underestimating the urgency of the consultation may negatively impact patient care; repeatedly overstating the urgency may annoy the consultant.

3. Call the consult early.
   - Call early in the day to allow the consultant the best opportunity to see the patient the same day;
   - Call early in the week, especially if attempting to schedule specialized procedures or diagnostic studies not routinely performed on weekends;
   - Call early in the hospital course; calling a consult on the day the patient is scheduled for discharge reflects poor planning and may not allow the consultant to make effective interventions.

4. Physician-to-physician/provider communication is critical!
   - Don’t delegate the responsibility of calling a consult to anyone who is not fully familiar with all details of the patient’s case;
   - If the referring physician/provider calls the consultant directly, the consultant is much more likely to return the favor after the patient has been evaluated.

5. Provide essential medical information.
   - In all but emergent circumstances, the consultant should reasonably expect to find a complete admission history and physical examination for the patient entered in the medical record;
   - In particular, the referring physician/provider should provide critical details that may not be immediately available to the consultant (e.g., information from outside hospitals).
6. Notify the patient to expect a visit from the consultant.
   - The referring physician/provider should always discuss plans for consultation with the patient to be sure that the patient is in agreement and to avoid any misunderstandings.

7. Acknowledge the recommendations provided by the consultant.
   - The referring physician/provider has the option to accept or reject the consultant’s recommendations. However, if the referring physician/provider elects not to implement the consultant’s recommendations, he or she should, at least, acknowledge in the medical record that the consultant’s recommendations have been received and reviewed.

8. Avoid “curbside” consultation except for simple, straight-forward problems.
   - “Curbside” consultation is best suited for questions with a factual answer that can be looked-up quickly in a reference source (e.g., drug dose, lab test interpretation, etc.). For more complex questions, a request for formal consultation is more appropriate;
   - Be willing to request formal consultation if that is suggested by the consultant;
   - “Curbside” questions should ideally be discussed between attending physicians/providers without involvement of trainees or other personnel.

9. If co-management of the patient is desired, the referring physician/provider should discuss that directly with the consulting physician/provider.
   - The patient’s attending physician remains in charge of the patient’s overall care, but can delegate specific aspects of management to the consultant, if mutually agreeable;
   - Co-management should not be assumed or presumed by either party. If the referring physician and consultant agree on co-management, the boundaries should be carefully defined and entered into the medical record by the referring physician.

10. Discuss the consultant’s findings and recommendations with the patient.

Guidelines for Physicians Providing Consultation
1. Answer the question that was asked.
   - Don’t be distracted by other interesting findings that are outside of the scope of the original question;
   - If the consultant uncovers other previously-unrecognized clinical problems that need to be addressed, the consultant should call the referring physician to discuss them further.

2. See the patient in a timely manner.
   - When the consult is called, establish the degree of urgency with the referring physician/provider;
   - As a general rule, all consults called to UAB Department of Medicine services should be seen and staffed within 24 hours, whenever possible;
   - All UAB DOM Divisions providing consultative services must make arrangements to provide consults on nights, weekends, and holidays when requested.

3. Make certain that the recommendations are clear and easy for the referring physician/provider to understand.
   - Be concise and succinct; use definitive language;
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- Recommendations offered in a list are easier to follow than recommendations buried in paragraphs of text;
- When the diagnosis is uncertain, listing every possible differential diagnosis is not helpful. Offer the top 5 possibilities;
- Prioritize your recommendations. Make clear which recommendations are critical, which should ordinarily be 5 or fewer. Other recommendations can go on a “non-critical” list.
- Indicate which (if any) of the recommendations will be carried out by the consulting team.
- Be very specific and offer detailed recommendations. The referring physician/provider should not be expected to have the consultant’s level of expertise. Clearly define drug doses, routes of administration, frequency and duration of dosing, specific tests to be ordered, etc.
- For handwritten notes, legibility counts. Recommendations that cannot be deciphered are not helpful and carry potential for harm.
- (Temporary recommendation – during the transition from paper to electronic medical records, potential exists for a consult note to be overlooked because it is in the “other” location. During the transition period, a consultant who leaves a note in the paper chart should add a notation in IMPACT to “see chart for recommendations.” Conversely, a consultant writing a note in IMPACT [or Horizon] should leave a notation in the paper chart to “see IMPACT [or Horizon] note for recommendations.”)

4. Physician-to-physician/provider communication is critical!
   - A telephone call from the consult attending/provider is usually appropriate and appreciated by the referring physician/provider. When the consult contains “critical” recommendations that need to be implemented as soon as possible, direct physician-to-physician/provider communication is essential;
   - Never leave “critical” recommendations in the medical record without notifying the referring physician/provider;
   - In less-critical situations, communication by other team members (e.g., resident to resident) may be acceptable.

5. The consultant’s note should be professional and respectful in language and tone.
   - An effective note should be informative without being patronizing and should be helpful without being condescending;
   - A consult note is not an appropriate place to offer criticism of other providers, services, or institutions;
   - “Chart wars” are counter-productive and should always be avoided; providers who disagree on management plans should discuss their differences of opinion directly.

6. The consultant should first discuss his or her findings and conclusions with the referring physician/provider, not with the patient.
   - Remember that the consultant’s recommendations may or may not be implemented by the referring physician/provider. Don’t confuse the patient;
   - If the consultant suspects a diagnosis with high potential for emotional impact (e.g., a new diagnosis of cancer), the consultant and the referring physician/provider should discuss who is in the best position to break this news to the patient.
7. Continue to see the patient as frequently as required until the medical issue has been satisfactorily resolved.
   - The appropriate frequency of follow-up depends on the severity and pace of the problem under evaluation;
   - When further follow-up is no longer necessary, the consultant should enter a formal "sign off" note into the medical record.

8. Arrange subspecialty outpatient follow-up, when necessary and requested by the referring physician/provider.

9. Define parameters for co-management when requested by the referring physician/provider.
   - A consultant should never assume a co-management role unless specifically requested to do so by the referring physician/provider. If the referring physician/provider requests that a consultant take over management of specific aspects of the patient’s care, the parameters should be carefully defined in a conversation and documented in the medical record;
   - Identify the contact person from the consulting team who will be writing the co-management orders and enter that information in the medical record.

10. Accept requests for "curbside" consultation only when the issue is simple, straightforward and clearly within the consultant’s area of expertise.
    - For questions where decision making is more complex, the consultant should not hesitate to suggest formal consultation and offer to see the patient;
    - "Curbside" questions are ideally discussed between attending physicians. Trainees should not offer "curbside" opinions without first reviewing the question with the attending consultant.