Consultation in Academic Medicine

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Outline

• Service to patient and primary care team.
  – John

• Educating the consult team.
  – Alan

• Educating the primary care team.
  – Alan & John
Successful Medical Consultation - Guidelines for the Referring Physician and the Consultant

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What is a Consult?

- In simple terms, a consult is a request made from one physician (or other provider) to another to give an opinion or advice on a specific patient.
- Consultation is usually sought when a physician 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 and the consult provider is essential for effective consultation.
If internists are not explicitly instructed in how to perform consultations, the outcome of their consultative efforts may be suboptimal. We suggest that consultations will be more helpful if the following principles are followed: the consultant should determine the question that is being asked, establish the urgency of the consultation, gather primary data, communicate as briefly as appropriate, make specific recommendations, provide contingency plans, understand his own role in the process, offer educational information, communicate recommendations directly to the requesting physician, and provide appropriate follow-up. If these ten "commandments" are followed, the consultation is more likely to be effective and satisfactory for all the participants.

(Arch Intern Med 1983;143:1753-1755)
Two Role Players

- Dr. Goldman’s sacred paper provides guidance for consultants.
- However, there are three critical participants in any consultation: the referring physician, the consultant, and (not to be forgotten) the patient.
- What about guidance recommendations for the referring physician?
Assumptions for Our Discussion

- I will refer to “physicians,” but recognize that a variety of other providers both request and deliver consultation in the modern medical environment.
- I will focus on inpatient face-to-face consultation. Outpatient consultation in an office setting follows many of the same principles, but usually with less urgency. Tele-consultation (the wave of the future!) is outside the scope of our discussion (mostly because of my ignorance of the topic).
- I will focus on consultation in an academic medical center and note some of the differences in practice in private hospital settings.
Guidelines for Referring Physicians Requesting Consultation

- You have primary responsibility for the care of your hospitalized patient.
- You recognize that the patient has a complex problem that requires specialized diagnostic or therapeutic input.
- Who you gonna call? And what guidelines should you follow?
#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 are encouraged to contact the consultant directly to clarify the question to be addressed.
- If the referring physician is interested in arranging a procedure (endoscopy, bronchoscopy, etc.), he or she should make that request clear to the consultant.
- A request/order for a consult should be placed in IMPACT and documented in the medical record.
#2 - Establish the degree of urgency.

- The referring physician 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.

- The consultant should be informed of the degree of urgency.
#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 communication is critical!

- Don’t delegate the responsibility of calling a consult to anyone who is not completely familiar with all details of the patient’s case.
- If the referring physician 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.
- The referring physician should provide all relevant details that may not be immediately available to the consultant (e.g., clinical information from outside hospitals, clinics, etc.).
#6 - Notify the patient to expect a visit from the consultant.

• The referring physician 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 has the option to accept or reject the consultant’s recommendations. However, if the referring physician 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 frequent “curbside” consultation

- “Curbside” consultation is best suited for questions with a factual answer (as opposed to opinion or clinical judgment) 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 without involvement of trainees or other personnel.
#9 - Clarify request for co-management

- If co-management of the patient is desired, the referring physician should discuss that directly with the consulting physician.
- 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 attending physician.
#10 - Discuss the consultant’s findings and recommendations with the patient.

- Let the patient know what the consultant has concluded and recommended.
- The referring physician should discuss his or her plans for implementing the consultant’s recommendations, or explain why that might not be advisable.
Guidelines for Physicians Providing Consultation

- You are on the consult service.
- You get a page and the caller requests a consult. It is, of course, 4:00 pm on a Friday afternoon.
- What are your responsibilities and obligations?
#1 - See the patient in a timely manner.

- When the consult is called, establish the degree of urgency with the referring physician.
- As a general rule, all consults called to UAB DOM 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.
#2 - 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.
#3 - Make clear recommendations

- Make certain that the recommendations are clear and easy for the referring physician to understand.
- Be concise and succinct; use definitive language.
- Recommendations offered in a list are easier to follow than recommendations buried in paragraphs of text.
- When the Dx is uncertain, listing every diagnostic possibility is not helpful. Offer the top ~5 DiffDx.
- 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.
#3 - Make clear recommendations (con’t)

- Indicate which (if any) of the recommendations will be carried out by the consulting team.
- Offer detailed and specific recommendations. The referring physician should not be expected to have the consultant’s level of expertise. Define drug doses, routes of administration, frequency and duration of dosing, specific tests to be ordered, etc.
- For a “composite” note written by a trainee and an attending, make sure the recommendations are not discordant.
- For handwritten notes, legibility counts. Recommendations that cannot be deciphered are not helpful and carry potential for harm.
#4 - Physician-to-physician communication is critical!

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

- 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.


The consultant should first discuss his or her findings and conclusions with the referring physician, not with the patient.

Remember that the consultant’s recommendations may or may not be implemented by the referring physician. 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 should discuss who is in the best position to break this news to the patient.
#7 – Provide follow-up consultative care.

- 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 – Define parameters for co-management

- A consultant should never assume a co-management role unless specifically requested to do so by the referring physician. If the referring physician 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.
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.
#10 – Assist with outpatient follow-up

- Arrange outpatient follow-up in your specialty area, when necessary and requested by the referring physician.
Educating the Consult Team

Alan M. Stamm, M.D.

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Outline

• Approaches:
  – teaching during rounds
  – scheduling dedicated teaching sessions

• Principles:
  – patient-centered
  – learner-centered
  – evidence-based
I. Teaching During Rounds

• Challenges:
  – multiple levels of trainees
  – absenteeism
  – interruptions
Keep the Group Together

• How to organize rounds:
  – each day, work around clinics, conferences, and meetings
  – start early, and do not start new consults on rounds, or
  – start late, and do not start new consults on rounds
Model Doing Quality Work

• Hazards of doing new consults during rounds:
  – accepting the primary team’s H & P
  – working with incomplete data
    • routine tests not yet completed
    • results available but not recognized
  – not reviewing images with radiologist
  – not truly understanding the patient’s problems and needs
Think Out Loud / Generalize

• Diagnosis – how do the symptoms, signs, lab results, and/or imaging allow us to classify this patient’s illness?
  – why is this pulmonary embolism?
  – why is this vasculitis?
  – why is this meningitis and not encephalitis?
• Diagnosis – when do we have enough information to recommend specific therapy, or why do we need additional testing?
  – flexible fiber-optic endoscopy
  – cardiac catheterization
  – kidney biopsy
• Differential diagnosis – what is the DDx?
  – what is the weighted DDx?
  – how does this change with age, antecedent medical history, or specific current findings?

  – engage everyone in defending and committing to a diagnosis
    • revisit on subsequent days
• Differential diagnosis – what is the accuracy of a particular finding, or constellation of findings, in a given setting?
  – fever & cough – caused by influenza
  – inflamed leg – due to deep vein thrombosis

– resource: *The Rational Clinical Examination* series in JAMA
• Differential diagnosis – what is the gain in diagnostic accuracy of a particular test?
  – fever & cough – rapid influenza assay
  – inflamed leg – duplex ultrasound for DVT
  – diarrhea – stool test for *C. difficile* infection
• Acknowledge what you don’t know.
• Assign someone else to search for the answer!
• Follow-up.
II. Scheduled Teaching Sessions

• Take advantage of established Divisional conferences:
  – Grand Rounds – if clinical
  – Case Conference
  – Board Review – if level appropriate
  – Journal Club – if articles applicable

  – advise trainees week by week
Special Sessions

• Frequency – once or twice a week.
• Instructor(s) – faculty or fellows:
  – those on service vs. all who serve?
• Content:
  – fixed, repeating vs. variable, drawn from a collection & adapted to patients seen?
• Format:
  – lecture vs. discussion after trainee preparation?
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• Review handout.
Interactive Discussion

• Every Monday:
  – assign 1-3 articles on a single topic to read and 3-5 questions to record answers
  – pick topics based on problems encountered
  – provide a hard copy or on-line syllabus

• Every Friday:
  – discuss their answers to the questions
  – discuss relevance to patients seen
  – emphasize important points
• Principles:
  – patient-centered
    • pick topics that are relevant
  – learner-centered
    • read and prepare answers before session
    • extra credit for reading beyond the required references
  – evidence-based
    • read primary sources of guidelines
Learner-Centered Models

- **Harvard Business School.**
  - provide case & questions on Monday, review answers on Friday

- **Multiple Small Feedings of the Mind (ACP).**
  - provide cases & questions on Monday, review answers on Friday

- **Medical Knowledge Self-Assessment (ACP).**
  - provide questions on Monday, review answers on Friday
Collateral Reward

• Development, maintenance, and updating of a syllabus or collection of cases / questions / answers / explanations / references is tangible evidence of scholarly activity.
  – something for your Teaching Portfolio at promotion time
Comments or Questions?
Educating the Primary Care Team

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Challenges

• Lack of contact & continuity.
• Uncertainty of interest.
  – example – hypertension
Approaches

• Teach during rounds.
  – address questions
  – generalize

• Provide references.
  – paper vs. email or *Impact* message link to article