

**LET'S TALK ABOUT  
CONSULTATIONS**

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A physician who is called upon to consult, should observe the most honorable 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 would impair the confidence reposed in him, or affect his reputation.

--1847 code of Ethics, American Medical Association



# ETHICAL PRINCIPLES-OF REQUESTING-CONSULTING RELATIONSHIPS

- 1) The patient's welfare must be the main concern of all providers
  - 2) All providers, as members of a common profession, have a duty to treat each other with integrity and respect
  - 3) All providers have an obligation to use health resources appropriately and prudently, avoiding unnecessary consultations
  - 4) Providers should obtain consultation when they feel they need assistance in caring for a patient. If a patient requests a referral when the provider does not believe it is indicated, the provider should discuss his or her clinical reasoning with the patient, seek out underlying concerns and anxieties, and create a mutually agreed upon plan of action consistent with patient desires and professional judgment
  - 5) Unless authority has been formally transferred, the ultimate responsibility and corresponding authority for a patient's care lies with the referring provider.
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# ETHICAL PRINCIPLES-OF THE PRIMARY PROVIDER

- 1) Consultations are indicated on request in doubtful or difficult cases, or when they enhance the quality of medical care
  - 2) Consultations are primarily for the patient's benefit
  - 3) A case summary should be sent to the consulting provider unless a verbal description of the case has already been given
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# ETHICAL PRINCIPLES- OF THE CONSULTING PROVIDER

- 1) One provider should be in charge of the patient's care
  - 2) The attending provider has overall responsibility for the patient's treatment
  - 3) The consultant should not assume primary care of the patient without consent of the referring provider
  - 4) The consultation should be done punctually
  - 5) Discussions during the consultation should be with the referring provider, and with the patient only by prior consent of the referring provider
  - 6) Conflicts of opinion should be resolved by a second consultation or withdrawal of the consultant; however, the consultant has the right to give his or her opinion to the patient in the presence of the referring provider.
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# ERRATA

- The requesting provider is always free to call in another consultant.
- The consultant provider should recognize the legitimate desire of the requesting provider for informal consultation and advice.

# **PRACTICAL PRINCIPLES**

THE TEN COMMANDMENTS OF EFFECTIVE CONSULTATIONS

# COMMANDMENT I. DETERMINE THY QUESTION

We cannot possibly answer a question we are not asked; we cannot receive an answer to a question we do not ask.

94% of MDs surveyed (n=323) felt that “the specific question addressed” was essential to an effective consultation.

Only 69.7% of subspecialty consultations (n=188) had a clear clinical question. Other studies have found incongruence between requesting provider and consultant (14% of cases), another found no specific question in 24% of cases. My favorite study showed consultants ignored explicit questions asked by requesting providers (12% of cases) !

# COMMANDMENT II. THOU SHALT ESTABLISH THE URGENCY

It is an important part of a consultant's role to balance the needs of all of the consultant service's patients. Urgent or emergent consultations need to be seen promptly, and elective in-patient consultations should usually be answered the same day as requested but in all cases within 24 hours.

66% of MDs surveyed (n=323) felt consultation urgency was essential to an effective consult.

81% of urgent consultations resulted in direct communication with the team.



# COMMANDMENT III. LOOK FOR THYSELF

While we must trust our requesting provider's assessments, it is important to verify their conditions before offering recommendations. Consultants are most effective when they are willing to gather data on their own.



# COMMANDMENT IV. BE AS BRIEF AS APPROPRIATE

The consultant need not repeat in full detail the data that were already recorded, but should touch on all relevant data.

Assessments and recommendations should also be as brief as possible without becoming inappropriately brief. *Leaving a long list of suggestions may decrease the likelihood that any of them will be followed, including the critical ones*

# COMMANDMENT V. THOU SHALT BE SPECIFIC

It is not sufficient to recommend a medication, one must recommend the dose, route, frequency, and duration, to be effective.

Surveyed providers valued knowing:

Generic name of medication, dose, route, frequency, and duration!



# COMMANDMENT VI. PROVIDE CONTINGENCY PLANS

Consultants should anticipate potential problems and document contingency plans...

*And provide a 24-h point of contact to help execute the plans if requested.*



# COMMANDMENT VII. HONOR THY TURF (OR THOU SHALT NOT COVET THY NEIGHBOR'S PATIENT)

In most cases, consultants should play a subsidiary role, however, some have argued that this commandment should actually be: Thou may negotiate joint title to thy neighbor's turf, if thy neighbor wishes to abide by it.

Consultants can co-manage any facet of patient care that the requesting provider desires; a frank discussion defining which specialty is responsible for what aspects of patient care is needed.

Corollary, if thy neighbor wanted your opinion, they would have asked for it: that is, unless your recommendations are about the clinical question you were asked, it may be harmful to rapport to communicate your thoughts about unasked questions.



# COMMANDMENT VIII. TEACH... WITH TACT

Requesting providers appreciate consultants who make an active effort to share their expertise. Judgments on leaving references should be tailored to the requesting provider's specialty, level of training, and urgency of the consult

For me this is the “Give a man a fish v. teach a man to fish”.  
Sometimes it's easier to be given the fish, sometimes not.



# COMMANDMENT IX. TALK IS CHEAP... AND EFFECTIVE

There is no substitute for direct personal contact with the primary provider.

Let me rephrase that:

There is no substitute for direct personal contact with the primary provider.

68% of MDs (n=323) felt that knowing whom to call is essential to an effective consultation.



# COMMANDMENT X. THOU SHALT FOLLOW-UP

Consultants should recognize the appropriate time to fade into a background role, but that time is almost never the same day the consultation note is signed.

Daily written follow-up is desirable; when the patient's problems are not active, the consultant should discuss signing-off with the requesting physician beforehand



# APOCRYPHA

Literature Citations: Only 7-29% of providers found literature citations helpful

Compliance: Over 50% of consultations (n=156) have recommendations that are not followed by the requesting provider (up to 2/3<sup>rd</sup> with preoperative consultations)

Writing Orders: 70% of surgeons (n=323) believed consultants could write orders after a verbal discussion (orthopedics the most likely to be okay with this).

Clinical question: only 41% of surgeons (n=152) wanted consultants to focus on a narrow clinical question.



# CONCRETE RECOMMENDATIONS

- Bullet your recommendations
  - Do not provide more than 5 recommendations
  - Separate assessments from recommendations
  - Recommendations that use the words “crucial” or “critical” are more likely to be followed.
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# QUALITY IMPROVEMENT

One of my colleagues at UCSF, Delphine Tuot under the guidance of Andy Auerbach, has developed a “Quality of Consultation Assessment Tool” (QCAT).

The QCAT is 13 item tool designed to rate the quality of a consult on 5 domains:

- Reason for consultation
- Diagnostic plan including rationales
- Therapeutic plan (listing medications with proper dose, route, schedule; discussing procedures and *periprocedural tasks*)
- Communication (documenting verbal discussions with providers; providing anticipatory guidance)
- Educational value (citing relevant articles; providing a well-developed differential diagnosis)

# CONCLUSION

Effective consultation is a skill; it requires constant attention to good principles, and just as it is important to debrief after family conversations, it is important to constantly assess our provision of care and work to improve it.



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