SESSION OUTLINE

INTRODUCTION

A medical consultation is a deliberation between physicians regarding the diagnosis or management of a particular patient making consultation medicine an important aspect of the practice of internal medicine. Because of busy schedules, the volume of consultations and the advances in communication technology, the interaction has evolved from a meeting of physicians at the bedside to independent patient interactions separated in time and space. Internists are often asked to assist surgeons in caring for patients in the perioperative period (co-management) providing risk stratification, optimizing medical conditions, and initiating interventions intended to reduce risk. Despite the considerable time spent in performing consultations formal training in the art and science of consultation medicine has been felt to be inadequate. Additionally, among the various functions traditionally performed by the consulting internist (preoperative evaluations, postoperative care, coordination of care) demands of modern day practice have called on the internist to acquire or refine new knowledge and skills. More options, however, can lead to more opportunities to mishandle consultations, which can worsen outcomes, lead to dissatisfaction for the patient and the referring physician, and place the consultant at medico legal risk. Internists must therefore understand their roles and responsibilities when consulted and be able to communicate effectively.

The overall goal of this session is to educate students and residents about the evolving role of the medical consultant and to improve patient care by improving the consultant’s ability to communicate with and understand the needs of referring physicians.
# Learning Outcomes

## Principles of Medical Consultation and Perioperative Care

Author: E Gurza  
Date: 4/1/13

### Learning Objectives from GIM Core Curriculum:

*At the conclusion of this session the participant will be able to:*

1. Know & apply the principles of an effective consultation process  
2. Understand the norms of behavior in professional relationships specific to the role of the consultant  
3. Know what constitutes a comprehensive preoperative assessment  
4. Understand what separates co-management from the standard consultation  
5. Demonstrate the incorporation of cost awareness principles into complex clinical scenarios

### Objectives Specific to this Session:

<table>
<thead>
<tr>
<th></th>
<th>TEACHING METHODS</th>
<th>ASSESSMENT METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Know the principles of effective consultation</td>
<td>Readings</td>
</tr>
<tr>
<td>2</td>
<td>Compare the different responsibilities and expectations of the medical consultant when performing co-management or the traditional consultation</td>
<td>Readings</td>
</tr>
</tbody>
</table>
| 3 | Describe & employ the strategies to improve consult process and improve compliance with consultant recommendations | Readings  | Written exam  
|   |                       | Case vignettes | Multisource feedback  
|   |                       | Experiential | Attending eval |
| 4 | Propose & employ methods that promote more effective communication through verbal discussion | Readings  | Written exam  
|   |                       | Case vignettes | Multisource feedback  
|   |                       | Experiential | Attending eval |
| 5 | Model the accepted ideal consultation behaviors | Experiential | Written exam  
| 6 | Identify the components of a complete perioperative evaluation | Role Model  | Multisource feedback  
|   |                       | Experiential | Attending eval |
| 7 | Demonstrate the ability to work effectively as team member | Readings  | Written exam  
| 8 | Describe the general measures of clinical stability for safe care transitions | Role Model  | Multisource feedback  
|   |                       | Experiential | Attending eval |
| 9 | Demonstrate the ability to help coordinate the care of patients being managed by multiple services | Role Model  | Written exam  
|   |                       | Experiential | Multisource feedback  
|   |                       | Experiential | Attending eval |
| 10 | Integrate the principles of cost-effective care & resource allocation that does not compromise quality of care & is based on valid & reliable research | Readings  | Chart review  
|   |                       | Case vignettes | Chart review  
|   |                       | Experiential | Chart review |
| 11 | Routinely incorporate valid & reliable protocols/guidelines as appropriate to ensure consistent quality of care & reduce variability | Role Model  | Chart review  
|   |                       | Experiential | Chart review |
| 12 | Understand the basic principles of reimbursement (coding) for the care of the consult patient | Readings  | Chart review |
This session describes the different roles that internists can perform as medical consultants and provides strategies for improving the effectiveness of the consult process. It will also introduce the participant to the knowledge and skills required to manage complex medical patients undergoing surgery.

1. Provide an overview of the goals and objectives of the rotation
2. Teaching to the curricular milestones that describe the principles of medical consultation and perioperative medicine
3. Review of the evidence for how to improve the consultative process
4. Review the norms of behavior that should govern the consultative process

### AGENDA & METHODS

<table>
<thead>
<tr>
<th>TEACHING METHODS</th>
<th>TIME</th>
<th>DESCRIPTION OF CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written pretest</td>
<td>15 min</td>
<td>Written pretest (elective content)</td>
</tr>
<tr>
<td>Self-study</td>
<td>60 min</td>
<td>Readings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General principles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Types of consultation</td>
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<tr>
<td></td>
<td></td>
<td>The process of consultation</td>
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<tr>
<td></td>
<td></td>
<td>Optimizing the process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The preoperative assessment: What is wrong with “clearing” a patient for surgery?</td>
</tr>
<tr>
<td>Introduction</td>
<td>15 min</td>
<td>Structure/Components/expectations of rotation</td>
</tr>
<tr>
<td>Small groups</td>
<td>55 min</td>
<td>Develop an understanding of what is expected of a medical consultant by interactive review of case vignettes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The importance of consult medicine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expectations &amp; responsibilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategies to improve the process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Methods for more effective communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional behavior of the consultant</td>
</tr>
<tr>
<td>Post test</td>
<td>5 min</td>
<td>Session content</td>
</tr>
</tbody>
</table>
Small conference room

1. Description of Elective
2. Faculty materials

The assessment procedures are aligned with the competency-based learning objectives. At the completion of this session participants will be assessed by and receive formative feedback on data acquired form the following:

1. Faculty as well as other members of the health care team will provide competency-based assessment which includes direct observation of patient management and chart review
2. Written exam of core content

Long-term outcomes from your session would you like to see measured?
1. Satisfaction
2.

Please provide at least 3 content questions which will be used for the end-of-rotation content exam

A 64 year old lady with longstanding diabetes mellitus and hypertension was admitted because of acute decompensation of her longstanding systolic heart failure. The etiology of her heart failure was felt to be hypertensive heart disease and that of the acute decompensation from dietary indiscretion and suboptimal compliance with taking her medications. She responded well to intermittent doses of IV furosemide with improvement in her dyspnea, the noted JVD and disappearance of the S3. Because of a slight rise in the serum creatinine, felt to be from overdiuresis, the heart failure service was consulted. Recommendations were left in the medical record to initiate a furosemide drip. The following day when the fellow conveyed to the attending that the drip had not as yet been started; the fellow was told to sign off.

You are asked to see a 73 year-old woman for a preoperative assessment before a cervical fusion. Her electrocardiogram shows an old inferior myocardial infarction. You feel the patient is stable but you want to
contact the patient’s PCP and determine if there has been a cardiac history and if any evaluation has been performed. When you come in the next day you find that the patient was taken for surgery.

For each of these cases briefly describe alternative behaviors that might improve the consult process.

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**COURSE EVALUATION**

Participants will evaluate the faculty and the clinical experience by means of:

1. the evaluation methods as established by SSOM and the Internal Medicine residency program
2. 

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**READINGS**

2. Overview of the principles of medical consultation and perioperative medicine. Cohn S, Macpherson D. UpToDate (accessed 5/21/13)

CASE VIGNETTES

1. You have been formally consulted to assess cardiac risk for a patient with coronary artery disease undergoing elective spine surgery. After interviewing and examining the patient, you are concerned about the presence of a recently placed coronary stent. You recommend delaying surgery for several months. The surgeon disagrees with you and plans to proceed with the operation. In this situation, what is the MOST appropriate action for you to take?

A. Consult a cardiologist for a second opinion about the safety of the operation
B. Write a consultation report that supports the surgeon’s plan to proceed with surgery
C. Withdraw from the case after discussing your opinion with the patient in the presence of the surgeon
D. Do not leave a consult report in the chart

2. You are co-managing a 59 year-old patient with diabetes on the general surgery service who underwent a hemicolectomy. Upon chart review, you note a newly elevated creatinine of 4.1 mg/dL. The patient is receiving enalapril and metformin. In a comanagement model, which if the following actions is MOST appropriate:

A. Recommend to the surgeon to consult nephrology
B. Order the discontinuation of the enalapril and metformin yourself
C. Recommend to the surgeon that further tests be ordered to evaluate the elevated creatinine
D. Request permission from the surgeon to investigate this unexpected finding

3. You are asked to perform a traditional consultation a neurosurgical patient with a postoperative fever. You intern wants to know the best way to get the surgeon to follow through with your recommendations. Which strategy is MOST likely to improve compliance by the consulting physician?

A. Page your recommendation to the surgeon
B. Include multiple recommendations for diagnostic testing
C. Withhold recommendations unrelated to the consultation question
D. Perform the consult within 72 hours

4. You just performed a traditional consult on a 72 year-old woman on the orthopedic service who complained of chest pain after her cervical spine fusion. Her electrocardiogram reveals possible new T-wave inversions in V1-V4. Although her symptoms are atypical, you think she should be ruled out for a myocardial infarction with serial enzymes. Which is the BEST next step?

A. Write your recommendations in the chart and see your next patient
B. Page the physician in charge of her care to discuss each recommendation and its urgency
C. Send a text page to the physician extender for the orthopedic service that you are consulting cardiology for them.
D. Write orders in the chart to check cardiac enzymes and to place the patient on telemetry.
5. You are called to evaluate and help manage delirium in a 75-year-old man who underwent thoracic surgery 4 days ago. Another hospitalist in your group had previously seen him for a preoperative evaluation. You feel that the patient is stable and does not need pharmacologic treatment for delirium. When writing your consultation report, which of the following is MOST important?

A. Describe in detail the patient’s medical history which led up to the operation.
B. List and discuss a complete differential diagnosis for the patient’s symptoms.
C. Leave contingency recommendations for medical management if the patient worsens.
D. Leave no more than 5 recommendations.

6. A 64-year-old woman with end-stage renal disease and uncontrolled hypertension is scheduled for the repair of a hip fracture. You are consulted for preoperative evaluation. The orthopedist also requested a nephrology consult. Which of the following communication strategies is MOST appropriate?

A. You should not confer with the other consultant on the case.
B. You do not need to review data concerning the patient’s renal disease.
C. You must keep abreast of the other consultant’s recommendations.
D. You should communicate the nephrologists’ recommendations to the surgeon.
FACULTY MATERIALS

The following is taken from the Society of Hospital Medicine’s Consultative & Perioperative Medicine Essential for Hospitalists at shmconsults.com

Comments on Question 1

The Importance of Consult Medicine and Traditional Methods for Consultation
Surgeons have traditionally consulted general internists and medical subspecialists to evaluate their patients’ health prior to surgery and to manage their acute and chronic medical problems. The role of “medical consultant” is increasingly being thrust upon hospitalists. It is estimated that 92% of hospitalists care for patients on medical consultation services. Their training and practice patterns make hospitalists particularly suited for performing inpatient medical consultation. Hospitalists are more readily available than primary care providers (PCPs) and medical subspecialists who divide their time between the clinic and the hospital. Their working knowledge across all fields of internal medicine often allows a hospitalist to replace multiple subspecialty consultants, providing the surgeon with a “one-stop” source for help with medically complicated patients. Hospitalists’ familiarity with inpatient care and hospital operations allows them to shepherd surgical patients through the perioperative period, which may result in better outcomes, greater cost-efficiency, and shorter lengths of stay. Moreover, what hospitalists can offer to RPs and the expectations of the RPs continue to grow. The RP may just want to “curbside” the hospitalist, may desire a traditional consult, or may expect the hospitalist to comanage the patient. More options, however, can lead to more opportunities to mishandle consultations, which can worsen outcomes, lead to dissatisfaction for the patient and the RP, and place the consultant at medico-legal risk. Hospitalists must therefore understand their roles and responsibilities when consulted and be able to communicate effectively. The most important question that must be answered with each request for a new consult is what kind of consultation the RP wants: curbside, traditional, or comanagement.

Traditional Medical Consultation
In traditional (also known as formal) consultation, the consultant evaluates a patient only at the request of the RP who maintains responsibility for all aspects of the patient’s care. The rules of the game were enshrined in 1960 when the Judicial Council of the American Medical Association (AMA) described the ethical principles for traditional medical consultation (Table 1). The RP defines a specific question to be addressed, and the consultant generally does not address other issues unless they are urgent. The consultant gives recommendations to the RP but does not write orders or call consults. The RP is still in charge of the patient’s care and treatment plan. Communication between the consultant and the patient is generally limited to data gathering. In this traditional modconsults should avoid discussing their opinions directly with the patient. If the consultant does not agree with the RP’s plan of care, the consultant has an obligation to discuss that disagreement with the RP. If a discussion with the RP does not resolve the disagreement, the consultant may speak with the patient in the presence of the RP and/or disengage from the case.
Table 1. Principles for Traditional Medical Consultation

- One physician should be in charge of the patient’s care.
- The attending physician has overall responsibility for the patient’s treatment.
- The consultant should not assume primary care of the patient without consent of the RP.
- The consultation should be done punctually.
- Discussions during the consultation should be with the RP and only with the patient by prior consent of the RP.
- 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 RP.

RP = referring physician.

The AMA also defined responsibilities for the RP (Table 2). These principles seem mostly to have been put in place to urge RPs to consult only when it is necessary and not to consult just to help their colleagues financially. The AMA does not endorse reflexive consults. Consults need to be formally requested by the RP and are for the good of the patient.

Table 2. Responsibilities of RPs Requesting Traditional Consultation

- Consultations are indicated “on request” in doubtful or difficult cases, or when they enhance the quality of medical care.
- Consultations are primarily for the patient’s benefit.

RP = referring physician

These principles clearly emphasize the primacy of the RP. In the article Ten Commandments for Effective Consultations, Goldman et al admonishes the consultant to “honor thy turf (or thou shalt not covet thy neighbor’s patient).” This reinforces the principle that when performing a traditional consult, the consultant should play a supporting role.

In summary, medical consultation is an important part of most hospitalists’ practice. When performing traditional consultation, the hospitalist adopts a narrowly focused, subsidiary role. The consultation only occurs at the invitation of the primary physician and addresses a limited set of issues. The consultant leaves recommendations, not orders, and communicates them to the primary physician rather than the patient.
Comparing the Medical Consultant's Different Responsibilities and Expectations When Performing Comanagement or Curbside Consultation Comanagement

Although the traditional consultation role is still practiced, especially in academic medical centers, other arrangements are spreading. A survey by Salerno et al. showed that many surgeons find the traditional consultation model to be too limiting (Table 3). Only 41% of the surgeons responding to the survey agreed that consultants should be limited to the specific question, and only 37% felt that consultants should not write orders unless they are previously discussed with the primary team. Most of the surgeons wanted a "comanagement" relationship with the consultant. Typically in comanagement arrangements, the hospitalist is directly responsible for managing the patient's medical problems. For example, on a comanagement service for orthopedic surgery patients at Rochester Methodist Hospital, a tertiary care center, the hospitalist manages postoperative medical care, decides when to consult medical subspecialists, contacts the PCP, and assists with medical aspects of discharge planning. Although the scope of practice for comanaging hospitalists varies in different settings, the hospitalist usually has wide latitude in choosing which problems to address, what tests to order, and which treatments to implement. It is expected that the hospitalist will directly discuss the medical aspect of the care plan with the patient. In some models, the hospitalist automates a consultatively defined subset of medically high-risk patients without a prior request by the RP.

Table 3. Differences Between Surgeons and Nonsurgeons in Consult Preferences

<table>
<thead>
<tr>
<th>Question</th>
<th>Surgeons (n = 110)</th>
<th>Nonsurgeons (n = 170)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants should be limited to a specific question</td>
<td>41</td>
<td>69</td>
<td>&lt;.00</td>
</tr>
<tr>
<td>Consultants should not write orders unless discussed with the primary team</td>
<td>37</td>
<td>59</td>
<td>&lt;.00</td>
</tr>
<tr>
<td>A comanagement relationship is desired</td>
<td>59</td>
<td>24</td>
<td>&lt;.00</td>
</tr>
<tr>
<td>Literature references are useful as part of the consult</td>
<td>18</td>
<td>41</td>
<td>&lt;.00</td>
</tr>
<tr>
<td>Consult recommendations should have a description of importance and urgency</td>
<td>18</td>
<td>69</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Making 55 recommendations limits compliance with the consult</td>
<td>23</td>
<td>23</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Recommendations are preferred at the beginning of the consult</td>
<td>41</td>
<td>54</td>
<td>&gt;.02</td>
</tr>
<tr>
<td>Initial recommendations should be discussed verbally with the referring service</td>
<td>69</td>
<td>79</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>Regardless of the patient's acuity of illness, progress notes from consultants are desired</td>
<td>78</td>
<td>67</td>
<td>&gt;.05</td>
</tr>
<tr>
<td>I find informal &quot;curbside&quot; consultations helpful in caring for patients</td>
<td>70</td>
<td>67</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

*Scores of 4 or 5 on a 5-point Likert scale.

Comanagement models have both advantages and disadvantages compared to traditional consultation. On the positive side, a comanagement service for orthopedic surgery patients at the Rochester Methodist Hospital showed that the comanaged patients had fewer minor complications. There was no effect, however, on the incidence of moderate or severe complications, overall costs, or length of stay. Moreover, surgeons and nurses greatly preferred the comanagement service over standard consultation. Hospitalists, on the other hand, have given mixed reviews on the effect of comanagement on job satisfaction. While some prefer the greater autonomy in patient care afforded by comanagement, others worry about diminished prestige from being perceived as an assistant or employee of the surgeon, potentially unsustainable workloads or work hours, uncertain medicolegal risk, and pressure to care for problems beyond their training and experience.

Unlike traditional consultation, where responsibility ultimately falls on the RP, comanagement relationships require shared responsibility. A potential problem with this model is fragmentation of care between multiple providers, leading to interventions that are omitted, duplicated, or in conflict. Another risk with comanagement is that the surgeon may become disengaged from responsibilities on the wards, leaving the hospitalist to deliver care beyond their appropriate scope of practice. Thus, negotiations between services result in a formal, mutually beneficial agreement about each provider's roles and responsibilities. The comanagement agreement also should create clear avenues for communication between the RP and hospitalists.

The AMA has issued guidelines for comanagement stating that "responsibilities should be delineated according to the scope of the physicians' expertise" and that "a single physician should be ultimately responsible for ensuring that the care is delivered in a coordinated manner." The AMA guideline also states that patients need to provide informed consent to be cared for under a comanagement arrangement.

The financial aspects of comanagement also bear additional discussion. In 2010, Centers for Medicare and Medicaid Services (CMS) eliminated the billing codes for consultation, and many private payers have followed suit. Hospitalists practicing comanagement services should now use the same "Initiative Care" and "Subsequent Care" codes for inpatient care. Because the surgeon is usually paid a global fee for performing the operation and delivering associated perioperative care, comanaging hospitalists should bill for the specific diagnoses that require their expertise (e.g., diabetes or coronary artery disease) rather than the surgical issue (e.g., hip fracture).

Curbside Consultation

Physicians are often also asked to provide "curbside" or informal consultation. In this situation, the consultant is asked to render an opinion or provide advice without personally evaluating the patient (or, in many cases, the medical record). Although some consultants deplore this practice, it is probably too widespread and beloved to eliminate. One study found that 70% of generalists and 88% of specialists provided at least 1 curbside consultation in the preceding week. Another study found that 83% of nonsurgeons and 53% of surgeons believed that curbside consults are helpful. For busy consultants, provision of informal advice is necessary in some situations if they are to have adequate time to care for patients who require formal consultation or comanagement.

Informal consults can place hospitalists in precarious situations. The consultant is making recommendations based on another physician's impressions and observations. In order to limit medicolegal liability and provide the best care possible, hospitalists who perform curbside consults should follow the guidelines outlined in Table 4. Most importantly, never offer to perform a formal consult if the patient has complex issues and never bill for a curbside consult. This advice is all the more important in providing the complete workup for nephrology range problems. Not diagnosing HIV is not reasonable. Finally, keep your own name out of the chart. If your name is mentioned as a consultant, you may have legal responsibility for that patient. Fortunately, courts in the United States have generally ruled that the informal consultant does not have a legal relationship and is therefore at low risk for malpractice liability. The risk may increase in situations where the consultant examines the patient, reviews the medical record, or communicates with the patient directly.
Table 4. Curbside Consultation Guidelines

- Keep the consultation brief and simple.
- Offer to perform a formal consultation if the question is complex or if consulted repeatedly about a patient.
- Try to provide general advice, rather than specific recommendations.
- An informal consultant’s name should not be listed in the chart without the consultant’s permission.
- The consultant should never bill for a curbside consult.

Data from Manan and Jansen.

In summary, traditional consultation is often supplemented or supplanted by a range of other care models. Under co-management, hospitalists often prospectively identify patients who might benefit from their expertise and address all relevant medical problems. The hospitalist writes orders and addresses questions and concerns from patients, nurses, and ancillary staff. At the other extreme, when asked to provide “curbside” advice, the hospitalist must carefully assess whether it is safe to render an opinion without personally evaluating the patient.
Comments on Question 3

Correct!

Strategies to Potentially Increase RP Compliance with Consultant Recommendations

Effective Consultation

In the 1980s, there was considerable interest in identifying factors that led to more effective consultation. These studies generally did not look at clinical outcomes; rather, effectiveness of consultation was inferred by the extent of the RP's compliance with the consultant's recommendations. Failure of the RP to follow a recommendation has long been a major frustration for consultants. In academic medical centers, approximately 50% to 75% of all recommendations were followed. Compliance rates tended to be higher in community hospitals, although the practice of the consultant writing orders directly (foreshadowing comanagement relationships) may have contributed to this finding. Although there were no randomized trials, observational studies found that certain factors seemed to influence the likelihood that the RP would follow a recommendation (Table 5).

### Table 5. Factors Improving Compliance with Consultant's Recommendations

<table>
<thead>
<tr>
<th>Consultant Behavior</th>
<th>Recommendation Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation performed within 24 hours of request</td>
<td>Recommendation verbally communicated to referring physician</td>
</tr>
<tr>
<td>Consultant followed up (≥2 follow-up visits)</td>
<td>Recommendation relates to central consult question</td>
</tr>
<tr>
<td></td>
<td>Limited number of recommendations (5 or fewer)</td>
</tr>
<tr>
<td></td>
<td>Definitive recommendation (avoiding phrases such as “consider” or “might do”)</td>
</tr>
<tr>
<td></td>
<td>Specific details in recommendation</td>
</tr>
<tr>
<td></td>
<td>Labeling recommendation as “crucial”</td>
</tr>
<tr>
<td></td>
<td>Recommendation for therapeutic intervention (vs diagnostic)</td>
</tr>
</tbody>
</table>

These factors can be grouped into those pertaining to the consultant’s professional behavior and those related to the recommendations themselves and how they are communicated. Generally, compliance improved when the consultant communicated effectively and exhibited professional behavior and dedication to good patient care. These factors are described in more detail in the following sections. Some factors are not modifiable by the consultant, such as the observation that recommendations for diagnostic interventions are less likely to be followed than recommendations for therapy. If an extensive diagnostic workup is indicated, consultants need to be more vigilant. RPs unfamiliar with the diagnostic tests or the workup may not follow through with the recommendations. In these instances, it is particularly important to document the needed tests in a detailed manner and communicate them verbally. Refrain from using words such as “consider” when recommending a diagnostic test. The RP is relying on you for guidance. Compliance in this setting is likely to increase if the consultant follows up on the patient daily.
Correct

Methods for More Effective Communication with RPs Through Verbal Discussion

Verbal Communication

Effective verbal communication is the cornerstone of effective consultation. It helps to ensure both excellent patient care and future consultation from the RP. Three of the "10 Commandments" of effective consultation, which were developed by Goldman et al in 1983 and modified by Salerno et al in 2006, deal with verbal communication between the consultant and RP (Table 6). Effective communication begins when the consultant first learns of the consult and is addressed by Goldman's first commandment, "Determine the question." Trying to understand why the consult was requested and what particular question needs to be answered can help to elucidate expectations and uncover underlying assumptions. Goldman et al noted that in 34% of consultations in their hospital, the RP and the consultant did not agree on the reason for consultation. Failure to communicate will often result in dissatisfaction, duplicative efforts, and prolongation of care. Requests for "medical management" often leave the consultant annoyed but may accurately communicate what the RP really wants. Comanagement may be a good option in those situations.

<table>
<thead>
<tr>
<th>Commandment</th>
<th>Meaning</th>
<th>Commandment</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Determine the question</td>
<td>The consultant should call the primary physician if the specific question is not obvious.</td>
<td>1. Determine your customer</td>
<td>Ask the requesting physician how you can best help them if a specific question is not obvious; they may want comanagement.</td>
</tr>
<tr>
<td>2. Establish urgency</td>
<td>The consultant must determine whether the consultation is urgent, emergent, or elective.</td>
<td>2. Establish urgency</td>
<td>The consultant must determine whether the consultation is urgent, emergent, or elective.</td>
</tr>
<tr>
<td>3. Look for yourself</td>
<td>Consultants are more effective when they are willing to gather data on their own.</td>
<td>3. Look for yourself</td>
<td>Consultants are more effective when they are willing to gather data on their own.</td>
</tr>
<tr>
<td>4. Be brief as appropriate</td>
<td>Leaving a long list of suggestions may decrease the likelihood that any of them will be followed, including the critical ones.</td>
<td>4. Be brief as appropriate</td>
<td>Leave as many specific recommendations as needed to answer the consult but be the RP if the consult needs help with order organization.</td>
</tr>
<tr>
<td>5. Be specific</td>
<td>Consultants should anticipate potential problems; a brief description of therapeutic options may save time later.</td>
<td>5. Be specific, thorough, and direct from the very minute to help when requested</td>
<td>Consultants should anticipate potential problems, document contingency plans, and provide a 14-line plan of care to help organize the plan if requested.</td>
</tr>
<tr>
<td>6. Provide contingency plans</td>
<td>In most cases, consultants should play a subsidiary role.</td>
<td>6. Provide contingency plans and discuss their execution</td>
<td>Consultants can and should communicate any form of patient care that the RP desires; a frank discussion defining who is responsible for what aspects of patient care is needed.</td>
</tr>
<tr>
<td>7. Don't run riot on your neighbor's turf</td>
<td>There is no substitute for direct personal contact with the primary physician.</td>
<td>7. Don't run riot on your neighbor's turf</td>
<td>Judgments on leaving referrals should be tailored to the RP's specialty level of training and urgency of the consult.</td>
</tr>
<tr>
<td>8. Teach with tact</td>
<td>Consultants should recognize the appropriate time to fade into a background role, but that time is not the same day the consultation note is signed.</td>
<td>8. Teach with tact and pragmatism</td>
<td>There is no substitute for direct personal contact with the primary physician.</td>
</tr>
<tr>
<td>9. Talk is cheap and effective</td>
<td>There is a limit to the amount of time that can be spent on the consulting service. Consultations are a 24-hour process and the consultant should be made aware of their time constraints.</td>
<td>9. Talk is essential</td>
<td>Daily written follow-up is desirable when the patient's problems are not across the professional responsibility, the consultant should discuss signing-off with the RP beforehand.</td>
</tr>
<tr>
<td>10. Provide appropriate follow-up</td>
<td>Follow-up daily</td>
<td>10. Provide appropriate follow-up</td>
<td>There is no substitute for direct personal contact with the primary physician.</td>
</tr>
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</table>

Table 6. Original and Modified 10 Commandments for Effective Consultations

Verbal communication is also essential to Goldman's second commandment, "Establish urgency," for when the consult needs to be completed. RPs often complain about delays in receiving the consultant's recommendations. Establishing the urgency of the consultation request helps the busy consultant assign appropriate priority to various tasks. This can prevent delays in patient care and potentially expedite discharge. Direct discussion between the primary physician and consultant on urgency can also clarify expectations and improve physician satisfaction. In general, consultations performed promptly (on the day the request is made) are associated with greater RP compliance with consultant's recommendations.

Effective communication does not end with understanding the reason for and urgency of the consultation. Goldman's ninth commandment, "Talk is cheap and effective," focuses on communication after the recommendations are determined. Salerno's 2006 survey showed that both surgeons and nonsurgeons agree that "talk is essential" (Table 3). Sixty-nine percent of surgeons and 79% of nonsurgeons endorsed the statement that, "Initial recommendations should be discussed verbally with the referring service." Particularly with the initial evaluation and especially if there are diagnostic testing or urgent therapeutic needs, hoping that the referring team will see the consultant's note in the chart is not enough. Direct discussion also allows for effective communication of the urgency and importance of each recommendation—a service desired by 78% of surgeons and 69% of nonsurgeons, according to Salerno et al.

Comanagement services do not exempt the physicians from communicating with one another. Even though a comanagement arrangement may allow the hospitalist to write orders or call consultants without prior permission, it is still important for the hospitalist to discuss significant changes in the patient's clinical status with the primary physician. A good comanagement model will have clear and effective communication avenues built into the model.

The medical consultant not only has a duty to communicate with the RP but should also communicate with the patient's family and other providers when necessary. It should not be the practice of the hospitalist to have the consultant provide service to update the PCP on important internal medicine issues. Communicating with the PCP also allows for scheduling appropriate outpatient follow-up and delineation of outstanding issues that need further outpatient evaluation. In a comanagement setting, the generalist must arrange for appropriate medical follow-up and inform the PCP of the important events.

In summary, verbal communication is essential in all phases of the consultation process. Upon receiving the referral,
Comments on Question 5

Methods for More Effective Communication with RPs Through Written Consultation Reports

The Consultation Report

An effective consultant must also be able to compose a well-written consultation report. Effective written communication is the focus of 3 of the 10 commandments proposed by Goldman et al17 and Salerno et al18 (Table 6). Appropriate brevity (commandment 4) is both the written history and physical is welcome. The consultant should document enough data to justify the conclusions, recommendations, and the level of billing, but it is not necessary to reiterate information recorded elsewhere. Similarly, the consultant should avoid writing verbose treatises or pontificate ad nauseam on the differential diagnosis. The effort to be brief, however, must not limit the level of detail in the recommendations. Hospitalists should remember that the RPs might not be familiar with the medications and diagnostic tests being recommended. Thus, a recommendation to "start an ACE inhibitor" is better stated as "start lisinopril 10 mg PO daily, hold for SBP <100." Detailed recommendations are more likely to be followed by RPs than vague ones. Providing appropriate contingency plans for potential problems (commandment 6) can also be helpful. This is particularly important when the consultant signs off the case because it helps the RP to continue caring for the patient independently. For example, the above recommendation for blood pressure management with lisinopril might also include "increase the dose of lisinopril to 20 mg PO daily tomorrow if SBP remains above 140."

Specificity (commandment 5) in recommendations is similarly valued. Consultants should focus their recommendations on the consultation question. On the other hand, most surgeons welcome input on other urgent issues identified by the consultant. Studies from the 1980s found that limiting the number of recommendations (usually to no more than 5) improves compliance.11 However, Salerno’s 2006 survey found that only 22% of surgeons agreed with the statement that “making over 5 recommendations limits compliance with the consult.” Thus, although trivial recommendations should be avoided, consultants should not feel compelled to adhere to any rigid limits on the number of recommendations. If there are multiple recommendations, the most important recommendations should be listed first. Try to indicate the urgency of the recommendations and think about not including any recommendations that are not urgent.

In Salerno’s version of the commandments, the consultant is also advised to offer to write orders for the recommended interventions. It is thought that writing orders for the RP improves patient care efficiency, reduces the chance that miscommunication will lead to a medical error, and eliminates RP noncompliance. Comanagement arrangements make that strategy easier to put into practice, but it is still important for the hospitalist to document the assessment and plan in the medical record and communicate with the RP. There are still institutions, however, where consultants are forbidden to write orders.

Some physicians advocate placing the recommendations at the beginning of the consultation report. It is not clear that this strategy makes a difference. Overall, it is probably best to have consistency in how you write your note so that your RPs know where to look. Moreover, any important recommendations should be communicated verbally. Your note should serve as a reference.

In summary, the written consultation report should be both appropriately brief when reiterating information found elsewhere in the medical record but also sufficiently detailed when giving recommendations, so that the RP will not have difficulty implementing them. There is no need to arbitrarily limit the number of recommendations if they are important. In institutions where it is allowed, the hospitalist may elect to offer to write orders for complicated plans.
Correct!

**Professional Behavior for Medical Consultants**

The final 4 commandments of effective consultation deal with the professional conduct of the consultant. As described above, the medical consultant's role can vary from that of a subsidiary player in traditional consultation (as assumed by Goldman et al) to one of a potential collaborator under a comanagement model of care. This wide range of options led Salerno et al to modify Goldman's commandment of "honor thy turf" to "thou may negotiate a joint title to thy neighbor's turf."^4

Some patients will receive care from multiple consultants. Unless engaged in a comanagement role, the hospitalist is not expected to coordinate all of the consultants' recommendations. However, it is still crucial to review the recommendations of the other consultants. Because hospitalists have some experience in all medical specialties and are trained to be comprehensive in their care, it is easy for them to inadvertently tread on another consultant's domain. Thus, the concept of "turf negotiation" also applies to the hospitalist's relationship with other consultants. Consultants should come to an agreement about which problems each consultant will address. The medical consultant should not reiterate the recommendations of other consultants nor should a chart war start if you disagree with another consultant's plan. It may also be just as important to state in your note (and on the phone) which problems are being managed by another consultant and which you are following.

The role of the consultant as teacher has also evolved. Goldman's original commandment to "teach with tact" may not be relevant for the majority of consultations. Salerno's survey found that less than 1 in 5 surgeons find literature references to be a useful part of the consultation. The hospitalist should remember that overly enthusiastic teaching, done with the best intentions, may be misinterpreted as a sign of arrogance or condescension. A potential advantage of a robust comanagement relationship is the opportunity to foster mutual education through conferences and informal teaching.

The remaining commandments are largely unchanged over the past quarter century. Consultants must still look for themselves (commandment 3) by personally gathering primary data. This includes gathering outside hospital records as necessary, talking with the patient's PCP and other outside subspecialists, reviewing the recommendations and assessment of other consultants already involved, systematically reviewing the chart for all relevant data, and of course, performing a history and physical examination. It does the patient and the RP a disservice to trust another provider's description of the physical examination or interpretation of the electrocardiogram.

Consultants should also follow-up on their patients' condition (commandment 10). All but the most basic consultation requests require the consultant to follow-up. This process has been shown to improve compliance with recommendations. Regular follow-up visits also allow the consultant to prioritize recommendations, by listing only the urgent ones in the initial consult report and adding less crucial recommendations in subsequent notes. Seventy-eight percent of surgeons wanted the consultants to write daily notes, regardless of the patient's acuity.^4 Although the busy hospitalist may be tempted to stop following an apparently stable patient, the experienced consultant recognizes that the RP may lack the ability to take over the management of the patient's medical problems. When the time does come to sign off, the RP should be notified through both verbal and written communication with an invitation to re-consult whenever needed.

In summary, the professional behavior of the consultant can be just as important as the medical advice that is provided. Hospitalists should ensure that the RP understands and agrees with the role they will play (traditional consultation vs comanagement) and negotiate with other consultants about which problems each party will address. Consultants should teach when requested but avoid rendering unsolicited didactics. Regular follow-up visits by the consultant are the rule rather than the exception and are expected by most surgeons.