Courtesy and Conflict in General Medical Consultation

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General

The Golden Rule and common sense should be the guiding precepts with all consultations. We will investigate certain issues related to all consultations, with special emphasis on general medical consults. Above all, the consultant should maintain a professional, collegial attitude and always avoid antagonizing the primary service.

The first step in any consultation is to determine the question being asked. This may seem like a simple thing, but there is a wealth of literature to support that this initial step frequently goes awry .[1-3] In seeking to identify this question, the simplest and most effective option is for the consultant to speak directly with the primary service.[1,4] Review of the patient's medical record to determine the reason for the consultation should be secondary. The outcome of a consultation, in terms of satisfaction for both the primary service and the consultant, not to mention the direct impact on the patient, is crucial to the correct question being asked, understood and answered.[3]

Specific Problems

General medical consultants often feel they are only being called to transfer a patient off of the primary service. The consulting service should make clear that their primary job is to answer a question or provide assistance with a specific problem. While the consultant is addressing the primary team's concerns, it may be in the patient's best interest to transfer services. When this is the case, a transfer should ensue.

The appropriateness of a consultation is always an issue for the consultant, who may feel that the primary service should be able to manage a given problem without outside input. Regardless of this, if the primary team asks for help, they likely do not feel confident in their abilities to manage the problem.[5] The consultant then functions to support the primary team and has an important educational impact. If this kind of request persists as a chronic problem, the consultant should discuss this with the referring physician directly.

Problems may arise when the consultant does not agree with the management plan that has already been instituted by the primary team. Obviously when initiating a consult, the primary team can reasonably expect that alterations in their plan may be needed. However, no one appreciates being made to feel ignorant. When the consultant disagrees, it should done politely with as little conflict as possible. Significant disagreements should be discussed with the primary team prior to being documented in the medical record. This discussion may reveal additional information of which the primary service was aware but which was not well documented in the record.

The patient may initiate a discussion about the appropriateness of his care. While the consultant should never lie, direct criticism of the primary team's management should always be avoided. Discussion about the pros and cons of various strategies should occur between the patient and the primary team after the consultant has had time to brief the primary team on his concerns and any recommended alterations.

Consultants may be disappointed when the primary team fails to follow all of their recommendations. It is unrealistic to expect that every recommendation will be completely carried out. In fact, it has been well demonstrated that even when the primary team agrees with the recommendations and feels the situation is acute, not all recommendations are followed.[3] In this situation, the consultant should make an attempt to discover why the recommendations were not implemented. This is best done with personal contact between the consultant and the referring physician.

Consultation Format

While there is likely no ideal format to a written consultation, there are several key elements. It must contain the information being sought by the requesting service, it must be easy to read, and it must be concise.[6] In this section, we give suggestions on how to achieve these goals and maximize everyone's satisfaction in the process.

The note should contain a brief review of the history and the reason for the consult. If there are any doubts about the question the consultant is asked to address, these should be answered with direct communication with the requesting service before the note is written. The consultant should avoid a detailed recapitulation of information that is readily available in the chart.[1] When information in the chart is scant, the history may need to be more detailed. The question being posed should be answered directly and succinctly. Reasoning should be provided for all management decisions. Both of these interventions have been shown to increase compliance.[3]. Recommendations should be limited

to the question originally asked, but can reasonably be expanded to any issues which are in the consultant's general domain. The note should include any anticipated side effects or complications of recommended therapy as well as contingencies for possible deterioration in the patient's clinical status.

When making recommendations, the consultant should avoid direct conflict in the chart. If the consultant feels changes to the plan are essential, this can be tentatively voiced in the chart but should be communicated directly to the primary team at the earliest convenience. For preoperative patients, the consultant should avoid documenting his opinion that surgery be delayed or cancelled without first discussing it with the primary team.[1] Opinions regarding the relative risk of proceeding with a given intervention should be documented in a manner that leaves the ultimate decision up to the primary team.

Often multiple equivalent therapies are available for a given problem. If a service has initiated treatment for the problem the consultant is to address, and it is equivalent to but not the first choice of the consultant, the argument should be avoided. In the same vein, if multiple equivalent diagnostic options are available, the consultant should not raise objections about which is necessarily the first or most important. The consultant should limit the number of his recommendations to no more than five. Evidence is clear that the longer the list of recommendations, the less likely they are to be implemented. Surprisingly, there is no correlation between compliance and the severity of the patient's illness.[2] The consult will serve as an educational tool for the requesting service. This may be maximized by providing literature references, either as citations or by placing articles directly in the chart. References should be limited to no more than two articles and should come from journals to which the primary service would not typically have reason to access. Avoid articles from general journals or those in the primary service's specialty.[1]

Physician-to-physician Communication

The importance of communication cannot be overly stressed. Lack of communication is cited as the most common reason for dissatisfaction on the part of referring physicians.[7] This is not formally addressed during residency training, perhaps because there is no well-defined curriculum.[8] General opinion seems to hold that with increasing demands on physicians' time, communication can suffer. It has been well-documented that poor communication in consultation leads to adverse outcomes.[3,9] These include complete failure of the consult, increased healthcare costs, increased patient risk from potentially unnecessary interventions, missed diagnoses and delayed treatment. It is of paramount importance that at some time during the consultation process, the consultant speaks directly with the primary team.[1,4] Face-to-face contact is always preferred but given the realities of healthcare today, telephone contact is an adequate substitute. Consultants should refrain from communicating solely in writing.

Physician-to-patient/family Communication

This begins with an introduction (including name and specialty), followed by an explanation of the specific question that was asked of the consultant. In discussions with the patient and/or the family, one should avoid directly contradicting the primary team. If the consultant comes to a different conclusion about the patient's diagnosis or the appropriateness of therapy, avoid discussing it with the patient before discussing it with the primary team. Any conflict in management should be reviewed with the primary team and they should be allowed to discuss the pros and cons of the two differing opinions. If the patient or family directly questions the consultant about the plan, all questions should be deferred to the primary team, indicating that full discussions should ensue. Lastly, the consultant should fully document the extent of any discussions about diagnosis and therapy with the patient in the medical record. This is a point that is frequently omitted.[10]

Follow-up

Regardless of the extent or complexity of the recommendations, every consultant should return at least once to ensure that his recommendations were understood and implemented. It is important to check for proper dosing and scheduling of medications. Consultants should be especially careful to see if recommendations for interventions that require direct nursing or physician action (daily weights, blood gases, etc.) have been implemented as this has been demonstrated to be an area of decreased compliance.[2]. If the patient's clinical status worsens, the consultant may only be aware of this on follow-up visits. This may prompt further recommendations not originally envisioned. Of course, not all recommendations will be followed completely and follow-up visits give the consultant the opportunity to reiterate those that are vital. Again, this should be done without undue criticism to the primary team. The consultant must always keep in mind that the primary team may not feel that the input is as vital as does the consultant.[3]

The general medical consultant has the unique responsibility of acting as a liaison between the primary team and the patient's primary care provider. Documenting the name of the primary care provider in the patient's chart, if not already present, is important, and the consultant should serve as a conduit of information. The consultant may thus be able to uncover important information known only to the patient's outpatient provider. In addition, the consultant may secure appropriate follow-up for the patient upon discharge. The provider responsible for the ongoing care of problems is often omitted from written consultations.[6]

Signing Off

At least one follow-up visit is appropriate, even for the simplest consults,. At some time, however, the consultant's further input will be of minimal benefit. When the problems for which the consultant was originally called are stable and the patient is tolerating recommended therapies, it is appropriate for the consultant to "sign off." Whenever this occurs, the consultant should leave a note thanking the primary service for the opportunity and indicate willingness to return in the future if the need arises.

Unfortunately, there are also times when consultants reach a level of frustration because their advice is not followed. If the consultant's recommendations are not being followed, reasons due to poor communication should be ruled out. If the consultant has discussed the recommendations directly with the primary team, has documentation detailing this in the medical record and stressed the importance to patient care, and ultimately those recommendations are still not implemented, it may be appropriate to sign off.

Research Questions

While the early 1980s saw a flurry of literature related to general medical consultation, there has not been much published since that time. Previous studies have examined the frequency with which other services consult general medicine and for what diagnoses. Given the relative increase in the acuity of hospitalized patients over the past two decades, advances in diagnosis and management and the advent of inpatient rehabilitation, these frequencies have likely changed and need to be reexamined. In addition, while much has been written about the appropriate format and content for general medical consultation there is little methodology behind it. Further study is needed to determine the best format for presenting consultation recommendations, to ensure compliance and further education.

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