

Ten Commandments for Effective Consultations

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● 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.

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Although medical house staff and practicing internists spend much of their time performing consultations, few training programs offer formal instruction in the subtleties of this art.¹ Most physicians learn how to perform a consultation through trial and error, resulting in considerable variability in consultative skills. Thus, some consultants are much sought after by their colleagues, while others have trouble translating their expertise into effective consultations.²

These difficulties reflect the complexity of the consultation process and the many ways in which it can go awry. The primary physician may call a consultation for inappropriate reasons or may fail to frame and communicate a specific question to the consultant. Even if an appropriate question has been clearly expressed, the consultant may ignore it or leave suggestions that are overlooked or deemed irrelevant. Attention to a few basic principles can prevent the frustration generated by an ineffective consultation. Without pretending to be all inclusive, the following ten "command-

ments" of effective consultation may serve as a guide to the performance of this most important skill.

I: DETERMINE THE QUESTION

All too often a consultant's note will meticulously recapitulate the case and offer detailed recommendations but fail to address the question for which the consultation was called. In one series of medical and subspecialty consultations at the Brigham and Women's Hospital, Boston,³ the requesting physician and the consultant had totally different impressions of the reasons for which the consultation was requested in 15% of cases. Another academic consultative service⁴ reported that among preoperative diabetic consultations, no specific question was asked in 24% of cases, and consultants ignored the question in another 12% of cases. Not surprisingly, the impact of these consultations was far less than those in which both parties agreed on the issue at hand.

Often, the primary physician has not clearly communicated the question; in some instances, the physician has not even considered the case carefully enough to delineate a specific issue. To prevent such lapses, some programs encourage interns to write the question in the progress notes on the day of consultation. Occasionally, though, the consultant simply overlooks these requests. Should the issue not be immediately obvious, a phone call to determine the primary physician's expectations is well worth the time and effort. Then the question can be rapidly and directly answered. Thus, a typical consultation note should begin by stating a specific problem, such as "Called to see this 56-year-old woman with breast cancer for opinion on cause of leg weakness. . . ."

II: ESTABLISH URGENCY

Requests for assistance reach consultants via a variety of routes, including the hospital mail, ward clerks, and phone calls from students, house officers, and attending physicians. Regardless of how the request is communicated, the consultant must determine whether the consultation is emergent, urgent, or elective. Emergent or urgent consultations should usually be discussed directly between physicians, even if such discussion is inconvenient, eg, when an entire surgical team is in the operating room. This precaution can prevent subsequent problems in communication or delays in appropriate care.

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Once it is clear that a consultation is emergent, the consulting resident or fellow may make immediate recommendations after telephone discussions with his or her staff attending or may ask that the attending physician see the patient at once with the junior members of the team. Alternatively, if a consultation is purely elective and more pressing matters are at hand, a telephone conversation can also serve to explain the delay to the primary physicians.

III: LOOK FOR YOURSELF

A consultant should not expect to make brilliant diagnostic conclusions based on an assessment of data that are already in the medical chart. Usually, if the answer could be deduced from this information, the consultation would not have been called. In our series,³ only 9% of consultations were requested to obtain assistance in interpreting already available data. While we do not believe that consultants should take over primary responsibility for a patient's care, we find that they are most effective when they are willing to gather data on their own. Pertinent historical and physical examination data should be obtained independently. Also, because of their expertise and special orientation, consultants often may extract overlooked information by reviewing old charts and roentgenograms, by calling physicians at other hospitals, or by repeating routine procedures such as Gram's stains and urinalyses. Similarly, before ascribing ECG changes to lead placement, the consultant should repeat the ECG rather than leave a note recommending that a surgical colleague perform one. The extra effort involved results in better care provided a day sooner.

IV: BE AS BRIEF AS APPROPRIATE

Although the hospital chart serves as an important medical and legal document, consultants' notes need not repeat in full detail the data that were already recorded by the primary physicians. The medical record should not serve as a cue card for case presentations; necessary notes can be made on file cards or note paper. Thus, an appropriate "present illness" might be limited to: "History as described. Would only add that a phone call to record room of prior hospital disclosed normal chest roentgenogram one year ago."

V: BE SPECIFIC

Detailed discussions and reference citations are vital parts of academic training, and they may be much appreciated by primary physicians, especially medical house staff. In other settings, however, such as when consulting for surgeons, the consultations should be brief and goal-oriented. Otherwise, key points can be lost in a mass of less important musings.

In either situation, however, the impressions and differential diagnosis should be expressed concisely in order of likelihood, often in the form of a list. Similarly, the suggestions that follow should be explicit and clearly related to the matter at hand. Several researchers have shown that consultations are more likely to be effective if recommendations are specific regarding drug dose, frequency, and route.⁵⁻⁷

These studies also showed that leaving a long list of suggestions decreased the likelihood that any of them would be followed, including the crucial ones.⁸ Thus, the consultant must resist the temptation to suggest tests that are not crucial to the case just to validate his or her "expert" status. In our survey at the Brigham and Women's Hospital, we found that an average consultation resulted in recommendations for additional tests costing a mean of \$300. There

seems to be no correlation between the cost of the recommended tests and the impact of the consultation.^{3,4}

VI: PROVIDE CONTINGENCY PLANS

The consultant must remember that, regardless of the wisdom of the original suggestions, any patient's status is dynamic, and initial recommendations may prove irrelevant 24 hours after they are made. For example, if a patient has worrisome arrhythmias, a description of loading and maintenance doses of quinidine might be followed by specific instructions for initiating procainamide therapy, in case the quinidine therapy is ineffective.

A corollary to this principle is that consultants should try to anticipate potential problems, such as what kind of postoperative complications might be expected in a particular patient. A brief description of therapeutic options to be employed should these problems arise may save valuable time later.

VII: HONOR THY TURF (OR THOU SHALT NOT COVET THY NEIGHBOR'S PATIENT)

Occasionally, a primary physician will want a consultant to assume responsibility for immediate- and long-term care of a patient; but, in most cases, consultants should play a subsidiary role. They should be careful to address the problem for which they were called and to avoid running arguments in and out of the medical record with other services, especially if the problem lies outside their domain.

Just as a medical resident quickly learns to permit an intern to try various management options if either one is equally likely to succeed, a consultant must learn that more than one diagnostic or therapeutic approach is appropriate for many patients. If the strategy that is chosen by the requesting physician seems as reasonable as the one that the consultant would normally pursue, it is more appropriate for the consultant to indicate agreement with this course than to go to great lengths to describe a different but equivalent strategy.

When consulting on surgical patients, the medical physician should remember that his or her role is not to engage the patient in a detailed discussion of whether the surgery is indicated or likely to succeed. Although the consultant has a responsibility to the patient, this responsibility should be expressed through discussions with the primary physician and not by competing for the attention and loyalty of the patient. Occasionally, a chronic or newly discovered medical problem may mandate postponing surgery. Usually, though, such problems will pose a long-term rather than an immediate issue, and the medical consultant's role will be to arrange appropriate follow-up.

VIII: TEACH . . . WITH TACT

Requesting physicians appreciate brevity and clarity, but they also appreciate consultants who make an active effort to share their expertise and insights without condescension. Occasionally, a consultant will tell a patient about a recent study relevant to the case; later, the patient may quote the article to the primary physician, who may not be familiar with it. Few physicians enjoy expanding their horizons in such a manner, which can rob them of their competence in the eyes of the patient. Consultants in such cases are unlikely to be called again.

While copies of references are often graciously received, they are only a supplement to, not a replacement for discussing the principles of the case with the requesting physicians. References should be brief, pertinent, and current. Rarely will more than two references on a topic be appreciated, and those chosen should generally have a

direct clinical bearing on the patient's problems. In general, the most worthwhile references to copy are from first-line subspecialty journals to which the requesting physician may not subscribe, or landmark articles from general medical journals published before a house officer began training. Copying a recent article from a front-line journal that the primary physician should have read may be done with good intentions, but such a policy can generate ill feelings.

IX: TALK IS CHEAP . . . AND EFFECTIVE

There is no substitute for direct personal contact with the primary physician after a consultation has been performed, especially if the consultant thinks that the recommendations are crucial or controversial. Suggestions are much more likely to be followed if appropriate, and inappropriate suggestions are much less likely to be made. For example, a consultant should never write in a chart that surgery should be postponed without first talking with the surgeon. In many cases in which such a note is contemplated, the surgeon will have information that is not obvious from the chart, and a personal discussion will lead to agreement that surgery is the appropriate course.

The consultant should remember that the consultation note carries a tremendous weight in the management of a case. A surgeon would be foolish to proceed with surgery when a consultant suggests that such a course is dangerous, and both medical or surgical physicians must go to great lengths to document in the chart why the consultant's recommendations are not being followed. Good care and good relations are not likely to ensue from a series of suggestions such as: "1. Cancel OR. 2. CT. 3. LP for CSF immunoglobulins"—especially if they are not followed up with at least a phone call.

X: FOLLOW-UP

Consultants should recognize the appropriate time to fade gracefully into a background role, but that time is almost never the same day that the consultation note is signed. Several investigators have shown that suggestions are more likely to be translated into orders if consultants write periodic follow-up notes with recommendations.^{4,6,8} In addition, many complications such as postoperative deep vein thrombosis or myocardial infarction do not become evident until three to five days after surgery. Thus, the responsibilities of a preoperative consultant do not end when the patient is wheeled into or even out of the operating room.

Even if recommendations have been discussed with the requesting physician, the consultant should review the chart to be sure that crucial recommendations have been acted on, and that important orders have been carried out. Especially early in the academic year, busy house officers may overlook some essential recommendations. For the consultant, checking for such lapses is analogous to a good medical resident's review of the intern's chart.

The consultant should also review pertinent laboratory data and be sure that such data are incorporated into future plans, but the consultant should not transcribe the daily laboratory data into the progress notes before the house officer has had the opportunity to do so. If, however, it does not seem to be the practice of the house officer to record such data, then such a role is appropriate for the consultant.

Although the preceding commandments are by no means all-inclusive, they provide an overview of some of the principles that the consultant must keep in mind. Failure to adhere to these principles will frequently result in ineffective interactions, and, because poor communication also leads to poor feedback, the consultants in such cases are those least likely to understand their own impact. For example, our data indicated that consultants thought that their recommendations were crucial to patient management in about 35% of consultations, whereas the requesting physicians thought that the consultations were crucial for management only about half as often.³ Differences in opinion on the impact of the consultation were especially striking in those cases in which the consultant and the requesting physician disagreed on the reasons for the consultation; in such instances, the consultant had a higher opinion of the impact of his or her work than the primary physician in more than three fourths of the cases.³

These findings indicate that poor communication can extend to disagreement on the impact of a consultation. These breakdowns could be avoided if several of our commandments were obeyed, if the consultant was clear on the issue at hand, and if the consultant spoke directly to the requesting physician after the consultation was performed to be sure that the appropriate measures were taken.

Although most of this essay has described principles for the consultant, the requesting physician also plays an important role in the process. Our data³ indicate that consultations that are ordered for specific purposes, such as to obtain or arrange a procedure or test, are more likely to be highly rated by the requesting physician and to have management impact. A corollary conclusion is that consultations are more likely to be useful if the requesting physician has already thought about the case enough to frame a specific question, and then expresses it clearly, instead of requesting a consultation before the issues have been defined.

Consultative medicine is an important aspect of internal medicine practice, and consultation rotations now comprise about one third of the time spent in many medical house-staff training programs. Although many of the guidelines for effective consultations may seem to be an extension of the clinical common sense that should be acquired on regular inpatient services, some of the strategy and politics of consultative medicine are unique. If the consultant remains acutely aware of his or her role vis-a-vis the requesting physician and the patient and adheres to the principles we have outlined, the resulting consultation should prove more effective and enjoyable for all involved.

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