The Case of the Difficult Consult

Case Written by Dr. Teresa Chan

Case
Dr. Teresa Chan

Objectives:
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Dr. Brent Thoma

Expert Responses
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Curated Community Commentary
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"Well… That did not go as I expected!" exclaimed Melanie. Melanie, an off-service first-year rotator in the emergency department, had hung up the phone. The strength with which the phone was slammed down suggested that it had gone much worse than she had expected.

"What's wrong?" asked Geoff, a third year resident in Emergency Medicine, "You sounded like you were getting some push-back from the senior medicine resident, eh?"

"Yeah. I mean, I've called for consults before on the ward, but that was so much more difficult than usual," she reflected. "He just kept on asking me question after question. He wanted the exact blood pressure of the patient, and when I couldn't give it, he made some snarky response about how I should 'know better.' Does that happen to you?"

"It used to happen a lot, but I think over the years I've found a way to give consults so that everyone seems to walk away happy," replied Geoff. "Honestly, I don't really know when that transition happened. But now, I just seem to get the consults I want, when I want them. Still, sometimes, even I have consults that don't seem to go so well."

Melanie leaned back and sighed. "There must be something you do differently. I can't imagine doing this job everyday if I had to get that kind of push-back every time I talked to another doctor."

Questions for Discussion

1. What would you do if you were faced with the Case of the Difficult Consult?
2. What advice would you give these two learners?
3. How would you intervene?
4. What wisdom would you share with them?

Competencies

ACGME	CanMEDS
Interpersonal and Communication Skills Professional Values	Collaborator Communicator Professional

Intended Objectives of Case

1. List components of evidence-based frameworks of an effective consultation.
2. Describe strategies to teach junior learners how to communicate with a consultant.
3. Discuss unprofessional behaviors that occur during consultations.
4. Summarize strategies that may help to overcome difficulties encountered during the consultation process.

Expert Response

Get Their Interest PIQUED with the 5Cs

by Teresa Chan HBSc, BEd, MD, FRCPC, MHPE (Candidate)

Consultations from the Emergency Department can be difficult. They are wrought with many layers of complexity. There are issues around hierarchy, interpersonal relations, competing interests, divergent values... The list goes on and on!

There have been two models recently that have sought to break down the complexity of the ED consultation into some simpler models. Chad Kessler, Associate Professor at Duke University's School of Medicine, has derived the 5C's model of consultation. The components of the 5C's are:

1. **C**ontact
2. **C**ommunication
3. **C**ore question
4. **C**ollaboration
5. **C**losing the loop

He has gone on to even validate this checklist through a number of studies (8,11), making this the most evidence-based educational model for ED consultations.

Meanwhile, I have also worked on studying the ED consultation phenomenon. I too have created a mnemonic (PIQUED), but this one aims to aid learners delivering consults early in their career:

Preparation
Identification of all Parties
Questions
Urgency
Educational Modifications
Debriefing & Discussing

Both of these models might act as a framework for junior learners. Anecdotally, I have found that those with trouble have left off some key item in either or of these models. There are also other resources for improving outpatient referrals by Stille et al. (10), as well as numerous other studies that point towards the need for better communication when transitioning care (1, 2, 3).

Improving consulting skills is a key skill for any learner in the ED. By improving these interactions, we hope to improve communications, and ultimately enhance patient care.

Reference in this article are listed on page 6.

About the Expert

Dr. Teresa Chan is a published author on the topic of ED Consultations. Her works include: **Chan T**, Orlich D, Kulasegaram K, Sherbino J. "Understanding communication between emergency and consulting physicians: a qualitative study that describes and defines the essential elements of the emergency department consultation-referral process for the junior learner." Can J Emerg Med. 2013 Jan 1; 15(1): 42–51.

Expert Response

Five Tips to Make Your Consults Go Smoother

by Robert A. Woods MD, MMEd, FRCPC

Oh, I can relate to the vignette when I think back to my training. As I progressed through residency, I eventually learned how to get my consults "wrapped up in a bow" before I picked up the phone. If I was not prepared, the conversation would not go well. It would take a long time and sometimes I wouldn't get what I needed for my patient. It took lots of practice.

Here are some tips on how to make this "trial and error" learning process go a little smoother:

1. Gather your ingredients

Make sure you have all of your patient's data in front of you:

- old chart
- lab results
- imaging results
- names of previous specialists
- rough dates of previous procedures/major investigations
- other pertinent info

Before you call, think: 'What would you want?'
"If I were the consultant, what would I need to know in order to further manage this patient?"

This is a good habit to get into when you are on the other side of the ER on off-service rotations. Get their perspectives so you can consult them effectively and efficiently when you get back to the ER.

2. Get the consultant's name

It is amazing how often this fails to occur. For example, you forget to ask, and two hours later, your patient never got his/her ultrasound. You call the after 5pm person, and she knows nothing about it.
Q: "Who approved this ultrasound earlier?"
A1: "Uhhh... I don't know..." **Not good!**
A2: "Dr. So-and-So approved it at 15:32." **Better!**

3. Lead with the headline

Clarify the purpose and urgency of your consultation. Don't present a history and physical exam but rather a diagnosis (or suspected diagnosis), the data that supports your thinking, and your question for the consultant. Then let the consultant ask what they need to know. It's much more efficient this way.

EXAMPLE 1: "I got this 42 year-old guy here who presented with general malaise and a rash over his previous total knee arthroplasty site. He has a history of IVDU and he's looking pretty sick. I was hoping you could admit him?... His vitals?... Oh, they are BP 78/42, HR 133, O2 97%." **This consult request needs work.**

EXAMPLE 2: "I have a 42 year-old male with a history of IVDU presenting in septic shock from a possible septic arthritis/endocarditis. He is quite ill and I need help with ongoing management." **This consult request is much better.**

4. When you ASSUME...

Don't set yourself up for failure by assuming you know what the consultant will do. Tell the patient you are going to talk to the consultant to ask their opinion. When the patient asks if they are going to get a particular test or treatment or be admitted, just say that's up to the consultant. That way if you thought the patient needed an angiogram or a CT, but the consultant doesn't, the patient isn't misinformed.

5. Look at the evidence

There are some great models out there (5C's, PIQUED) designed as templates for ED consultation. Check them out and see what works best for you. I hope these tips can help you shorten the transition to competent consultations. You'll still have the occasional difficult consult, but when you sound like you know your stuff, good things will happen for your patients.

About the Expert

Dr. Robert Woods is a published author around the topic of ED consultations. His works include:

Lee RS, **Woods R**, Bullard M, Holroyd BR, and Rowe BH. "Consultations in the emergency department: a systematic review of the literature." Can J Emerg Med. 2008; (25): 4–9.

Curated Community Commentary

By Brent Thoma MD, MA

A qualitative methodology was used to curate the community discussion. Tweets and blog comments were analyzed, and four overarching themes were extracted from the online discussions. Prior to publication, we sent this analysis to two of our community members to perform a "member check" to ensure credibility. Thank you to Elisha Targonsky and Amy Walsh for their participation in this process.

1.Be respectful and professional

The need to maintain composure was the most often cited item. Many comments noted that problems escalated if this did not occur. Tips for making it a priority included a complete introduction, keeping the patient central in the discussion, remembering that you and the consultant are on the "same team," inviting an in-person discussion whenever possible, thanking the consultant for their assistance and never disparaging the patient or other staff.

"If you don't know what's going on with the patient, just be straight up about it."

– Elisha Targonsky, @ETtube

2. Preparation is key

Beyond taking the common steps of gathering all of the necessary information, having a standard approach and formulating a specific question, there were several tips for preparation. The importance of "knowing the audience" in terms of their usual approach to receiving consults and the information that they want was highlighted along with the need to "close the loop" on the plan for the consultation.

3. It's a two-way street

This is an item that many are guilty of neglecting while working busy shifts. It is easy to forget that, for any number of reasons, the consultant could be having a very bad day. Tips for incorporating this understanding into consultation behaviors included noting that the patient is in need of their expertise, ensuring that you are truly listening to their perspective, and empathizing with any difficulties that you are aware of (e.g. a backlog of consults or a poor outcome for a recent patient).

4.Consultation skills need to be taught by an experienced coach.

There was widespread agreement that the teaching of this communication skill was not commensurate to its importance. Suggestions for teaching the skill included teaching consultation frameworks such as SBAR, the C's or PIQUED, having learners observe consultations, priming learners for their own consults, and having them do a "mock consult" with you before calling the consultant. Our participants thought that teachers should coach learners to "lead with the headline" and state what they are requesting up front. They should also be clear about the urgency of the consultation.

"I found when my frustration was about to boil over that it was helpful to pause (and) place some blame on myself... that helped me keep things polite and get the patient cared for appropriately." – Amy Walsh, @docamyewalsh

Contributors

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References & Links

Descriptive Studies on Consultations

1. Salerno, S. M., Hurst, F. P., Halvorson, S., & Mercado, D. L. (2007). "Principles of effective consultation: an update for the 21st-century consultant." Archives of internal medicine, 167(3), 271.
2. Iwata M, Yamanaka K, Kitagawa Y. "The level of agreement regarding patient disposition between Emergency Physicians and consultants in the emergency department." Int J Emerg Med. 2013; 6(1): 22
3. Boulware, D. R., Dekarske, A. S., & Filice, G. A. (2010). "Physician preferences for elements of effective consultations." Journal of general internal medicine, 25(1), 25-30.

Observational Studies

4. Matthews AL, Harvey CM, Schuster RJ, Durso FT. "Emergency Physician to admitting physician handovers: an exploratory study." Proceedings of the Human Factors and Ergonomics Society 46th Annual Meeting; (2002). Baltimore, MD: 1511-1515.

Reviews on Consultations

5. Kessler CS, Chan T, Loeb JM, Malka ST. "I'm clear, you're clear, we're all clear: Improving consultation communication skills in undergraduate medical education." Acad Med. 2013; 88(6): 753-758.
6. Kessler CS, Asrow A, Beach C, et al. "The taxonomy of emergency department consultations – results of an expert consensus panel." Ann Emerg Med. 2013; 61(2): 161-166.
7. Lee RS, Woods R, Bullard M, Holroyd BR, and Rowe BH. "Consultations in the emergency department: a systematic review of the literature." Can J Emerg Med. 2008; (25): 4–9

Models for Consultation

8. Kessler CS, Kalapurayil PS, Yudkowsky R, Schwartz A. "Validity evidence for a new checklist evaluating consultations, the 5Cs model." Acad Med. 2012; 87(10): 1408-1412.
9. Chan T, Orlich D, Kulasegaram K, Sherbino J. "Understanding communication between emergency and consulting physicians: a qualitative study that describes and defines the essential elements of the emergency department consultation-referral process for the junior learner." Can J Emerg Med. 2013 Jan 1; 15(1): 42-51.
10. Stille, Christopher J., et al. "Development and validation of a tool to improve paediatric referral/ consultation communication." BMJ Quality & Safety 20.8 (2011): 692-697.

For Medical Educators

11. Kessler CS, Afshar Y, Sardar G, Yudkowsky R, Ankel F, Schwartz A. "A prospective, randomized, controlled study demonstrating a novel, effective model of transfer of care between physicians: The 5 Cs of consultation." Acad Emerg Med. 2012; 19(8): 968-974.

About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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We would love to hear how you did. Please email teresamchan@gmail.com or tweet us @Brent_Thoma and @TChanMD to let us know.

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The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

Usage