

GUIDELINES FOR CONSULTATIONS

Physicians are professionals, and as professionals, expect and deserve a certain amount of respect from their physician colleagues. We have had some discussions about the process of requesting and performing consultations at this hospital, and how this process might be improved.

The following suggestions are offered as “guidelines” both for physicians requesting consultations, and for physicians performing consultations. Much of what follows has been previously suggested by Dr. John Van Brakle and is not original with me. Also, much of what follows is simply a reflection of the type of professional behavior which I believe all of us learned at one time, but are now often too busy to follow. In addition, I believe that if the “guidelines” were followed we would significantly improve professional and patient communication, improve the quality of patient care, and reduce the cost of the care which we deliver to our patients.

Remember, the request for a consultation from the attending physician to another physician or health care professional is a request for an opinion regarding a specific issue related to the patient’s diagnosis or care.

- The consultation request should address a specific question or a specific need. e.g. “Please help diagnose my patient’s problem”, “Please recommend the best treatment for my patient’s condition”, “Please evaluate my patient medically before a planned operation”, or “Please see my patient for possible abdominal aortic aneurysm repair”, etc.
- A personal call to the consultant from the attending physician stating the reason for the consultation request, what is expected from the consultant, and whether orders should be written by the consultant is appropriate, encouraged, and a simple professional courtesy. The attending/referring physician may know or have information about the patient which is not available in the medical record which would be helpful for the consultant to know.
- It should be clear in the consultation request whether the attending physician is requesting the consultant’s advice, opinion, or direct involvement in the patient’s care.
- “Courtesy Consultations” are appropriate and should be placed to physicians who have been closely involved with the patient’s care, but whose opinion is not necessarily needed or required by the attending physician. An example would be a “courtesy consultation” to the patient’s family physician by the attending surgeon who is preparing the patient for an uncomplicated mastectomy. A patient charge should not be generated for a “courtesy consultation”.

- “Teaching Consultations” are also appropriate for the benefit of residents in training and medical students when an interesting or unusual patient problem becomes apparent to the attending physician, but the services of another physician are not necessarily required. Patients should be informed that their problem is unusual or interesting and asked if it would be acceptable to have another physician and some resident physicians stop by to review the patient’s record and briefly interview and examine the patient. A patient charge should not be generated for a “teaching consultation”. This type of consultation is in the best interest of the goals of a teaching institution, its medical staff, resident physicians, and students.
- It should be made clear at the time of the request for the consultation whether the attending physician wants the consultant to discuss his/her findings and recommendations with the patient and the patient’s family or whether the recommendations should be discussed with the attending physician either solely or primarily.
- The consultant should always introduce him/herself to the patient and his family if they are present. He/she should inform the patient and family that he has come to see the patient at the request of the attending physician and should mention the referring physician by name. He/she should specify why he was asked to see the patient by the referring physician. It is also helpful to ask the name of the patient’s primary care physician. After the evaluation the consultant should tell the patient that he will discuss his findings and recommendations with the patient’s attending physician and that together they will develop a plan for the patient’s future care.
- It is useful for the consultant to provide his professional card or to provide his name in writing to the patient and his/her family.
- After the consultation is performed, a personal call from the consultant to the attending physician detailing the findings, recommendations, and suggestions regarding the further involvement of the consultant in the patient’s care is appropriate as a professional courtesy and in the interests of the highest quality patient care. The initial question asked by the attending physician should be answered by the consultant at this time.
- At this point, it should be clarified as to whether the attending physician wants to write all of the orders in the patient’s chart or whether the consultant has the authority to write orders for diagnostic tests and treatments.
- The consultant should not write an order for another consultant to see the patient without discussing this with the attending physician. The consultant should not order an invasive diagnostic or therapeutic procedure for a patient without first discussing this with the attending physician. Do not write an order unless specifically cleared by the attending physician. You are offering an opinion which the attending physician may or may not choose to follow.
- As a consultant, discuss the need for post discharge follow up of the patient with the attending physician.

- If the consultation request is for “patient management” and the consultant feels that the extent of his/her involvement would be best served by a transfer from the referring physician to the consultant’s service, this should be discussed with the attending physician after the patient is seen and evaluated.
- The consultation report should be completed before the consultant leaves the patient care unit. This note should answer the question which was originally addressed in the consultation. The note may be brief, but should be followed by a longer more detailed note, preferably one which is dictated and transcribed so that it will become a *legible* part of the patient’s permanent medical record. References can be provided if useful, but not simply to “show off”.
- It is useful to have a copy of the detailed consultation report mailed to the attending physician as well as to the patient’s primary care physician.
- As a consultant, never criticize the previous or present treatment to the patient or his/her family.
- As a consultant, if you have strong objections to the patient’s present diagnosis or treatment, do not start an argument in the medical record. Discuss your opinions with the referring physician directly.
- As an immediate response it is acceptable to say “I don’t know, but I will find out” or “I need a little time to think and/or talk this over with someone else”. This is preferable to guessing. If you really don’t know - look it up!

Hopefully by following the above simple guidelines we will improve communication between physicians and between physicians and patients. This improvement in communication will lead to better professional relationships between physicians and health care providers and may significantly reduce the risk of medical malpractice. I believe that if these guidelines are followed we also may see a significant reduction in the duplication of studies and in the cost of care which we deliver to our patients.

David M. Caccese, M.D.