Calling the Consultant!

APPD WORKSHOP 2018
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Workshop Overview:

Subspecialty consultations are common occurrences in medical centers, allowing opportunity for enhanced patient care through collaboration between subspecialists and hospitalists. The consultation also provides a unique platform for an educational exchange for all learners on both sides of the consult. Prior curriculum examining the educational aspects of the consultative interaction have been heavily focused on the subspecialty trainee. However, the full impact of this interaction can be experienced by all learners from both sides participating in both sides of the consultation.

The purpose of this workshop is to provide a practical strategy to implementing a robust educational infrastructure to subspecialty consultation to benefit trainees at all levels on both sides of the consultative experience.

Goals & Objectives:

1. Explore how the resident and subspecialty fellow interaction can be a meaningful educational opportunity
2. Recognize and minimize barriers that prevent the consultant-learner interaction from reaching its highest potential as an educational tool
3. Identify and utilize competency-based evaluation tools for both residents and fellows in the consultant interaction
4. Create an educational approach to the consultation encounter that would be applicable to your home institution for both hospitalists and subspecialists
Consultation Cases:

Included in this consultation toolkit are 4 cases with associated discussion guides. 2 cases are written for the perspective of a physician who is calling a consult (hospitalist, ER, PICU/NICU) and 2 cases are written for the perspective of a physician providing the consult (subspecialists). Case based learning can be easily incorporated into didactic teaching sessions and can provide a framework for introduction of the educational opportunities within consults and introduction of consultation models.

Case 1:

Allie is a 3rd year medical student on her first clerkship: general pediatrics. She is asked by her team to call a consult to the infectious disease (ID) service for their input in the care of a 4 year old boy with fever of unknown origin whom she has been assigned to follow. Her senior resident, Kate, gives her the ID service pager number, and reminds her to “Ask a Question”.

When Robert, the ID fellow, calls her back Allie nervously says “hi!” and then launches into her patient presentation – the exact same one she just received good feedback for on rounds. She is abruptly cut off by Robert who says: “Woah – why are you calling me?! Who is this patient?! Who are you?! What team are you calling from anyway?”. Allie is flustered and provides the requested information and then starts back in on her presentation.

She is interrupted again by Robert who says “It doesn’t sound like you don’t know the question for us! Have your senior call me back.” Allie says she will and hangs up the phone defeated. After taking a few deep breaths she turns to her senior resident and requests that she call Robert back, explaining what had happened.

The senior resident sighs, wondering why all her medical students can’t figure out this very simple task; after all she had told her to make sure to have a question.

Discussion Guide:

1. Consider this encounter from the perspective of each learner: What went well and what didn’t go well? How could each person involved have improved this consultation?
   - Medical Student: Allie
   - Senior Resident: Kate
   - ID Fellow: Robert

2. What are some of the opportunities for helping a junior learner (Student, Intern, Resident) learn from the consultation encounter

3. How does your hospital or program teach consultation communication? Are there opportunities for improvement or change to increase the educational potential?
Case 2

Luke is a junior resident rotating through the emergency department for the first time. He just completed his PICU month and has found a passion for critical care. He has called many consultants from both inpatient floor teams and the ICU to have subspecialist provide routine and semi-urgent consultations for patients in his care.

During his overnight ER shift, he assumes care of a 3 year old patient who arrives after a 45 minute first time febrile seizure. On arrival to the room, he notes the patient is still febrile to 39 with otherwise stable vital signs and responsive to noxious stimuli. He does a cursory neurological examination, jotting down “grossly intact” before leaving the patient’s room to staff with the ER attending. Finding that everyone is busy with a trauma patient, he calls neurology for a consultation.

Rosie, the neurology fellow, returns his phone call and listens patiently as he reviews the history and reports his exam: “nothing focal.” He poses his question: “Anything you want us to do?”. Rosie pauses and takes a deep breath. “I think we need to back up. Can you answer some questions for me?” She then begins to ask some clarifying questions about the history and exam as well as clarifying what work-up Luke has done. Luke becomes frustrated: “We are really busy tonight and I just need to know what your recommendations are and when you will be coming to see the patient!!” Rosie explains that overnight, often recommendations are provided via the phone and that she relies on the residents to provide clear clinical information. She requests Luke to call her back when he is able to provide the additional information and his own thoughts on the patient.

Discussion Guide:
1. Consider this encounter from the perspective of each learner: What went well and what didn’t go well? How could each person involved have improved this consultation?
   - Junior Resident: Luke
   - Neurology Fellow: Rosie
   - ER Attending/Fellow
2. How is the consultation encounter changed when the consultant will not be seeing the patient before providing recommendations (phone consultations)? Are there unique educational opportunities within the phone consult?
3. In an acute or emergent situation in which a consultant is providing recommendations over the phone, what are the key components to be included in the encounter? How should the urgency of the consult be communicated?
Case 3

Sarah is a pulmonology fellow who is on her last week of a month on service. Tired, she receives another page to have “pulmonology on board” for a patient with asthma. Sighing, she jots down the information and says that she’ll get back to the primary team before hanging up the phone. She turns to her co-fellow and says: “I don’t understand these residents! No one wants to think for themselves. A patient wheezes once and rather than think it through they just call me to make me do the work for them. I’m sick of it!” She then grumpily turns back to her computer to begin to work her way through the consults.

Brad is a senior pediatrics resident who was just accepted to a heme/onc fellowship and is completing a pulmonary elective. He overhears this exchange and privately thinks to himself “I will never do that when I’m a fellow!” Sarah turns to him and gives him the basic information for the asthma consult, waving her hand to him and saying: “It’s just like all the other ones you’ve done. Teams never have a question, just want us on board and then they don’t even read our note anyway. Do the best you can, we need to be ready to staff in an hour.”

Discussion Guide:

1. What do think is contributing to Sarah’s response to the consultation encounter? Are her feelings justified? Why/Why not?
2. Is there a hidden curriculum within the consultation encounter that raises issues of professionalism? Communication Skills? Do you think these are unique to your program?
3. What opportunities for education did Sarah miss by responding the way she during the consultation conversation? What were the missed opportunities the two fellows had with their junior colleague, Brad during this exchange?

Case 4

It’s Monday morning and Kavitha, the pediatric cardiology fellow, is just sitting down at her desk when her pager starts to ring. She receives 3 consults back to back: 2 from the ICU and 1 from a floor time. She quickly gathers the relevant information and all three teams tell her that the consults are urgent. She sits down to organize herself and triage her own interpretation of the acuity of these cases when she receives 2 additional consults: 1 non-urgent consult triggered by a team ordering an echocardiogram and 1 consult for a stable patient whose team wants cardiology to “weigh in” on the EKG prior to discharge which is planned by early afternoon. Adding these consults to her list she begins to work through each one in the order of urgency she has established based on the information provided.
About an hour after the original phone calls she starts getting paged by the ICU teams, asking where she is and why the consults aren’t completed yet. “We need your recommendations now!” She asks if there has been a change in the clinical status of the patients and receives the reply that “no, nothing’s change but my attending wants a plan!”. She assures then that they will be seen that day by both her and the attending. As she hangs up the phone, she receives a page from her attending that there is an emergent cardiac catheterization she needs to attend. They briefly review the list of consults to be done that day, agree that none are medically urgent and Kavitha puts aside that work to attend to the cath.

By mid-afternoon Kavitha and her attending have begun their rounds on the 5 consults called. Kavitha is frustrated and overwhelmed as she has been repeatedly paged by teams demanding to know what the delay in the consultation has been. By the end of the afternoon, Kavitha is exhausted and still needs to sit and write all her notes. She calls all the teams back and briefly provides recommendations without any further explanations so she can complete her notes and get home.

**Discussion Guide:**

1. What are there different ways Kavitha could have handled the initial consultation phone calls to have helped her manage her day, the volume of consults and avoid her frustrations?
2. How does a consulting team or consultant establish the urgency of a consult? Which team should make that determination? What if there is a difference of opinion?
3. In situations where unpredictable emergencies arise how should a consultant team handle communication with teams in which care or recommendations may end up being delayed? In what timeframe is it reasonable to “check back” if a primary team has not heard back from a consultant and time-sensitive care is dependent on their recommendations (i.e. discharge home)?
Models for Consultations:

Several studies have examined and proposed different models for teaching residents how to call a consultation. Based on qualitative data examining the essential elements of this encounter from both the perspective of the individuals requesting the consults (ICU, ER, Hospitalists) and those receiving the consult (medical and surgical subspecialist consultants) these models provide a framework for the initial encounter. Consideration of incorporating such a framework into a resident, fellow or student workshop can provide a common language and optimize the communication during the encounter.

The 5 C’s


This model was developed and implemented with different learner levels as an adaption of a previously published framework entitled 7Cs of consulting with the goal of improving resident and student doctor consultation communication skills. The model was tested with standardized encounters with improved communication and satisfaction reported from participants trained in the model.

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<th>The 5 C’s of Consulting</th>
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<td>4C</td>
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<td>5C</td>
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*Adapted from: Kessler et Al. Journal of Emergency Medicine 2012. Table 2*
CALLING THE CONSULTANT!

PIQUED


The PIQUED model, proposed in this study, was built from focus group interviews with ER physicians and consultant colleagues in which the core elements of the consultation were identified. The model, designed for the junior learner, was intended to optimize the communication exchange with potential enhancement of the educational value inherent in the encounter.

4 Core Components

1. Preparation & Review
   Initial Work-up
2. Clinical Communication
3. Questions
4. Discussion after Referral

Modifiers

- Urgency
- Educational Modifications

Preparation and Review
Identification of Involved Parties
Questions
Urgency
Educational Modifications
Debrief & Discuss

*Adapted from: Chan et al. JGME 2013 Figure 1.

The 5 C’s + PIQUED


In this perspective article, the 2 previous consult models are reviewed (5C’s and PIQUED) and then a combined model is proposed which may have wider applications than either individual model. The article highlights the educational potential of introduction and regular use of these models, opportunity for validation in other healthcare settings, and potential exploration of changes in patient care outcomes with improvement consultation communication.
**Combined Model: 5C’s + PIQUED**

| Preparation                               | - Primary team completes initial work-up and resuscitation  
|                                          | - Primary team has reviewed investigations & generated question |
| Contact & Communication                   | - Initial call to consultant  
|                                          | - Key Components: Introduction, Patient Details, Case specifics |
| Core Question(s)                          | - Provide core question for consultant  
|                                          | - Consultant pose questions of primary team |
| Collaboration                             | - Receptive to recommendations & collaboration |
| Urgency                                   | - Modify timing, behavior and information based on urgency of clinical situation |
| Closing the Loop                          | - Review plan  
|                                          | - Thank consultant for time & recommendations |
| Educational Modifications                 | - Adjust above framework based on learner level involved |
| Debrief and Discuss                       | - Ask and/or Provide feedback to colleague regarding case |

*Table adapted from Kessler et. Al Academic Medicine 2013 Table 1.

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**CONSULT**

Podolsky A, Stern D, Peccorala L. *The Courteous Consult: A CONSULT card and training to improve resident consults. Journal of Graduate Medical Education. March 2015*

Built from a survey of resident and fellow physicians at a single institution, this consultation model emphasizes professionalism and communication skills among junior learners and describes an implementation process of the model for learners at their institution. Proposed with mnemonic CONSULT the paper provides their framework model as a pocket sized card to aid in recall and integration of the communication technique into practice.
### CONSULT CARD

**C** | Contact the consultant Courteously  
*Who you are including training level, team and state: “I am requesting a consult please”*

**O** | Orient  
*Patient name, MRN, location in hospital*

**N** | Narrow Question  
*Pose a focused question regarding diagnosis and/or management*

**S** | Story  
*Provide a succinct story: pertinent HPI, hospital course and work-up with anticipated plan*

**U** | Urgency  
*How quickly should the patient be evaluated?*  
*Emergent (30mn-1hr), 2-3 hours (very urgent), 8 hours (urgent), 24 hours (routine)*

**L** | Later  
*Make a follow-up plan with consultant team and provide your contact information*

**T** | Thank You!

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**Tips for Calling a Consultant**

1. Orient listener to the components of the call  
2. Be Courteous and Polite **Even when the other person is not**  
3. Avoid calling consults to have a team “on board” without a question  
4. Diagnostic Questions: Have a differential diagnosis in mind & begin/anticipate work-up  
5. Therapeutic Questions: Have a proposed management approach in mind  
6. Have pertinent information available if consultant requests  
7. LEARN: follow-up with the consulting team to ask questions and discuss outcomes of the case

*Charts adapted from Podolsky et. Al JGME 2015 Figure 1.*
Consultation Tips: Best Practices from the Front Lines

There are numerous educational opportunities during the consultation encounter for both the fellow consultant or the resident consulter. Optimizing the communication during this encounter often allows for teaching, critical thinking and exploration of further questions generated by the shared care of a patient. Although often we think of the fellow in the role of teacher, often residents calling the consult can take the role of teacher in providing additional perspective on the care of their patient, share other consultation service’s recommendations with the consulting fellow and through their own reading of their patient’s case. Below are tips residents and fellows provided for optimizing the educational potential of the consultation.

**From the consultant fellow:**

1. **Know your Patient**

   Before calling a consultant, you need to know your patient. This is more than knowing the clinical history and examination, which you absolutely should know. It includes your thought process on the case. If it’s a diagnostic question, what is your differential and what work-up have you already done. If it’s a management question, how you would approach the care? The more critical thinking you have already done, the more you will get out of the consult.

2. **Have a Question**

   We will both learn more if you have a clinical question for me to focus the consult on. If you pose the question before telling me the history, I am able to listen with the question in mind and may have some clarifying questions but likely will not have to have you go back over details of the history you already provided – saving us both time!

3. **Let Me Teach You**

   One of my favorite parts of the consult is finding the teachable moment or pearl(s). Sometimes I am able to do this by discussing the recommendations in detail, sometimes I am busy and may provide this by sending articles or referencing articles in my note. Everyone’s short on time but taking the few extra minutes to learn about a patient from a different perspective is important to understanding that patient’s care.
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4. Tell Me Succinctly What You Know and What you think

When you call the consult include a BRIEF summary of the patient’s history, hospital course and relevant work-up. If I need additional information I will be sure to ask so make sure you have the chart handy. I’m interested in hearing what you think – when you ask your focused question if you include your decision making and approach I’m able to provide some teaching during the initial consult call and potentially shape the work-up to include your thinking and plan.

5. Read My Note

I spend A LOT of time on my consultation note. The goal of the note is not just for me to document the patient’s history and exam from the perspective of my subspecialty but it is also an important communication document to detail my decision-making and thought process as it pertains to your patient. Please take the time to read it through, even if I’m unable to sit down and go everything in detail in person on a given day, I will have done that for you in my note.

From the consulting resident:

1. Be Respectful and Professional

Please be courteous to me when I page you and I will be respectful as well. Let me know if you anticipate difficulty in completing the consult within the expected timeframe because of emergencies or the volume of consults you have that day. When discussing the patient, please do so from the perspective of a teacher and help me learn how to think critically and communicate effectively.

2. Push Me Politely to Think Through the Case

I like when fellows push me to think through a consultation question or patient case so that I better understand my patient and their care. As long as you are respectful, I will learn a lot by being pushed to answer a few questions or focus my question to clarify my own thoughts about a patient and their care.

3. Teach Me About the Consult

I am eager to learn about my patient and I usually learn best when a consultant fellow calls or meets me in the work room to review the recommendations of the consultation. I learn better in these encounters when compared to reading written notes. I recognized that everyone’s days are busy and time is short, but even 5 minutes makes a big difference in my learning. If once weekly, a consultation team makes a 15 minute appointment to discuss a complicated patient or relevant topic with a team I will make myself available to learn and discuss at that time.
4. Communicate with me the timeframe to expect recommendations

*If I know a timeframe within which to expect your recommendations, I won’t need to check in on what the status of a consult is. This saves time for both of us! If something changes and you can let me know, we can often adjust our (and our patient’s) expectations. Similarly, I will do my best to be clear about the urgency of the consult question from both a medical and psycho-social perspective so that you are able to appropriately triage the day.*

5. Allow for Collaboration in Care

*With medically complex kids there are often multiple subspecialists involved in their care and sometimes they make conflicting recommendations. I am learning how to collaborate with multiple providers and perspectives in the care of a patient. Understanding your recommendations and how they relate to others helps me better collaborate in care. Similarly, listen to my perspective as the primary resident for the patient and the plan we are developing.*
ACGME CORE COMPETENCIES and EPAs

**General Pediatrics Residency Sub-Competencies**

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<tr>
<th>Competency</th>
<th>Description</th>
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<tbody>
<tr>
<td>PC1</td>
<td>Gather essential and accurate information about the patient</td>
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<tr>
<td>PC 2</td>
<td>Organize and Prioritize responsibilities to provide patient care that is safe, effective and efficient</td>
</tr>
<tr>
<td>MK1</td>
<td>Critically evaluate and apply current medical information and scientific evidence for patient care</td>
</tr>
<tr>
<td>PBL1</td>
<td>Identify strengths, deficiencies and limits in one’s knowledge and expertise</td>
</tr>
<tr>
<td>PROF4</td>
<td>Self-awareness of one’s own knowledge, skill and emotional limitations that leads to appropriate help-seeking behaviors</td>
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**Resident EPAs:**

4. Manage patients with acute, common diagnoses in an ambulatory, emergency, or inpatient setting
11. Manage information from a variety of sources for both learning and application to patient care
12. Refer patients who require consultation
15. Lead an inter-professional health care team
16. Facilitate handovers to another healthcare provider either within or across settings

**Shared Subspeciality Fellowship Sub-Competencies**

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<tbody>
<tr>
<td>PC2</td>
<td>Make informed diagnostic and therapeutic decisions that result in optimal clinical judgement</td>
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<tr>
<td>PC3</td>
<td>Develop and carry out management plans</td>
</tr>
<tr>
<td>PC4</td>
<td>Provide appropriate role modeling</td>
</tr>
<tr>
<td>MK1</td>
<td>Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems</td>
</tr>
<tr>
<td>PBL1</td>
<td>Participate in the education of patients, families, students, residents, fellows and other health professionals.</td>
</tr>
<tr>
<td>PROF1</td>
<td>Professional Conduct: High Standards of ethical behavior which includes maintaining appropriate professional boundaries</td>
</tr>
<tr>
<td>ICS1</td>
<td>Communicate effectively with physicians, other health professionals and health-related agencies</td>
</tr>
<tr>
<td>ICS3</td>
<td>Act in a consultative role to other physicians and health professionals</td>
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</tbody>
</table>

**Shared Fellow EPAs:**

- Provide consultation to other healthcare providers caring for children and adolescents and refer patients requiring further consultation to other subspecialty providers if necessary.
References & Resources:

**Reviews & Studies**


**Consultation Models:**


Podolsky A, Stern D, Peccorala L. The Courteous Consult: A CONSULT card and training to improve resident consults. Journal of Graduate Medical Education. March 2015

**For Medical Educators:**

Chan T, Thoma B, Woods R, Lin M. ALiEM: Medical Education in Case Series: Case 1.01 The Case of the Difficult Consult.


**For fun**

http://rebelem.com/how-to-call-a-consult/