



Photo by a.drian Used via Creative Commons license. Photo available at: <http://bit.ly/1bEv7bY>

Case 2013.1 The Case of the Difficult Consult

By Teresa Chan, MD

Edited by Brent Thoma, MD

“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.”

You observe this interaction between Geoff and Melanie. As someone more experienced (senior resident, MedEd Fellow, Attending), what advice might you give these two learners? How would you intervene? What wisdom would you share with them?

Give us your response at ALiEM!

MEDIC EXPERT'S CORNER

Get their interest PIQUED with the 5Cs Useful Consultation models & mnemonics

By Teresa Chan

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) Contact
- 2) Communication
- 3) Core Question
- 4) Collaboration
- 5) Closing the loop

He has gone one to even validate this checklist through a number of studies.(8,11)

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:



Dr. Teresa Chan is a published author on the topic of ED Consultations.

Some of most recent 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.

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.

Also: Watch for new works soon in the December issue of *Journal of Graduate Medical Education* and the *Journal of Academic Emergency Medicine* (as she has two articles *in press*).

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 Chris Stille

et al. (2011), 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.

References: Found on the following page. Numbers in this article correspond to the references on page 2.



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.

FIVE TIPS TO MAKE YOUR CONSULTS GO SMOOTHER

Tips learned by trial and error

By Rob Woods

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
- And 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.



Academic Life in
Emergency Medicine



2 Get the consultant's name.

It is amazing how often this fails to occur. e.g. You forget to ask, and 2 hours later your patient never got their 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 y o 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 y o 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.

Rob Woods MD MMed FRCPC

Emergency Physician & Program Director

University of Saskatchewan

READING LIST

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.



Curated from the Community

by Brent Thoma

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

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.

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.

We would like to extend a big thank-you to the following contributors to our online discussions:

Susan Shaw
Michelle Gibson
Lindsay Melvin
Nikita Joshi
Amy Walsh
Elisha Targonsky
Tom
Dina Wallin
Corey Heitz
Justin Ryel
Todd Raine
Anand Swaminathan
Terry Kind
Rob Bryant
Seth Trueger
George F
Richard van Wylick

Our Favourite Quotes

From Elisha Targonsky

(@ETtube)

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

From Amy Walsh

(@docamywalsh)

"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."

It's a two-way street.

This is an item that I think I have been guilty of neglecting a few times 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 (ie a backlog of consults or a poor outcome for a recent patient).

Consultation skills need to be taught by an experienced coach.

There was widespread agreement that the teaching of this communication skill was not commiserate 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.

Thank-you for using this MEDiC series case.

Contributors

Case 2013.1 Author

Teresa Chan

Editors

Brent Thoma, Michelle Lin

Expert Reviewers

Robert Woods, Teresa Chan

Online Synopsis Curator

Brent Thoma

Did you use this MEDiC resource? We would love to hear how you did!

Please email <teresamchan@gmail.com> or tweet us (@BoringEM, @TChanMD) to let us know.



Academic Life in
Emergency Medicine

