# Chapter 2
# Effective Perioperative Consultation

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## BACKGROUND

Medicine consultants engage in the care of the surgical patient at various points along the perioperative timeline. Four primary phases have been described in the perioperative continuum (see Table 2.1) [1]. The original commandments of effective medical consultations were first written by Lee Goldman in 1983, and their wisdom has been distilled into various publications since that time [2]. Referring physicians comply with consultant recommendations 54–95% of the time, varying by setting [3]. Compliance and effective consultation is most likely to result when these time-tested principles are applied consistently in day-to-day consultative workflow, regardless of when the consult occurs within the perioperative continuum.

## EFFECTIVE CONSULTATION

### DEFINE THE CLINICAL QUESTION CLEARLY

On an outpatient basis, the first step is to review the referral. If a referral is placed in the electronic medical record (EMR) without a specific reason, then reviewing the referring physician's clinic note may help elucidate whether the patient is being seen for general preoperative risk stratification and optimization or if there is a more focused question, or both. If the reason for consultation remains unclear, then a direct physician-to-physician conversation may be necessary.

In the inpatient setting, the consultation may be requested either prior to surgery or postoperatively. When the consult is requested, take the opportunity to clearly define the clinical question during the initial conversation. In addition to a preoperative evaluation or consultation for a specific question, medicine may be consulted to co-manage the

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**TABLE 2.1** PERIOPERATIVE CONTINUUM

| Time period | Description |
|---|---|
| Preoperative | From the decision to have surgery to arrival in the preoperative area. Risk stratification and optimization are often requested in this timeline. |
| Day of surgery | From arrival to the preoperative area through OR, recovery, and transition to the inpatient floor. |
| Postoperative inpatient | From arrival to the postoperative floor to hospital discharge. Pathways involving protocol-driven early interventions (enhanced recovery) may be implemented in this period. This is the time period in which medical complications may arise and necessitate consultation. |
| Post-discharge | From hospital discharge through return to function. The patient's clinical course in this period, often managed by the primary care provider and the surgeon, may be influenced significantly by the quality of communication from the inpatient to outpatient setting and arrangement of appropriate post-discharge follow-up. |

patient's medical comorbidities in the inpatient setting. In one study, 59% of surgeons preferred a general medicine consultation over a focused consult [4]. The importance of clearly defining the clinical question has been underscored by study findings indicating that 14% of requesting physicians and consultants disagree about the primary reason for consultation, and that in 12% of consults the requesting physician felt that consultants ignored explicit questions [3].

### ESTABLISH URGENCY

In both the outpatient and inpatient settings, mutually agree upon an appropriate time frame for evaluating the patient and delivering recommendations—an accelerated timeline may be necessary depending on the reason for consultation (e.g., tachycardia in a patient who may be septic) or the timing and urgency of surgery. In the outpatient setting, the timing of the evaluation and recommendations largely depends upon the urgency of surgery.

### KNOW YOUR ROLE

The perioperative care of medically complex patients often involves many providers from different specialties including surgery, anesthesia, and medicine. To avoid errors and confusion for the patient, it is important for each specialty to understand their role, including the medicine consultant.

- The role of the medicine consultant is typically either a consultative or co-management role. In the consultative role, the consultant provides only their opinion which can be for a specific question or can be more general. In the co-management role, the consultant typically takes over certain aspects of the patient's care, including placing orders.
- Avoid making recommendations to referring providers in areas in which the consultant is not an expert or communicating specific recommendations to the patient that the referring provider may not choose to follow. The medicine consultant should avoid recommendations on specific types of anesthesia or surgical planning, or telling the patient the surgery will be delayed or canceled.

## TRUST YET VERIFY

Reviewing the data available in the electronic medical record and clinical impressions of the referring provider when the consult is received is vitally important for establishing background and context, but obtaining an independent history and physical exam remains critically important. Personally reviewing and interpreting outside records as well as directly communicating with outside providers such as the primary care physician or outpatient specialist(s) adds value to the consultation. Consultant-specific expertise may allow extraction of previously overlooked valuable clinical information [5].

## CLOSE THE LOOP

Communicating and documenting consistently, effectively, and clearly is crucial for an effective consultation. The principles of good communication and documentation include:

- Initial or time-sensitive recommendations are best delivered verbally to a provider caring for the patient.
- Be as specific as possible with recommendations including medication names, dosages and duration of therapy, or specific tests.
- Consultations are often densely worded and recommendations may be hard to find or confusing. A separate or highlighted section (e.g., with bulleted items) for key recommendations is a service to the referring provider. Referring providers may prefer a written consultative format in which the reason for consult, impression, and plan are presented first.
- Consultation can be a teachable moment, but whether to educate a referring provider depends upon the consultant's tact

and timing in delivery, if the referring provider is receptive at that time, and if there is need to educate.

- Avoid engaging in chart wars. As a consultant, not all of your recommendations may be adopted by the primary service. If disagreements in care arise, these are best discussed verbally rather than documented in the EMR. Using language such as "consider" may help avoid disputes.
- Consider providing concrete recommendations to address clinical scenarios which are likely to arise. Not all contingencies can or should be planned for, however, and providing plans for every contingency is unnecessary and may result in recommendations that are difficult to follow.

### FOLLOW UP APPROPRIATELY

The frequency of and need for follow-up consultation vary upon the patient's clinical status and comorbidities, recommended testing, and whether the consultation was requested for a focused question or a co-management relationship. In general, patients who need to be followed more closely include the following:

- Patients who are not improving with recommended treatment
- Patients who are at risk of complications due to their comorbidities
- Patients who have testing that requires further management
- Patients who are being co-managed

The consultant should communicate and document the follow-up plan clearly to the referring provider. In the inpatient setting, communicate whether the consultant will see the patient daily or not and clearly communicate when signing off on a patient including information of who to contact should new questions arise.

## KEY CLINICAL PEARLS

- Referring providers may prefer a written consultative format in which the reason for consult, impression, and plan are highlighted or presented first.
- Building trust over time and collaborative relationships with referring providers increases the ability to advocate for and provide high value care.
- Direct communication is vital when referring providers and consultants have discordant perceptions of the key clinical question or their respective roles in the patient's care.

## REFERENCES

1. Thompson RE, Pfeifer K, Grant PJ, Taylor C, Slawski B, Whinney C, Wellikson L, Jaffer AK. Hospital medicine and perioperative care: a framework for high-quality, high-value collaborative care. J Hosp Med. 2017;12(4):277–82.
2. Goldman L, Lee T, Rudd P. Ten commandments for effective consultations. Arch Intern Med. 1983;143(9):1753–5.
3. Cohn SL. The role of the medical consultant. Med Clin N Am. 2003;87:1–6.
4. Salerno SM, Hurst FP, Halvorson S, Mercado DL. Principles of effective consultation. Arch Intern Med. 2007;167(3):271–5.
5. Chang D, Gabriel E. 10 tips for hospitalists to achieve an effective medical consult. Hospitalist. 2015;2015(7).