Preoperative Medical Consultations in a Community Hospital

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To evaluate the practice of consultations in the community hospital, chart reviews and consultant/surgeon interviews were conducted for 85 consecutive medical preoperative consultations for patients discharged from the Surgical Service. In 78 cases (92%) the authors agreed with the need or reason for the preoperative consultation; the majority were required for the management of chronic medical problems. Continuity of care was considered important by surgeons and consultants. Verbal communication was common, particularly from surgeon to consultant. Brief response time, specific recommendations, focused evaluations, and physician satisfaction with the existing system were the rule. However, 23 preoperative consultations (27%) were judged to be deficient. Compliance with recommendations was high (95%) but other measures of consultation effect were low. Key words: compliance; consultation, surgery. J GEN INTERN MED 1987;2:89–92.

IT IS ESTIMATED that internists spend between 15 and 55% of their time performing consultations,[1] by which they provide a vital and essential service to the quality of care in hospitals. In the last decade, several studies conducted at university hospital training programs have evaluated the consultation process.[2-8] A method for measuring the quality of consultations was developed, based on compliance with written recommendations, impact on diagnosis and/or management, development of new diagnoses, and the general usefulness of recommendations. Excessive length of discussions,[2] nonspecific and excessive number of recommendations,[2, 3] poor communication,[6, 7] and confusion over reasons for consultations[7] were associated with poor efficacy. Positive correlations were found for presence of follow-up,[2-5] specific and brief recommendations,[2, 4, 5] and short response time.[5]

We report the results of our examination of the practice of preoperative medical consultations in the community hospital setting, which to our knowledge has not been previously studied. Our review was restricted to preoperative medical consultations because of the frequency of its utilization in community hospitals such as ours and because of the substantial amount of scientific data that has recently been published regarding the standards of the medical consultation in this setting.[8, 9]

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METHODS

Mount Sinai Hospital is a 379-bed teaching hospital in Hartford, Connecticut. Over a two-month period, December 1, 1984, through January 31, 1985, we reviewed all the preoperative medical consultations for patients discharged from the inhospital Surgical Service. Our study consisted of two components: chart review and consultant/surgeon interview.

Chart Review

Within a week of the patient's discharge, each consultation was evaluated in five different areas independently by both authors. Conclusions were reached jointly. Minor discrepancies in the reviewers' findings were resolved by consensus. The following areas were reviewed:

1. *Need for consultation* — We considered a preoperative consultation necessary when one of the following criteria was present: patient age >70 years (age at which surgical risk increases[10]), presence of an acute or chronic medical problem requiring evaluation and/or management, assessment of laboratory abnormalities, and need for confirmation of an illness.

2. *Quality of consultation* — The consultant's note was reviewed in the context of the data available in the chart at the time of consultation. The consultation was judged satisfactory when depth of discussion, attention to detail and recommendations were appropriate. A consultation was rated deficient when the information it contained was extraneous and unfocused, or the assessment was superficial and/or inadequate, or specific medical issues evident in the chart were not addressed (such as laboratory abnormalities, specific diseases, or medication administration). Medication administration was considered deficient when the two authors agreed that the treatment was substandard.

3. *Recommendations* — The consultants' recommendations were reviewed as to number (i.e., excessive?), type (diagnostic vs. therapeutic), and compliance rate.

4. *Consultation impact* — Impact was measured by compliance with recommendations, changes in surgical plan, or diagnosis of new problems.

5. *Need for postoperative follow-up by consultant*—We determined there was need for postoperative follow-up if the medical problems present preoperatively persisted postoperatively.

Consultant and Surgeon Interviews

An attempt was made to interview the consultant and the surgeon within a month of surgery and within two weeks of discharge of the patient from the hospital. Only those who clearly recalled the case and the consultant/surgeon interaction were included in the results. Each participant was asked:

"What was the reason for the consultation?"

"How did the consultant/surgeon communicate with you?"

In addition, the surgeon was asked about the consultant's response time and the consultant was asked whether he or she had previously cared for the patient.

RESULTS

Eighty-five consecutive preoperative consultations were identified and reviewed. Eighty (94%) of the consultants and 79 (93%) of the surgeons were interviewed. Seventy-three surgical operations were classified as elective and 12 as emergency. There were 40 general surgery cases, 17 urology, 12 orthopedic, 4 gynecology, 4 ophthalmology, 3 neurosurgery, 3 cardiovascular, and 1 each from dental and ENT services. Thirty-three surgeons (range: 1 to 16 patients per surgeon) and 40 members of the Department of Medicine (range: 1 to 5 consultations per consultant) were responsible for the care of the patients.

TABLE 1

Medical Problems Encountered by Consultants in Three or More of 85 Patients Studied

	No.	(%)
Clinical conditions		
Hypertension	36	(42)
Arteriosclerotic heart disease	23	(27)
Heart murmur	22	(26)
Diabetes	18	(21)
Arrhythmia	17	(20)
Anemia	14	(17)
Chronic obstructive lung disease	12	(14)
Urinary tract infection	8	(9)
Status post coronary bypass	6	(8)
Peripheral vascular disease	5	(6)
Seizure disorder	4	(5)
Steroid dependency	4	(5)
Rheumatoid arthritis	4	(5)
Hypothyroidism	4	(5)
Chronic anticoagulation	3	(4)
Fever	3	(4)
Laboratory abnormalities		
Electrocardiogram	43	(51)
Low hematocrit	14	(17)
Low potassium	12	(14)
Chest x-ray	9	(11)
Miscellaneous	25	(29)

TABLE 2

Reasons for Preoperative Consultation for the 85 Patients Studied

		No.	(%)
Consultation needed		78	(92)
Age > 70 years	34 (40)		
Assess chronic illness	68 (80)		
Assess acute illness	13 (15)		
Assess laboratory abnormality	59 (69)		
Confirm illness	3 (3)		
Consultation not needed		7	(8)

Chart Review

The medical problems in our group were similar to those in the general population, namely cardiovascular and diabetes-related diseases, with a disease prevalence similar to that found in a study of preoperative consultations in a university hospital[8] (Table 1). The preoperative consultations were needed most frequently for the assessment and management of these chronic medical problems (Table 2). Many patients had two or more reasons. We identified seven patients (8%) for whom preoperative consultation was not necessary according to our criteria.

For 62 patients (73%), we found the preoperative consultation to have included a detailed history and physical examination, attention to laboratory abnormalities, and appropriate therapy recommendations. No preoperative consultation was considered unfocused or found to contain extraneous information; however, in 23 cases (27%), the consultants' notes were deficient in other respects. In eight cases, the consultant's evaluation was generally deficient, lacking an adequate history and physical, or ignoring relevant clinical issues and/or laboratory abnormalities. Fifteen consultations were judged deficient in specific areas. In six cases (7%) we felt that the use of medication was not optimal. In five cases (6%) the consultant failed to address one or more specific laboratory abnormalities. In four cases (5%) the consultant failed to evaluate a specific clinical issue adequately.

The consultant made recommendations for 62 of the 85 patients. In 52 of the cases, the consultant actually wrote the recommendations on the order sheet in the chart. The recommendations were usually brief and either therapeutically or diagnostically directed: recommendations about medication were made for 52 patients, laboratory tests for 39 patients, procedures for 4 patients, and anesthesia for 1 patient.

Consultation impact was high when measured by compliance with the recommendations. In 59 of 62 cases, the recommendations were followed. Consultation impact was less using other criteria. In seven cases (8%) the consultant diagnosed a new illness not noted by the surgeon. In six cases (7%) the consultant had an impact on the surgical decision; in five cases the consultant delayed surgery, and in one case the consultant cancelled surgery and transferred the patient to the medical service.

In 68 cases (80%) we judged postoperative follow-up of medical problems to be required. In 61 (90%) of these cases the consultants followed the patients postoperatively. In 17 cases (20%) we judged postoperative follow-up not to be necessary. Of these, only four cases were followed postoperatively by the consultant. In total, of the 65 patients who received postoperative follow-up, 61 (94%) had been followed justifiably.

Consultant and Surgeon Interviews

Seventy-eight of the 80 consultants and 78 of the 79 surgeons interviewed recalled the details of the preoperative consultation. Seventy-four percent of the internists and 70% of the surgeons perceived the primary reason for the consultation as being for assistance in the management of chronic medical problems. Forty-six percent of the internists and 64% of the surgeons emphasized the continuity of prior care. In 69 of 80 cases, the consultant had previously cared for the patient. Seventy-seven surgeons (98%) felt that the response time had been appropriate and brief, i.e., less than 24 hours from admission.

Both surgeons and consultants emphasized the major role of verbal communications in their consultation process (Table 3). Only 6 of 78 consultants received any information from the chart. Although the majority of surgeons also relied on verbal communication, they received at least part of the consultant information from the chart in 63 of 79 cases.

TABLE 3

Communications Between Consultant and Surgeon Regarding the 85 Patients Studied

	Surgeon Received Information from Consultant (79 Interviews)	Consultant Received Information from Surgeon (80 Interviews)
Verbally	15	59
Verbally and through others*	0	4
Through others*	0	9
Verbally and by chart	40	4
By chart	22	2
By chart and through others*	1	0
Don't remember	1	2

*Nurse, physician assistant, desk clerk, patient's family.

DISCUSSION

Our study looked at preoperative medical consultations over a two-month period in one community teaching hospital. We do not know whether our results typify community hospital consultation practices. However, it may be that our results reflect the quality of consultations in the community hospital environment more accurately than prior studies that were uniformly restricted to academic centers.

In the majority of cases in our study the consultant had previously cared for the patient. Both consultants and surgeons emphasized continuity of care as a major factor in justifying preoperative consultations and postoperative follow-up. This is in contrast to consultations in university medical centers.

The importance of verbal communication between the consultant and the surgeon in the consultation process has been emphasized.[7] In this community hospital, interphysician communication was frequently verbal in nature and not recorded in the patient's chart.

Problems identified in university studies of excessive response time, nonspecificity of suggestions and excessively detailed histories and physicals with extraneous reference citations,[2-7] did not appear to any significant degree in our study. The response time was almost always brief and the recommendations focused on specific therapeutic or diagnostic medical management issues.

In contrast to the comprehensive approach often taken by academic consultants, we found shortcomings in the consistency of the depth and thoroughness of the written consultation. Deficiencies related to poor evaluation of patients' problems, lack of attention to abnormal laboratory and ECG findings, and lack of attention to therapeutic issues. The consultants evidently "glossed over" some aspects of the case rather than carefully "looking for themselves," a key characteristic of a good consultation.[11]

The degree of compliance with the consultant's recommendation as a method of measuring the consultation effect may not be appropriate in the community hospital setting. In our study almost all the recommendations were followed, which is not surprising since in 52 of the cases the consultant actually wrote the orders on the order sheet in the chart. On the other hand, in only six cases was surgery delayed or cancelled as a consequence of the preoperative consultation, and in only seven cases did the consultant confirm the presence of a new illness not identified by the surgeon.

Demonstrating the need for preoperative consultation may become a crucial issue in the near future. Trends towards "bundling of services," capi-

tation systems, and "MD DRGs" may radically change incentives for the practicing physician[12, 13] and necessitate proof of appropriateness of consultation. Despite the potential for overutilization in this system, our review agreed with the need for preoperative consultation in 92% of the cases, and for postoperative follow-up in 94%.

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REFLECTIONS

Sobriety and Time

ACCORDING TO EUGENE ROBIN,[1] "In the context of a specific illness, the doctor should attempt to optimize the patient's chances for as happy and productive life as possible." Most patients with the disease of alcoholism become productive relatively soon after they become abstinent. When, however, do they become happy?

During recovery from alcoholism, the initial absence of drinking is "being dry." But, as Alcoholics Anonymous says, at best, dryness is a step, a bridge to the more complex state of sobriety.[2] Sobriety is a secure and happy state, an ability to live comfortably, peacefully and joyously with oneself. Contentment, experts agree, is vital and necessary for true sobriety.

When does the recovering alcoholic become sober? It seems to us that many patients would like to know. After all, we supply prognostic information, when we can, for the other diseases we treat. Among the fears foremost in the minds of sick or newly dry alcoholics are, "When will my need to drink go away?" and "Will I always want to drink?"

We became interested in recovery time after taping interviews with an abstinent patient at three months and again at three years. The difference was remarkable; our patient had achieved sobriety within three years. Curious to know whether the time it took our patients to achieve sobriety was typical, we reviewed many articles and texts. There is no shortage of writings on the disease but extremely little on the course of recovery.[3] Vaillant proposes some answers.[4] He distinguishes early abstinence from the securely abstinent (e.g., sobriety). In his study, after three years, the securely abstinent (sober) men appeared to be functioning as well as non-alcoholics. They were unlikely to die and far more able to enjoy their survival. In their responsibility as parents, success as employees, and marital enjoyment they were comparable to men for whom alcohol had never been a problem. They had been as symptomatic and antisocial as those whose disease had continued to progress.

Although our knowledge is yet limited, it appears that contentment is desirable and may indeed be the best way to insure ongoing sobriety. It occurs gradually, probably usually taking two to three years. With knowledge of the time it takes to achieve full recovery, the physician can advise the patient, family and employer; can warn against the "quick fix"; and in partnership with other resources, can see to it that this otherwise deadly disease is adequately treated. — *Donal F. Sweeney, MD, and Peter F. McGoey, MA, Santa Barbara, California*

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