Dr. Joe Jacobson: The Consultation Process Through the Eyes of an Internist

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Joseph Jacobson, MD, trained as a hematologist/oncologist, serves as a practicing clinician, administrator, and in various quality-related roles at North Shore Medical Center (Massachusetts), Partners HealthCare, and with the American Society of Clinical Oncology. Since 2003, Dr. Jacobson has served as Chairman of the Department of Medicine for North Shore Medical Center.

Forum: What is the primary role of consults?

Dr. Jacobson: Medical consultation is the embodiment of the spirit among physicians to share their knowledge and experience with their peers, whether it is undertaken as a formal process or as an informal dialogue. To guarantee safe patient care and preempt medical legal consequences, it is important to be thoughtful and deliberate, and always to be aware of the limitations and flaws of human communication.

A "curbside" consult is an informal recommendation for managing an individual patient, based on a limited data set. It is completed without access to the patient and, usually, without access to the medical record.

Have you noticed a change in the volume of curbside consults?

Physicians are under greater time constraints now and consequently have less opportunity to interact as peers, so the face-to-face curbside consult occurs less often. But what has increased, I think substantially, are e-mail curbside consultations.

Has your hospital taken any kind of a stand on the timing or nature of consults?

A Partners HealthCare initiative focuses on improving the quality of consultations provided in emergency departments. Through a CRICO-sponsored project, we have begun to address the problems associated with obtaining high quality consultations. Basic elements of emergency department consultations are now being collected, with the results provided regularly to departmental and subspecialty leaders.

What do you see that concerns you?

We could all do a better job communicating. For instance, requesting physicians should always be explicit about defining the indications for, and the goals of, the consultation. Likewise, the consultant's note should reflect the indication for the consultation and should include clear-cut and explicit recommendations. Some or all of these elements are often lacking.

Since few of us receive formal training in how to perform a consultation, styles and content vary enormously. That lack of standardization limits the value of consultations. Some physicians consistently create consultations that are explicit; others write in a more meandering or narrative style which often lacks a well-defined assessment and clear-cut recommendations.

Are hospitalists being asked to provide more consultations for surgical and ED patients, knowing that a surgeon will be asked to evaluate them in the morning?

Early on in the five-year history of hospitalist medicine at NSMC, the hospitalists were routinely asked to admit patients with conditions that were outside of their comfort zone. It was not uncommon for orthopedic surgeons to ask them to admit patients following a fall with a fracture. It was also common for surgeons to ask for patients who had unexplained (potentially surgical) abdominal pain to be admitted to the medical service, or for them to request the ED physicians to admit other patients with injuries, including head trauma, to the hospitalist service.

By accepting such patients, it turns out we were doing them a disservice—we put them at risk for poor care and exposed the hospitalists to legal risk. To overcome that problem, NSMC established clear-cut guidelines to be used to assist the ED physician to assign the patient to the correct service. Guidelines now direct the assignment of ED patients to various services including hematology/oncology, cardiology, general surgery, orthopedics, urology, and trauma. Since the adoption of these guidelines, NSMC has perceived a marked improvement in the proper assignment of admissions to subspecialty services. That is not to say that hospitalists are not put under pressure now and then to admit an inappropriate patient; the guidelines, though, have empowered them to decline a patient when the admission is in conflict with established policy.

Do you think physicians are requesting more formal consults these days just as a means of protecting themselves from being named in a medical malpractice claim or suit?

It is the perception of many subspecialists that the number of inpatient consultations has grown markedly along with the hospitalist program over the past five years. This perception may be due more to the young age and in experience of many of our hospitalists rather than a conscious concern about malpractice risk.

Is help on the way for physicians trying to coordinate patient care among multiple providers?

Yes. Most of our PCPs and more than 50 percent of our specialists and subspecialists now share a common (Partners) electronic health record. It is an extraordinary advance for us, creating a common medical platform so that subspecialist notes appear side-by-side with that of the PCP. There is a joint responsibility to maintain a common problem list and participate in medication reconciliation. ■