Risks Associated with Specialty Consultation in the ED

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Why focus on specialty consultation in the emergency department (ED)? Listen in on a typical sign-out rounds.

The patient in Bed 1 has a new facial droop and difficulty speaking. In conjunction with the stroke team, we have given thrombolytics. The patient in Bed 2 has a severe sore throat with a fever and has been diagnosed with epiglottitis after a fiberoptic nasopharyngoscope exam. We've called ENT, and they will admit and observe the patient in the ICU overnight. The patient in Bed 3 came in with a week of on-and-off chest pain. His ECG is unchanged, and a six hour troponin is normal. Having discussed the case with his cardiologist by phone, we will discharge him to get a stress test later this week…

Although board certified Emergency Medicine (EM) physicians are highly trained specialists in emergency care, the safe practice of emergency medicine involves collaboration with almost every other medical specialist. Approximately 25 percent of patients in an academic ED, and 10–25 percent of community ED patients, will receive some kind of consultation.[1] Such patients are often at high risk or critically ill, and frequently need time-sensitive interventions.

A recently published review of ED malpractice closed claims from CRICO and several other insurers identified failure to consult as one of the top five themes.[2] "Failure to consult" included failure of trainees to consult with more senior physicians and failure to order either an immediate consultation in the ED or an appropriate outpatient referral. Yet, the process of specialty consultation in the ED has been largely unexamined in the literature and remains unstructured in many hospitals.

Early in 2008, the leadership of the Harvard Medical School Division of Emergency Medicine identified standardization of ED consultation processes, particularly communication and documentation, as an important area for improving patient safety. Soon after, a year-long consultation improvement project was begun at seven CRICO-insured acute care hospitals. The project was designed to identify essential elements of an "ideal" consultation, characterize current performance, and identify improvement strategies. Methodology included a structured medical record review, a survey of EM physicians and consultants, and meetings at each hospital to better understand providers' perspectives and potential barriers to effective consultation. Data from the prior six months were the basis of monthly performance reports for key services at each hospital. Throughout the project, these reports have served to facilitate discussions about developing standardized policies for consultation as well as strategies to improve consultation at each hospital.

Several important themes have emerged from the CRICO-sponsored project. First, it is important to have clearly defined communication at the beginning and end of a consultation. This includes an initial question for the consultant and two-way communication (verbal or in-person) between the EM physician and the consultant at the completion of the consult.

Second, recording the time of consult initiation and completion, and establishing standards for response timeliness, is important to patient safety. Prolonged stays in crowded EDs adversely affect the quality of care for patients requiring consultation and also for those who are in the ED reception area, waiting for an available bed. Finally, in academic centers, providing reliable, high quality consultation requires appropriate supervision of trainees.

Two-Way Communication

Two-way communication is the best way to reduce interpretation errors, as it allows both the EM physician and the consultant to ask questions. During the CRICO/RMF project, two key aspects of such communications were identified:

1. The EM physician should clearly state the reason for consultation, either in the form of a question (Did Ms. J have a stroke?), or as a specific task for the consultant (Assist with reduction of unstable elbow fracture.), and the consultant should clearly communicate recommendations back to the EM physician.
2. The EM physician and the consultant should communicate verbally at the completion of the consultant's evaluation. This allows both parties to ask follow-up questions and can reduce delays associated with composing, transcribing, and finding a written note.

A potential mechanism of facilitating two-way communication is to standardize consult notes to include prompts for communication. A prompt for the explicit "reason for consultation" at the top of a paper or electronic form would encourage the EM physician to state the reason. A check box at the bottom of the note indicating discussion between the EM physician and the consultant with a line for the consultant to write the name of the EM physician with whom he or she discussed the case would prompt two-way communication at consultation completion. An IT system that links paging to clinical notes could seamlessly integrate these prompts into the physician's workflow. For example, it could import the clinical question into the consultant's note and generate a prompt to speak with the EM physician at the completion of a consult.

Timeliness

In the context of heavy workloads, both in the ED and among the various consulting services, timeliness matters. Unfortunately, consultation notes often lack significant information about the times at which events occur. Consult request, consultant acknowledgement, and evaluation completion (closed-loop communication between the EM physician and the consultant) are critical time stamps for ED operations. The most effective means of ensuring that times are recorded is to use an electronic consult request-and-response mechanism that pages the consultant, records when the consultant responds, and notes the time when the consultant signs off the consult as complete. If an ED does not have such a system, handwritten documentation in the medical record is acceptable.

Supervision

At academic sites, a resident or fellow is often the initial person to perform the consultation. Supervision of the trainee during the consult varies from in-person evaluation by an attending, to a phone call between the trainee and the attending, to no supervision. Supervision policies establish standards for trainee-attending communication about each consultation, (ideally) ensuring that the trainee has the appropriate backup for the case, and the EM physician requesting the consultation can have confidence in the consulting service's decision making.

A common practice is for consulting service attending physicians to rely on trainees to make independent assessments and decisions, and to call only for "difficult" cases. Unfortunately, in some circumstances, the trainee may lack the experience to recognize when he or she needs assistance or may be less likely to call for backup (if this is considered optional), as doing so might be perceived as a sign of weakness or lack of independence. Institutional policies should clearly establish a consistent and objective standard for trainee-attending communication that accounts for patient and ED needs, as well as trainee experience and education level. One way of achieving this is to use a consultation note template that includes a field for "discussed with consultant attending," a blank for the attending consultant's name, and the date and time of the discussion.

Informal Consults

Informal or "curbside" consultation frequency varies from 17-30 percent across the seven CRICO-insured EDs.[3] These informal events are not routinely documented in a standard fashion either by EM physicians or consultants. When they are documented, it is often the EM physician who documents a conversation in the chart, and the consultant is frequently unaware that he or she is cited. This practice poses significant medico-legal risk to both parties. Informal consults may affect quality of care because consultants perform a less comprehensive assessment during informal consults than they do for standard consults and may feel little, if any, responsibility for the quality and thoroughness of their assessment or recommendations.

Regardless of these obvious defects, EM physicians often act upon these "informal" recommendations. Despite their established practice, informal consults are better avoided, as they have the potential to jeopardize patient safety and carry significant liability risk due to the lack of supporting documentation. Appropriate communication between the EM physician and the consultant includes whether the EM physician will document the discussion in the patient's medical record irrespective of whether it is a full or limited consultation (for example, a telephone call regarding the decision to admit a patient or arrange discharge with outpatient follow-up).

Hospitals enhance patient safety by defining standards for when informal consults are acceptable (e.g., discussion about a specific ECG finding with respect to the need for urgent catheterization, or personal review of an imaging study with an attending radiologist). Effective standards address documentation protocols for informal consults. For example, standards could specify that consults should either be documented by both parties or should only address information that is not specific to a patient (e.g., "what is the best way to get early follow-up care for a patient with a foot fracture?")…and not be documented.

Variable/Unclear Standards

Many hospitals lack clear standards for any consultations, lack standards for ED-based consultations, or have standards that are unenforced. Clear standards, particularly around the above principles of two-way communication, supervision, timeliness, and informal consultation are essential. The most effective standards are those developed locally to account for the unique issues of different consultant services while prioritizing the care of the ED patient. ■

References

1 Unpublished data

2 Kachalia A, Gandhi TK, Puopolo AL, et al. Missed and delayed diagnoses in the emergency department: a study of closed malpractice claims from 4 liability insurers. *Ann Emerg Med.* 2007;49(2):196–205.

3 Unpublished data