

Conquering Consultations: A Guide to Advances in the Science of Referral-Consultation Interactions for Residency Education



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Consultations with specialist services occur with regularity in the emergency department (ED). Emergency physician interactions with consultants in the ED offer an amazing opportunity for collegial patient care but can also present a number of challenges. Navigating the consultation process requires effective communication skills that are considered a core competency within the Accreditation Council for Graduate Medical Education, as well as the CanMEDS frameworks of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada. Because of time pressure, environmental complexities, patient acuity, and the fast pace of the ED, learning this skill can be challenging for trainees and is something many attending physicians will struggle with at times. It has been established that trustworthiness and familiarity are 2 key components within the referral-consultation process. Both components rely on reputation, which creates a challenge in a training environment in which one's knowledge base and clinical acumen is a constant work in progress. Moreover, poor communication contributes to problematic patient care and decreased patient satisfaction. Knowing this, we believe it is imperative that residents be formally trained in this important skill. In this article, we introduce and highlight the most recent advances in standardized approaches to the referral-consultation process, including the 5C (contact, communicate, core question, collaborate, close the loop), PIQUED (prepare, identify, question, urgency, educational modifications, debrief), and CONSULT (contact courteously, orient, narrow question, story, urgency, later, thank you) models. Common roadblocks and complicating factors involved in resident-consultant interaction are also reviewed, ending with best-practice recommendations for consultants involved in resident education, as well as free open access medical education resources. [Ann Emerg Med. 2019;74:119-125.]

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INTRODUCTION

As a learner, initiating and engaging in the referral-consultation process can be anxiety provoking. Emergency physician interactions with consultants in the emergency department (ED) offer an amazing opportunity for collegial patient care but can also present a number of challenges. It has been established that trustworthiness and familiarity are 2 key components within the referral-consultation process.¹ Both components rely on reputation. However, establishing trust and familiarity can be particularly challenging during residency because one's knowledge base and clinical acumen is a constant work in progress and the trainee pool continuously changes.

In the ED, consultations with colleagues occur regularly. When multiple providers are involved in clinical care, communication can become problematic. Interpersonal skills, power dynamics, and collegiality can have a major influence on interactions between providers. In fact, because of time pressures, environmental complexities, patient acuity, and the fast pace of the ED, effective communication is arguably even more critical in emergency medicine than in other areas of medicine.^{2,3} The main goal

of clinician communication is delivering care that leads to favorable outcomes for patients.⁴

When health care communication is discussed, it is impossible to ignore the concept of handoffs. Although consultation and handover of care are similar, they are not the same entity. Handoffs involve a transfer of care, whereas consultations in the ED involve an emergency physician speaking with another physician about ongoing patient care or intervention, or asking for advice.⁵ One recent study examining handoffs of care from an emergency physician to an admitting service found that only one third of admitting physicians experienced consistent, meaningful, in-person communication with the emergency physician, and most respondents admitted feeling distracted during handoffs because of competing clinical duties.⁶ Although handoffs and consultations both require effective communication, handoffs are beyond the scope of this article and will not be reviewed further.

Poor communication contributes to problematic patient care and decreased patient satisfaction.⁷ Furthermore, ineffective communication and lack of standardization can lead directly to inefficiency⁸ and harm to patients,

including increased morbidity and mortality.⁹ In the era of competency-based medical education, communication has become key in the competency frameworks of the Accreditation Council for Graduate Medical Education in the United States, as well as the CanMEDS frameworks of the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.¹⁰⁻¹² Even so, few emergency medicine residents receive formal training on the consultation process during their residency programs.^{2,9,13}

Beyond residency, good communication between all members of a patient's care team is critical to providing safe and effective care. This extends to the referral-consultant relationship, in which physicians must effectively work and communicate with many disciplines and must display refined communication skills to integrate and convey clinical recommendations and patient assessments that affect management.⁴

This article will focus on the referral-consultation communication process in the ED, beginning with types of consultations, standardized approaches to the consultation process, the social phenomenon, teaching the consultation process, and best practices for consultants. We anticipate that this will be a useful resource for emergency medicine residents, residency program leadership, and consultants wanting to refine their teaching skills during the consultation process.

TYPES OF CONSULTATIONS

Consultation is defined broadly as an interaction between 2 clinicians in which a question is asked of the consultant, a relationship with the patient is established by both parties, and recommendations are communicated.¹⁴⁻¹⁶ However, this broad definition encompasses multiple scenario types that differ in their urgency and the type of assistance requested. Four types of consultation in the ED have been described: critical intervention (eg, management of acute stroke), procedure request (eg, complicated fracture reduction), in-person evaluation and management (eg, advice on diagnosis and management), and remote evaluation and management (eg, teleconsultation).¹⁴ Each scenario has unique characteristics that affect the behavior of both parties involved in the consultation. Although current research on the factors affecting consultation does not distinguish between different types of consultation, the recognition of consultation subtypes will be an important component of future research.

STANDARDIZED APPROACHES FOR INITIATING CONSULTATIONS

Requesting consultation is a critical step in the consultation relationship, which has an effect on subsequent interactions between the consultant and

requesting clinician.¹⁷ Therefore, enhancing the quality of consultation requests may have a positive effect on consultation interactions. There are several innovations that have attempted to address this issue. One of the first emergency medicine–derived consultation formats was proposed by Go et al.¹⁸ They created a work sheet that provided structure to the consultation requests made by medical students during their emergency medicine clerkship.

Three more contemporary frameworks have been proposed for approaching the referral-consultation process: Kessler's 5Cs (contact, communicate, core question, collaborate, close the loop), Chan's PIQUED (prepare, identify, question, urgency, educational modifications, debrief) approach, and Podosky's CONSULT (contact courteously, orient, narrow question, story, urgency, later, thank you) mnemonic. The contents of these mnemonics can be found in the [Figure](#), and free open access medical education resources with further details can be found in the [Table](#). A fourth framework blends the PIQUED and 5C approaches.

Derived in 2012, the 5Cs model has the strongest evidentiary basis behind it for improving the quality of consultation requests and communication.^{19,20} Kessler et al²¹ conducted a randomized controlled trial that involved third- and fourth-year medical students completing an emergency medicine rotation. There were 3 groups: control, live training intervention, and asynchronous training, which involved an online didactic curriculum. They found a significant difference in students' mean total 5C checklist scores when comparing control versus live or online training sessions. This model had previously been validated in a simulation environment.²⁰

A 2013 study by Chan et al²² set out to define the key elements of an ED consultation request and sought out residents as part of the answer. Residents and attending physicians from emergency medicine, internal medicine, and general surgery were interviewed in a focus group or one-on-one, respectively. The findings of the study led to the development of the PIQUED approach to the referral-consultation process. This approach was based on the 4 key components of the referral-consultation interaction and the 2 modifiers as agreed on by the group.

Perhaps the most novel component of the aforementioned study is in the modifier titled "educational modifications." Within this modifier is the suggestion for teaching around the case, supervision by the emergency medicine attending physician, and teaching from the consulting physician to the junior learner.²²

Kessler et al²³ have also proposed a blended model that combines both the 5Cs and PIQUED models.

COMPARING CONSULTATION MODELS

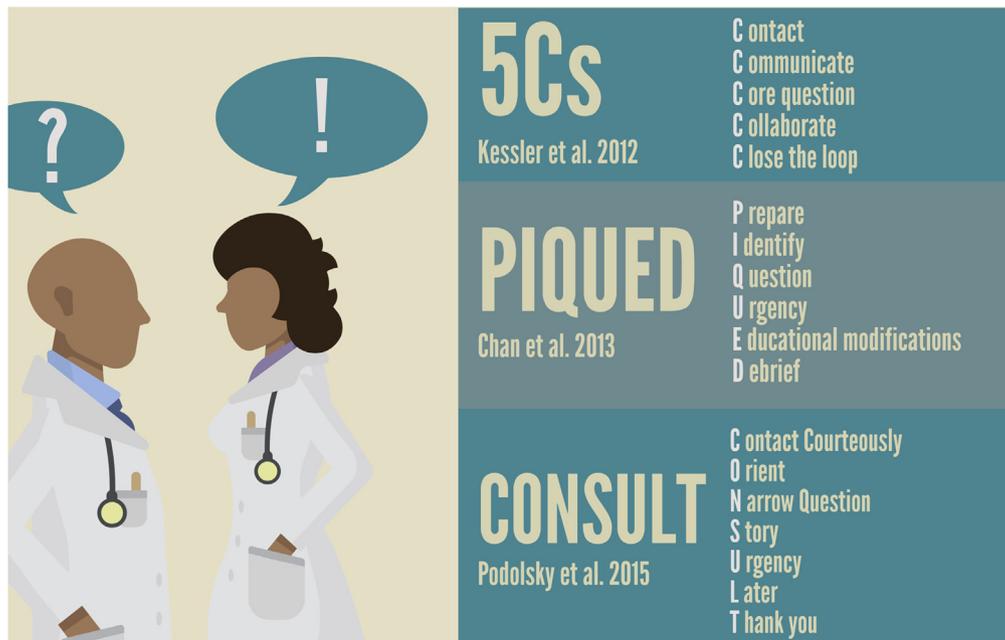


Figure. The 5C, PIQUED, and CONSULT frameworks for the referral-consultation process.

Most recently, in 2015, Podolsky et al²⁴ published an article on their CONSULT framework. They found that this approach was feasible after a 1-hour educational session and that it was acceptable and beneficial to residents. This model emphasizes cordial behavior with colleagues, something that is important, considering recent evidence from the literature that rudeness can affect the performance of teams in a simulated resuscitation.²⁵

In regard to enhancing teaching during consultation, Gupta et al²⁶ developed a model that resulted in increased in-person communication and teaching between interns and fellows involved in consultation. This 4-step model consisted of choosing a specific question for the consultation, requesting in-person discussion about the consultation, interns asking the fellow at least one question during the consultation to stimulate teaching, and interns reporting one point they learned from the fellow during rounds.

THE SOCIAL PHENOMENON

Interactions between consultants and providers requesting consultation are complex, and an understanding of the barriers and facilitating factors involved is critical to improving the consultation process. Several factors have been identified as conflict-producing

themes in the consultation process. Studies by Chan et al¹⁶ have noted bad or unknown reputation, poor communication, disagreeing with the plan of care, providing inappropriate care, failing to collaborate, and external stressors as conflict-causing themes, whereas trust and familiarity were the 2 main themes likely to positively influence the referral-consultation process.^{1,17} Of particular note was the perceived time stress on the ED as an external stressor, which was a factor for emergency physicians, consulting physicians, and residents.¹⁶ Both trust and familiarity require cultivation of a social reputation with consultants. Familiarity can be built through shared experiences, repeated interactions, and rotation through other services.¹ Trust can be more challenging to develop because the 3 main aspects of trust building—expertise, reputation, and reliability—require time to construct.¹ For this reason, it is imperative that educational programs for residents involve consultant physicians, whether through live teaching, simulation, or asynchronous modalities.

Consultative practices can shift over time within the ED, and these patterns can be analyzed for potential identification of areas of weakness in ED referral-consultation interactions.²⁷ Such initiatives could be further used to build interdepartmental trust in the referral-consultation process.

Table. Several key resources for teaching and assessing consultation skills in emergency medicine, broken down by topic.

Citation	Method	Pros/Cons
Resources reviewing 5C and PIQUED methods for structuring the referral-consultation interaction		
Golden and Carter ³⁸	Based on Kessler's 5C method. Derived from staff emergency and subspecialty physicians. Validated in resident and medical student populations.	Pros Includes video examples. Has a printable pocket card. Cons Limited content on becoming an effective consultant. Does not address how to learn from the consultation process.
Chan and Thoma ³⁹	Reviews Kessler's 5C and Chan's PIQUED models	Pros Crowd-sourced suggestions, including from consultant physicians. Deals with how to handle the difficult consultation. Case based, making it easy to relate to. Cons Specific to 2 models/frameworks.
Luckett-Gatopoulos ⁴⁰	Reviews Chan's PIQUED method	Pros Provides specific lines one can try in each category. Cons Uses only 1 framework.
Resources for assessing or evaluating trainees in learner-consultant interactions including simulation		
Chan and Sherbino ⁴¹	Work-based assessment sheets to be used for assessing competency. Can be used for assessing consultation skills in person or in simulation for residents.	Pros Evidence based and derived in multiple centers including resident and staff physicians. Provides a general framework through which to assess competency. Increases formative feedback through direct observation. Cons Not specific to the learner-consultant interaction. Requires staff physician time and buy-in.
Baylis ⁴²	Case designed for use in a simulation laboratory setting with a consultant as a confederate. Aimed at the junior resident level.	Pros Brings the consultant into the process as a confederate. Allows deliberate practice of consultation skills. Can be adapted to use any consultation model. Cons Requires simulation infrastructure and expertise. Uses only a single scenario that requires a procedural consultation.
Resources for handling the difficult referral-consultation interaction		
Orman ⁴³	There is no specific consultation method focused on in this resource. Instead, it is an excellent discussion about how to handle difficult consultant interactions. This is a resource for the senior resident or staff physician.	Pros Provides useful insight into very challenging scenarios. Cons Does not provide a specific framework and therefore is likely to benefit more senior learners and staff.

TEACHING CONSULTATIONS: FROM IDEAL STATE TO ANTICIPATING COMMON ROADBLOCKS AND BARRIERS

Several groups have called for an enhanced focus on teaching consultation skills in emergency medicine training programs, including the Society for Academic Emergency Medicine, whose 2012 consensus conference article

examined how this core skill could be assessed alongside many of the other interpersonal and communication skills mandated by the Accreditation Council for Graduate Medical Education milestones.⁸

Any curriculum based on ED consultations will likely benefit from a thoughtful integration of both the basic components and then more advanced concepts. As with

any interpersonal exchange, conflict is likely inevitable. However, mitigating conflict within the ED consultation-referral process may be possible,²⁸ and understanding the underlying social phenomenon may help with a trainee's understanding of how he or she might navigate the complicated interpersonal and power-dynamic-related processes that govern the ED consultation process, especially at a major teaching center.^{1,28,29}

As such, although the aforementioned models of teaching trainees to communicate consultation requests may be a good starting point, they may not be sufficient for creating a solid foundation for success when trainees enter the clinical environment. When this skill set is taught, designing curricula to integrate components that can prepare trainees to assess issues related to trust, power dynamics, and other overlying cultural phenomena may better prepare them to transition from a classroom or simulation laboratory to the real ED. Ex vivo simulation exercises can be a great way to discuss and explore perceptions that consulting services have of consultants and vice versa.¹⁷ Appendix E1 (available online at <http://www.annemergmed.com>) contains several role-play scenarios for use in a discussion group or simulation setting. Addressing perceptions and creating empathy from both sides may be of critical importance in fostering collegiality and improving interdisciplinary relationships.

In an effort to ensure that we provided free open access medical education resources for educators interested in this topic, we conducted our own search of the relevant online sources and augmented it with an open call on Twitter to ask for recommended resources. A selection of these resources is shown in the Table.

BEST PRACTICES FOR CONSULTANTS

In the ED, emergency physicians and residents sometimes have to act as consultants to others. For example, an in-patient service might request a consultation for a procedural sedation, an admitted patient who has not left the ED and acutely decompensates may require critical care, and a primary care physician may refer a patient from the clinic to the ED. Additionally, emergency medicine residents spend a large amount of time on "off-service" rotations. Most physicians have at some point experienced difficulties when requesting consultations, so it is extremely important to act collaboratively when in the consultant role.

It is important to remember spectrum bias when in a consultant role.^{30,31} For example, for the physician surrounded by chest pain patients on the cardiology ward, most of whom have acute coronary syndromes, it could be easy to slip into a dismissive attitude when someone refers a

patient with atypical chest pain. Remember that the referring physician would not have called if he or she were not worried about the patient. Many assumptions can be made on either side of the conversation, often driven by fatigue and feeling overwhelmed.

For individuals teaching off-service trainees, it may be useful to introduce some concepts involving how to act as a good consultant as well. Several studies have focused on consultant best practices that highlight several common elements.^{17,32,33} Agreeing to help as early as possible during the consultation request is a critical step that can change the conversation from one of negotiation to examine the patient to a collaboration on patient care. Such an approach also limits the perception of push-back (defined as a reluctance to perform the consultation) on the part of the requesting provider, which is a major barrier to building trust and familiarity. Direct communication, particularly in-person communication, increases consultation efficacy, facilitates teaching and learning, and also helps to develop trust and familiarity. Finally, teaching during consultation can have far-reaching benefits for learners, consultants, and patient care.³⁴ A number of curricula have been shown to improve fellow teaching skills, an effort that can also enhance the teaching skills of future faculty.³⁵⁻³⁷

LIMITATIONS

This article is intended to be a practical review of the latest evidence in referral-consultant interactions aimed at emergency medicine residents, program leadership, and consultant physicians. As such, it is limited by a lack of detailed discussion of how to handle difficult referral-consultant interactions. However, we have constructed several role-play scenarios that can be used to begin to explore difficult referral-consultant interactions (Appendix E1, available online at <http://www.annemergmed.com>). Most of the frameworks for learning the referral-consultation communication skills are aimed at residents and do not directly address consultation discussions between attending physicians, which may have different elements at play.

FUTURE DIRECTIONS

It is well known that breakdown in communication is linked to adverse patient outcomes. However, there is a lack of literature connecting a rigorous approach to the referral-consultant interaction (eg, 5C, PIQUED, CONSULT) and patient outcomes. Future research should attempt to study these frameworks with patient outcomes in mind. As mentioned previously, further research should

also be conducted to investigate the factors at play in each of the 4 types of consultations separately. Lastly, researching consultation communication strategies specifically for interactions between attending physicians would add to the current body of literature.

CONCLUSION

There are several methods for referral-consultant interaction in the literature, including 5C, PIQUED, and CONSULT. We recommend choosing a method based on experimenting with each one and incorporating it into the clinical and simulation setting. As with many concepts in medicine, the art of effective communication in the referral-consultant interaction is best learned by doing. This takes the form of selecting a rigorous approach and practicing it repeatedly.

Emergency physicians and residents probably have the most experience on both sides of the referral process and as such need to be experts in this important skill. Before calling a consultant, try to anticipate what he or she would do next and do not call until the patient is at that step. Do not tell consultants what to do. Anticipating what they would do and being collaborative with their plan goes a long way to providing high-quality, efficient care for your patient. The better the case is presented, the more likely trustworthiness and familiarity will be built for future interactions. Additionally, consultants will be more likely to teach tactfully to improve knowledge and expertise in regard to the case in question.

Understanding the interpersonal factors that underpin the art of consultations and referrals can help to improve these experiences. With greater attention to both the art and the science of focused interpersonal and communication skills, residents can improve patient care and their own experiences in the work environment.

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