(Patient details)

FIRST SENTENCE
- S - Sex
- A - Age.
- S - Social statement - Something relevant & interesting
- P - Past history - only what's relevant
- O - Onset of the problem - Acute, chronic etc.
- P - Presenting problem

Notes on how to become a good consultant

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Actual teaching of the process and method of consultation have often been ignored in many American training programs. The skills required for effective consultations are too often assumed to be obvious or not worthy of actual instruction or even discussion.

Problems with the current educational system in U.S. academic centers

- Bad consultations are common
- Junior staff (residents) initially see many or most consultations; attending physicians usually get information second hand. In many cases. attending physicians spend only a few minutes with the patient and never meet the family.
- Follow-up of the patient is often erratic and unpredictable. In many cases the attending physician never sees the patient following the initial consultation.
- Communication between consultants and referring doctors is often poor or nonexistent.
- Conflicts between physicians related to management are often unresolved
- Outpatient follow-up by consultants is usually non-existent or poorly coordinated and erratically planned
- Residents and interns often do not learn how to properly use consultants. Few senior staff teach junior staff *how* and *when* to consult and *what* to expected from a good consultation (because, often, the consulting senior physicians actually doesn't know how to be good consultant).
- Consultation is often perceived as an inconvenience for the consultant.
- Personnel relationships in most teaching centers are short-term
- Residents, rather than senior staff are often each other's role models.
- There are few or no consequences of a bad consultation and if there are bad consequences, the senior staff don't care.
- Criteria for consultations that are requested are frequently vague, inconsistent and often not logical.

Consultation skills

- Are life-long assets
- Are directly related to teaching skills
- Are fundamental to the education of specialists
- Are easily taught as part of daily clinical activity
- A formal consultation is the ID specialists procedure and professional lifeline

Characteristics of successful consultants:

Successful consultants have

- Respect of nurses, aides, students and ancillary personnel and even administrative personnel. This respect is earned by hundreds and thousands of daily interactions
- Skill in diagnosis and therapy
- A professional demeanor (dress, speech, etc) and good manners
- Availability
- Enthusiasm for their work
- A wide circle of referring doctors
- A "reputation"
- Good communication skills (oral and written)
- A practical and logical approach to solving big and small problems
- Good bedside manners.

The Consultant's Dilemma: Sometimes it is not possible to make all three parties in the consultation "triangle" (the consultant, the referring doctor and the patient) happy. When the triangle becomes a "quadrangle" (ie. involves other specialists) things can get even more difficult

Solution to the consultant's dilemma: In general when there is conflict involving the consultation triangle, the referring doctor is low person on this totem pole; the patient usually but not invariably occupies the top position. A few simple rules are useful:

- Always tell the truth
- The patient is more important than the referring doctor.
- Doing right is more important than making everyone happy
- When consultants are in conflict the "Captain of the Ship" has the authority to decide upon the course taken.

In the vast majority of cases, all parties in the consultation triangle or quadrangle can end up satisfied after a consultation..

General principle #1: The style and content of a consultation should be directed by the primary or secondary reasons for consultation. The length, style, content and focus of a consult should be directed at the reason for consultation.

Reasons for consultation

- Don't know what is wrong or what to do
- Know what is wrong, but don't know what to do
- Know what is wrong and what to do, but want confirmation or reassurance
- Doctor v doctor dispute (often one of the doctors is another consultant)
- Doctor v patient or the patient family (dispute or misunderstanding or lack of confidence)
- Medical-legal issue or problem

- Angry patient or angry family (bad outcome has occurred or is likely)
- Long complex case; everyone is tired, need a fresh review
- Hopeless case
- "Fascinoma"
- Technical procedure required/requested or a restricted drug is needed
- Treatment failure after a presumed diagnosis
- Follow-up of previous consultation (readmission)

Communicating after consultation: Give these issues proper consideration:

- How – oral, written (chart, letter, e-mail)
- When – immediately or not
- Who – primary doctor or surrogates? Other consultants?

Common mistakes

- Missing the point of consultation
- Not answering the primary questions(s) of the referring doctor
- Not explaining or clearly outlining an assessment and plan. Such plans should be concise, clear, and realistic
- Seizing control without a mandate (Alexander Haig approach)
- Loose talk (even if you think no one important is listening) It is also possible to negatively communicate without talking (facial expressions, sighs)
- Rigid attitude (the quality of one's compromises may be more important than the correctness of one's opinion) life and medical care are negotiations. Imagination is sometimes required in devising a management strategy.
- Overstaying your welcome
- Lack of follow-up
- Straying into someone else's bailiwick
- Poor manners with patients or staff (see loose talk above).
- Not clearly explaining your role to the patient (or the patient's family)
- Failing to strengthen (or actually hurting) the primary doctor's relationship with the patient (see loose talk above)
- Poor communication: writing too much or too little or not clearly writing or communicating yourrecommendations

Useful tips

- Write legibly with style and brevity. Simple declarative sentences are best.
- Contingency plans are generally good (e.g. if test A shows result B, then we will do C; if test A shows result D, then do E and F)
- Commit yourself to a diagnosis whenever possible, e.g. HAVE AN OPINION.
- If you plan to see a patient intermittently in follow-up, document when you are coming back.
- When you aren't sure what is wrong or what to do, start by stating what you do know and what things do not need to be done.

- Often it is best to state the obvious don't overestimate people's ability to assume they know what you are thinking (or not saying).
- Be honest and humble; patients and other doctors know honesty and humility when they see it or don't see it.
- Note in the chart what you told a difficult patient or family member. Direct quotes are often good.
- HOW YOU SAY SOMETHING IS AS IMPORTANT AS WHAT YOU SAY
- Explicitly educate the patient that you are a consultant
- When faced with a disagreement in management (between patients and doctors or doctors and doctors) outline the available options, give your ranking of choices and then let the primary doctor(s) decide
- When in doubt about how much to do, discuss it with the referring doctor.
- When multiple consultants are caring for the same patient state in writing what you plan to manage or advise upon if there is any chance for confusion.
- Don't mindlessly record lab data in your notes; interpret it if you mention it.
- It is not usually necessary to parrot the entire history and physical, especially those facts or issues that don't relate directly to your task at hand
- Rule of thumb: the more consultants, the less you should write
- Communicate with the referring doctor about any plans for office follow-up visits. DO THIS IN WRITING.
- When you can't help the patient or the referring doctor, sign off
- Don't embarrass the referring doctors. When they have the right diagnosis make sure that the patient and the referring doctors know it. When they have the wrong diagnosis, be diplomatic. (It is often possible to be both diplomatic and honest)
- It is possible and sometimes useful to carry on a dialogue in the chart (i.e. pose questions, propose answers, arrange meetings, stimulate discussion and push for resolution of unresolved issues).
- Avoid the passive voice in your writing
- Try to develop some style in your writing.
- Keep track of your ego: too much is bad; so is too little
- When a consultation leads to conflict or even vague "bad vibrations", talk directly to the primary referring doctor and discuss it.
- Smile when ever possible; nobody likes working with grumps
- Be enthusiastic about your work: people often have the wrong-headed notion that consultation is an inconvenience.
- Educate whenever possible but don't be a pedant