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Consultations: A Modest Proposal

When a consultation is requested for a patient in the emergency department, the attending emergency physician is usually seeking an experienced specialist to quickly provide expert care beyond the EP's scope of practice. The timely availability of such consultations in all EDs has been a focus of EMTALA regulations since this federal law was first instituted, and has remained a concern through all of its subsequent revisions.

In teaching hospitals, requests for consultations on the inpatient services typically are from residents and the responses, in turn, usually come from other residents. Because an inpatient may remain in the hospital for hours or days after a consultation, the attending physician assigned to the consult service is able to see the patient later on rounds and review the care and recommendations. Also, there are opportunities for the consult service to follow the patient's progress until discharge.

But in emergency departments, requests for consultations are usually made or directed by attending physicians, and the sometimes awkward nature of interactions between an attending from one service and a resident from another is only one of the many problems associated with ED consults. Though frequently not for life-threatening emergencies, the consultations may be the only thing preventing ED patients from being discharged. When the consulting resident is also responsible for inpatient care, clinic patient evaluations, and/or assisting in the OR, the competing demands for the resident's attention often result in increased lengths of stay and decreased satisfaction for ED patients, and frustration and anger for everyone.

At a time when the availability of residents to perform needed clinical services is shrinking drastically due to work hour restrictions, it is commendable that so many teaching hospitals are now trying to deal with consultation issues by establishing meaningful standards of care. I recently reviewed ED consultation policies in teaching hospitals throughout the country and found that most attempt to deal with the rapidity of response, the postgraduate training level of the responder, and attending supervision and responsibility; some also address the need for follow-up and continued care. Typically, the specified response time varies from 30 minutes to 4 or more hours, and the required postgraduate training level begins with PGY-2 (with the words "if possible" sometimes added), but few policies specifically delineate the nature and degree of attending supervision and follow-up.

I humbly propose that emergency department requests for consultations always result in some type of immediate response during which the EP and consultant can discuss the problem, any additional diagnostic studies necessary, and the appropriate time to complete the consultation. Rather than trying to determine the right level of training for all consultants, from all departments, I further propose letting each department chair or program director make that decision, with the caveat that if the EP afterwards feels the problem is beyond the ability of the designated respondent, the next person consulted be the consult attending or chief of service. Recognizing that direct supervision of consulting residents or fellows at all hours is neither possible nor necessary, I propose instead regular, frequent, and formal communications between the consulting resident and attending. If "routine" cases seen during the night are presented afterwards early in the morning, the attending can then decide if the consultation was carried out satisfactorily or, if necessary, that the patient should be recalled and, in either case, arrange for appropriate follow-up.

When the needs of the ED and the inpatient services do not have to compete with each other, and when consulting attendings have a real commitment to patient care and medical education, their contributions to emergency medicine are valued highly. □