The Role of the Medical Consultant in 2018: Putting It All Together

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Whenever the principles of effective medical consultation are discussed, a classic article published in 1983 by Lee Goldman et al. is invariably referenced. In the "Ten Commandments for Effective Consultation," Goldman argued that internists should "determine the question, establish urgency, look for yourself, be as brief as appropriate, be specific, provide contingency plans, honor thy turf, teach with tact, provide direct personal contact, and follow up.[1]" If these Ten Commandments were followed, then the consultation would be more effective and satisfactory for both the consultant and the referring provider. However, with the advent of comanagement in 1994 where internists and surgeons have a "shared responsibility and accountability,"[2] there has been a shift, and the once-concrete definitions of a specific reason for consult and the nature of "turf" have become blurred. Since 1994, the use of medical consultation and comanagement has skyrocketed, and today, more than 50% of surgical patients have a medical consultation or comanagement.[3] This may be due to increased time pressures on surgeons and better outcomes of comanaged patients (eg, fewer postoperative complications, fewer transfers to an intensive care unit for acute medical deterioration, and increased likelihood to discharge to home).[4]

Medical management of surgical patients in the hospital involves a different skill set than that required to manage general medical patients. Accordingly, in 2012, the Accreditation Council for Graduate Medical Education (ACGME) made medical consultation and perioperative care an End of Training Entrustable Professional Activities and ACGME subcompetency. Earlier this year, a nationwide perioperative curriculum for graduate medical education was consisting of eight objective and core topic modules and pretest/posttest questions selected from SHMConsults.com, including assessment and management of perioperative cardiac and pulmonary risk and management of diabetes, perioperative fever, and anticoagulants. Trainees were assessed using the multiple-choice questions, observed mini-cex, and written evaluation of a consultation report. Despite this encouraging development of curricula and competencies for trainees, there are still important gaps in our knowledge of basic patterns for consultation practices. For example, the type of patients and medical conditions currently encountered on our medical consultation and comanagement services had been previously unknown.

In this issue of the *Journal of Hospital Medicine*, Wang et al. answer this question through the first cross-sectional multicenter prospective survey to examine medical consultation/comanagement practices since observational studies in the 1970-1990s.[6] In a sample of 1264 consultation requests from 11 academic medical centers over four two-week periods from July 2014 through July 2015, they found that the most common requests for consultation were medical management/comanagement, preoperative evaluation, blood pressure management, and other common postoperative complications, including postoperative atrial fibrillation, heart failure, renal failure, hyponatremia, anemia, hypoxia, and altered mental status.[9] The majority of referrals were from orthopedic surgery and neurosurgery. They also found that medical consultants and comanagers provided comprehensive evaluations where more than a third of encounters addressed issues that were not stated in the initial reason for consult (RFC) and that consultants addressed more than two RFCs per encounter.[9]

These findings illustrate the paradigm shift of medical consultation focusing on a single specific question to addressing and optimizing the entire patient. This shift toward a broader, more open-ended reason for consultation may present some challenges such as "dumping" where referring surgeons and other specialists signoff their patients after surgery is completed, with internists processing the surgeons' patients through the hospitalization. These challenges can be mitigated with predefined comanagement agreements with clearly defined roles and collaborative professional relationships.

Nonetheless, given the recent developments in curricula and training competencies mentioned above, internists are better equipped than ever before to put everything together and take care of the medical conditions of the increasingly complex and older surgical patient. For example, if one is consulted to see a patient for postoperative hypertension, it is difficult to *not* address the patient's blood sugars in the 300s, lack of venous thromboembolism prophylaxis, delirium, acute renal failure, and acute blood loss anemia. The authors are correct to assert it is critically important to ensure that this input is desired by the referring physician either via verbal communication or comanagement agreements.

The findings of Wang et al. suggest some important future steps in medical consultation to ensure that our trainees and

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colleagues are prepared to take care of the entire patient regardless of whether the patient is on a consultant or comanagement agreement. This study shows that trainees are exposed to a diverse clinical experience on our medical consultation and comanagement services, which is in accordance with the objectives, assessment tools, and modules of the nationwide curriculum. It is likely that comanagement services will continue to expand as more of our medically complex patients will need either elective or emergency surgeries and surgeons have become less comfortable managing these patients on their own. We also may be asked to participate in quality improvement initiatives in the management of surgical patients, including the "perioperative surgical home programs," where physicians work on a patient-centered approach to the surgical patient using evidence-based standard clinical care pathways and transitions from before surgery to postdischarge.[7]We should share our experiences in quality improvement and the patient-centered medical home to ensure that our patients are optimized for surgery and beyond. As Lee Goldman et al. stated in the "Ten Commandments for Effective Consultations,[1]" consultative medicine is an important part of an internal medicine practice. Today, more than ever, the consultant or comanagement role or roles need to be carefully defined and clear communication and follow-up are important.

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