Lahey Clinic Internal Medicine Residency Program: Curriculum for Medical Consultation Rotation

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Goals of Rotation

- Learn the role of a consultant
- Learn the importance of good communication skills essential to an effective consultant
- Learn the effective documentation skills of a consultant
- Learn how to recognize and treat medical problems in surgical patients
- Review the literature to optimally address questions generated from consults

Medical Consult Service Team

The Medical Consult Service Team consists of a second- or third-year consult resident and covering attending physician.

General Internal Medicine (GIM) Consults

1st -call consult attending: Hospitalist (Dr. Courville, Dr. Johnson, etc.)

OR

2nd -call consult attending: On-call GIM attending (if hospitalists are too busy)

After receiving a consult, the resident will first notify one of the hospitalists who is on that week. The hospitalists will alternate serving as the covering attending for consultations that come in during the day. If the hospitalists are too busy, they will inform the resident to contact the on-call GIM attending, who will then serve as the covering attending.

Nephrology or Cardiology Consults

The consult resident will receive calls from the on-call nephrology attending or cardiology fellow to perform consults for these services. Residents present patients to the respective subspecialty attending or fellow. GIM and hospitalist consults take precedence over subspecialty consults, meaning the resident can defer the consult to the subspecialist if they become too busy.

Workday

The workday begins at 7:30 am (7 am on Tuesday and Thursday—see O*ther Responsibilities* section, below) and ends roughly at 5 pm, Monday through Friday. The resident may need to stay later than 5 pm to complete the work. The consult resident will sign #8000 (medical consult beeper) over to his/her beeper at the start of each day. New consults generated after 5 pm or on weekends will be covered by the on-call GIM attending.

Residents should attend morning report and lunch conferences unless an urgent consult is called in. The resident should see no more than five consults per day. All consults should be seen that day unless the consult is generated late in the day (i.e., after 4:30 pm). The consult may only be seen the next morning if deemed non-urgent and approved by the covering attending. This should also be communicated to the referring service.

Answering Consults

It is recommended that the consult resident speaks directly to a representative of the referring service to ensure that the reason for the consult is appropriately addressed. After receiving a request for a consult, the resident should notify the covering GIM attending before seeing the patient so the day can be planned accordingly.

Patient Interaction

When meeting the patient, the resident should identify him/herself as a consultant representing the medicine, nephrology, or cardiology service that the patient's admitting doctor has requested to evaluate for a specific problem (i.e., hypertension).

Write-ups

The resident should use the consult forms located on the floors and file each write-up in the consult section when it is complete. The write-up should begin with an opening statement addressing the reason for the consult. For example, "The patient is seen at the request of Dr. X for post op confusion." Notes should be focused and concise. The resident should leave a short note in the progress note section indicating that the consult has been initiated or completed. For example:

3/1/06
8 am

PGY-2/3 Medical Consult Service Note

Patient seen and examined, chart reviewed. Full note to follow in consult section.

OR

Patient seen and examined, chart reviewed. Please see consult section

Sally Smith, Beeper # 8000

Recommendations should be in list form and specific. The resident should not state, “Start antihypertensive,” but instead should write, “Start Norvasc 5mg po qd.” At the end of the recommendations, it should be noted that the consult team will continue to follow along with the primary service. Final recommendations must be reviewed by the covering attending before they are placed in the chart.

Presenting to Attending

After writing up the consult, the resident should page the covering attending to present the case and the treatment plan. The attending and resident then will see the patient together to review the findings and confirm the recommendations.

Communication of Recommendations

Once the consult is complete, the resident should contact the referring service and inform them of the recommendations and offer to write the appropriate orders in the chart. Recommendations should not be discussed with the patient without the referring physician’s prior consent.

Daily Follow-up

The consult resident should round on his/her patients, follow up on studies and write progress notes daily until the clinical issue is adequately addressed. The resident assumes responsibility for keeping the covering attending appropriately informed of the patient’s progress and test results. The resident should document in the chart when the consult team is signing off on a patient and conclude with, “Please reconsult if necessary.”

Transfer of Patient to GIM Service

Occasionally, the referring service may ask the consult team to transfer the patient to the medical service (i.e., postoperative patient with congestive heart failure). The covering medical attending must first approve this request. Active daily follow-up by the medical consult service team may minimize the need for such transfers.

Weekend Coverage

On Friday afternoons the resident must sign out patients to the covering attending(s) to ensure weekend coverage is in place. The resident should communicate clearly which patients must be seen over the weekend.

Off-service Continuity of Care

At the end of the rotation, the consult resident should sign out his/her active patients to the oncoming resident to ensure continuity of care. (See attached consult resident schedule)

Community Practice Patients

If a consult is called in on a community practice (i.e., Lexington, Arlington, etc.) patient, the resident must first notify the community attending and ask if he or she would like for the patient to be evaluated by the medical consult service; otherwise, the community attending will see the patient without the assistance of the resident.

Other Responsibilities

1) Evidence-based Didactic Sessions

Each Friday at 12:30 pm (or at another time determined by the hospitalist), the consult resident will give a 15-20 minute presentation addressing a clinical question generated by a consult seen earlier that week. It is expected that the resident will conduct a literature search and provide clinically relevant articles to the attendings during these sessions.

2) Procedures

On Tuesday and Thursday mornings, 7 to 9 am, the consult resident can go to the operating room to perform procedures (intubations, central lines, A-lines) under the supervision of a staff anesthesiologist. Contact the floor runner at ext. 1080.

3) Medical Morbidity and Mortality (M & M) Conference

The two consult residents for each month are responsible for coordinating and running the monthly peer review M & M conference scheduled on the third Thursday of each month during lunchtime conference.

4) Reading Curriculum and ABIM Board Review

The resident is responsible for reviewing the enclosed articles, which focus on common consult issues. In between consults is a good time to study for the boards. Please touch base with chief residents about resources for board review.

Feedback and Evaluations

During the two-week rotation, the hospitalist will provide informal feedback on a daily basis. At the end of the second week, the hospitalists will meet with the resident to review the resident's evaluation.

Principle Educational Goals Based on the ACGME General Competencies

In the tables below, the principle educational goals of the Medical Consult curriculum are listed for each of the six ACGME competencies:

1) Patient Care
2) Medical Knowledge
3) Practice-Based Learning and Improvement
4) Interpersonal and Communication Skills
5) Professionalism
6) Systems-Based Practice

The abbreviations for the types of learning environments and evaluation methods are defined below.

Learning Environments:

DPC	Direct patient care
AR	Attending rounds
RC	Reading curriculum
EBM	Evidence-based medicine (self-initiated and didactic sessions)
OP	Operating room procedures
MR/NC	Morning report and noon conference

Evaluation Methods:

GA	Global assessment
MCX	Mini-Cex
RP	Resident portfolio
NE	Nursing evaluation (360° evaluation)
PL	Procedure log

1) Patient Care

Objective	Learning Environment	Evaluation Method
Perform a focused comprehensive history and physical examination to best address the clinical question(s)	DPC, AR, RC	GA, MCX
Gather accurate, essential information from all sources, [e.g., medical interview, physical examination, test results and literature to optimally answer the clinical question(s)]	DPC, AR, RC, EBM	GA
Make informed recommendations about preventive, diagnostic and therapeutic interventions that are based on clinical judgment, scientific evidence and patient preferences	DPC, AR, RC, EBM, MR/NC	GA, MCX
Improve proficiency in procedures (i.e., A-lines, C-lines and intubation)	OP	GA, PL

2) Medical Knowledge

Objective	Learning Environment	Evaluation Method
Learn the role of a consultant	DPC, AR, RC	GA
Learn how to recognize and treat medical problems in surgical patients	DPC, AR, RC, EBM	GA
Learn current literature and standard of care guidelines applicable to the clinical question	AR, RC, EBM, MR/NC	GA, RP
Learn how to treat common cardiology and nephrology problems in non medical/surgical patients	DPC, AR, RC, EBM	GA

3) Practice-Based Learning and Improvement

Objective	Learning Environment	Evaluation Method
Identify deficiencies in knowledge base and develop an independent reading program to address these gaps	DPC, AR, RC, EBM	GA
Review the literature to optimally address questions generated from consults	RC, EBM	GA, RP
Facilitate the learning of members of the referring service	AR, RC, EBM	GA

4) Interpersonal and Communication Skills

Objective	Learning Environment	Evaluation Method
Communicate accurately and compassionately with patients and their families	DPC, AR	GA, NE, MCX
Learn the importance of good communication skills (verbal and documentary) essential to an effective consultant	DPC, AR, RC	GA, MCX
Professionally interact with referring service	DPC, AR	GA, NE

5) Professionalism

Objective	Learning Environment	Evaluation Method
Treat all patients, health care providers and hospital employees with respect and integrity	DPC, AR	GA, MCX, NE
Maintain patient confidentiality at all times	DPC, AR	GA, NE

6) Systems-Based Practice

Objective	Learning Environment	Evaluation Method
Demonstrate the ability to access resources (i.e., Up to Date, Pub Med, Attending Preceptor) to make recommendations that are evidence-based	RC, EBM	GA
Demonstrate the ability to work as a member of the medical consult team	DPC, AR	GA

Suggested References*

Gross RJ, Caputo GM. Kammerer and Gross' Medical Consultation. The Internist on Surgical, Obstetric and Psychiatric Services. 3rd ed. Williams and Wilkins, 1998.

Merli GJ, Weitz HH. Medical Management of the Surgical Patient. W.B. Saunders Company, 1998.

Kwoh C, et al. The Washington Manual: General Internal Medicine Consult. Lippincott Williams & Wilkins, 2004.

*These are located in the chief resident's office.