FAST FACTS AND CONCEPTS #266
CONSULTATION ETIQUETTE IN PALLIATIVE CARE

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**Background**  There are generally agreed upon rules for consultation (just as there are in social life) that can have profound consequences if they are breached. For those just starting to provide consultation services, it is wise to follow the rules until you develop enough familiarity to know when they can be breached. This Fast Fact reviews the rules of consultation etiquette for palliative care (PC) clinicians. See Fast Fact #298 for more specific guidance on PC consultation in the Emergency Department.

1) **Remember your stakeholders.** Although the focus of the consultation is a patient/family issue, your primary stakeholder is the attending physician that requested the consultation. Unhappy referring physicians mean fewer palliative care consultations!

2) **Make contact/clarify request.** Before you see the patient, contact the referring service to acknowledge that you received the request and to clarify the nature of the request. Determine what questions the managing service wants answered. The phrasing of this is important. ‘*Please tell me a little about Patient X so we can be most helpful to you*’ is an excellent open-ended query. Determine if there are areas that are “off-limits” and find out who the consulting team should talk with following your assessment – the referring clinicians or someone else on the care team. Remember, no matter what is written in the chart, the real story exceeds what is written, and the referring clinicians often have concerns/needs that are not evident from the chart. Particularly for palliative care consultations, this has an important secondary importance; in telling you about the patient, the service will receive emotional support in the telling the story. Be quiet and actively listen; acknowledge the underlying distress. **Cultural corollary:** in some institutions the rank of the person calling should match or exceed the rank of the person called. Strictly applied, for instance, an attending speaks to an attending. This is not true of all institutions or physicians, but it is wise to know your local culture. When in doubt, or conflict occurs, following the cultural corollary of your institution connotes respect.

3) **Negotiate roles.** Many referring clinicians will want the palliative care service to play an ongoing role in the management of the patient and family. This may range from providing information and counseling, to actively managing symptoms including writing medication orders, to assuming principal care for the patient and family. Others will want the palliative care service to maintain a strictly consulting role while the primary service implements recommendations.

4) **See the patient & gather your own data.** This includes reviewing the medical record, pertinent laboratory and diagnostic tests, interviewing the patient and family, examining the patient, and offering information and counseling if that was part of the nature of the request.

5) **Call the referring service.** Before you write in the chart, call the referring service with details of your findings and recommendations. With experience and familiarity with frequent referrers, this step may not be necessary. If appropriate, contact other consultants and clinicians involved with the patient (housestaff, nurses, discharge planners, etc.).

**Additional Tips**

- **Brevity** (in general, try to limit your recommendations to \(< 5\)) and **specificity** (e.g., exact morphine dose/route/schedule) are important to both communicate your key messages and increase the likelihood that your recommendations will be acted upon.
- **Plan ahead** – you are often in the best position to recognize likely future needs beyond the hospitalization; plan ahead to meet expected symptom control and other patient/family needs. Helping to expedite and simplify patient discharge is an easy and high-yield way of demonstrating your service’s value to referring clinicians.
- **Honor turf** – you may be one of many consultants; when in doubt about the expectations and plans of the referring clinician, clarify by personal contact.
- **Be accessible** – a referring physician or service needs to know how to reach you easily. He or she will be put off if they can’t reach your service. Indicate how you can be reached in your consult note.
Be responsive – acknowledge receipt of the request as immediately as possible and plan to see the patient the same day or within 24 hours. If unable to do this, contact the referring clinician directly to discuss.

References


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