Inpatient consultation in the academic setting can be an exasperating experience for the cardiology trainee. Perception of unnecessary consultation, suboptimal triaging of calls on the basis of acuity, and variable interactions with requesting services and providers are some of the challenges encountered. A general rubric for effective medical consultation was proposed in 1983 (1) and recently updated (2). Although the recommendations presented therein are useful, guidance regarding the “etiquette” of consultation as it pertains to the cardiology trainee is lacking.

As the cardiology fellow is often charged with accepting consults from staff physicians, the resultant power differential generates a unique dynamic. Moreover, the trainee may receive requests for consultation of lesser urgency at off hours that an attending physician may not. Finally, hospital trends in using more nonphysician providers to cover night shifts may make consultation more frequent. In our cardiology training experience, we have learned several lessons that may be helpful to bear in mind, particularly for incoming fellows.

1. **Use consults as educational opportunities.** There is an oft-cited notion that any endeavor in which the trainee engages represents an educational opportunity for said trainee. Conversely, the inpatient consult represents an excellent opportunity for the fellow to teach others. Requests for consultation are often made by residents and other (non-cardiology) fellows. These trainees are typically quite receptive to and appreciative of education, if delivered appropriately. We have found that a willingness to teach early and often pays dividends later in training as one’s peers become better equipped to handle cardiac situations unilaterally. The enthusiasm to teach, however, must be tempered by the circumstances of the consultation. The 3:00 AM consult on an unstable patient may not constitute the most opportune time to discuss the intricacies of phase 4 block. Similarly, we must know our audience. Although attending physicians may be interested in clarifying a certain point, “overteaching” in this context may be perceived as insulting.

2. **Be courteous, accommodating, and curious.** Many of the adversarial relationships that develop among services (surgical and nonsurgical alike) stem from poor social interactions. Something as simple as a polite demeanor can be invaluable in avoiding these situations. Beginning a conversation by stating one’s name, followed by “how can I help you?” may assuage difficult circumstances. The requesting providers are requesting cardiology consultation not out of malice, but rather for assistance. A consult speaks to 1 of 2 possibilities. Either the patient’s situation warrants evaluation by a specialist, or it does not, but the primary service feels uncomfortable managing the patient without assistance. In either case, the involvement of the cardiology team is in the best interest of the patient. As such, taking the call courteously and without objection is best. Second, the academic medical center is a mutualistic creature. Quite frequently, we have seen the fellow’s willingness to accept an admission or expedite a consult translate into a favorable scenario later. Whether this is the medicine service accepting transfer of a patient or the vascular surgery fellow lending a hand with a post-catheterization complication, things do “come around.” Third, although asking multiple questions can be perceived as being “difficult,” legitimate clarification is always warranted. Qualifying statements such as, “I’d like to
ask a few more questions in order to triage and assist. May I ask them now?" can go a long way in making the individual feel more at ease and diffuse any tensions naturally involved in the stressful hospital environment.

3. Learn to accept the troponin. Often regarded as the bane of the cardiology fellow, the high-sensitivity cardiac troponin (hs-cTn) assay is here to stay. As the source of many seemingly unnecessary consults, troponin warrants special consideration in this space. Familiarizing yourself with the institutional-specific details of the assay and learning to incorporate ancillary data and clinical context is critical. Educating other providers on the same is very helpful in this instance as well. Along with courteously accepting a consult call because it indicates a need by either patient or provider, abnormal troponin is not benign (3). Determining whether the elevated hs-cTn is actionable, however, is more difficult (4). Constructing an algorithm to logically and efficiently approach the abnormal troponin will serve the cardiology trainee well and alleviate much of the angst the assay can evoke. The issue of incorporating hs-cTn into clinical practice is an evolving one, and one’s approach will no doubt require refinement well beyond fellowship training. The first step is acceptance.

4. Elicit the precise reason for consultation. As with many things in medicine, effective communication is integral. The trainee is disadvantaged relative to the staff physician with respect to the ability to crystallize a clinical situation. Therefore, when the cardiology fellow accepts a consultation request, the concrete reason for consultation may not be immediately clear. This may be related to either a nebulous understanding espoused by the trainee placing the request or simply poor communication. Techniques such as summarizing can be very helpful, for example, “So if I understand you correctly, this is a 59-year-old current tobacco user with new onset of typical angina for 5 min relieved by rest who was admitted to your service in the context of normal electrocardiogram and troponin. You would like our assistance in choosing the optimal risk stratification test. Did I miss anything? Is there anything you would like to add?”

The other common mistake occurs on the receiving end, wherein the fellow hurriedly “accepts” the consult without properly vetting the request. What is intended as a time-saving measure frequently generates inefficiency. More importantly, if the initial exchange of information and establishment of expectations is murky, the end result is often unsatisfactory for both consultant and requesting service alike.

5. Approach effective consultation as a skill. In our experience, cardiology consultation is not the highlight of the fellow’s training program. However, as specialists, effective consultation defines us. The skill of inpatient consultation discussed herein also translates to the outpatient setting. Additionally, the typically more “popular” aspects of cardiology practice that involve diagnostics and therapeutics originate through patient referral. The respect a cardiologist earns among his or her noncardiology colleagues is contingent in large part on his or her effectiveness as a consultant. As trainees, we are well acquainted with the Core Cardiovascular Training Statement requirements pertaining to procedural skills, but in fact, the first training statement emphasizes well-communicated consultation (5). Indeed, the skill of effective and efficient consultation is as important as any other in the cardiologist’s armamentarium and is worth honing.

**REFERENCES**


RESPONSE: One Good Consult Begets Another, While Providing a Learning Experience

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Fellowship training is a great opportunity not only to learn cardiovascular medicine, but also to learn about the nuances of interspecialty interaction that are best typified by interaction with colleagues from other disciplines during a formal or informal consultation. Although there is no formal treatise that dictates the rules of engagement as a consultant, a published list of suggestions or so-called commandments addressing how to be an effective consultant provides a useful general framework (1–3).

Inpatient cardiology consultations may be generated by trainees, referring physicians, or noncardiac specialists; by cardiologists looking for a more specialized opinion; by allied health care professionals; or, at times, solely by the patient or persuasive family members. The consult may occur in various settings including the emergency department, intensive care, or general ward, but may also be “a curbside quickie.”

In general, in an effective consult everyone is a winner: the referring physician or allied health care professional, the patient, as well as the consultant.

Drs. Abudiab and Van Woerkom provide a cardiology fellow’s perspective on inpatient consultations that is both generally appropriate as well as informative, particularly for incoming cardiology fellows. They highlight the fact that a consult is a great opportunity to educate the referring team, but caution that the depth and extent of teaching should match the circumstances so as to avoid overteaching at inopportune moments. I would add that this is an opportunity for the consultant to learn, bearing in mind the adage that the best way to learn is to teach.

Drs. Abudiab and Van Woerkom also place appropriate emphasis on being courteous, accommodating, and inquisitive; to appear both professional and interested in knowing about the patient; as well to clearly understand what questions are being asked of the consultant. I would go a step further in saying that a consultant must verify medical facts about the patient without totally relying on the information provided second hand by the referring individual, especially if that person is a trainee. It is astounding in real practice how often a patient who is thought to have a normal cardiovascular examination by the primary team turns out to have abnormal cardiac physical findings of relevance and diagnostic significance. Thus, check the patient facts yourself in an unobtrusive manner, so as not to get blind-sided.

Drs. Abudiab and Van Woerkom raise the ever-increasing issue of how to effectively deal with troponinitis (elevated levels of troponin, especially high-sensitivity troponin, without a clear-cut electrocardiographic and or/clinical explanation). They quite rightly point out that it is an evolving field that requires acceptance as a reality but will ultimately require sound clinical judgment and detailed knowledge of the patient to make the right interpretation.

A consultant should be easily available for follow-up but should be prepared to fade away when not needed. Over the past nearly 4 decades, I have regularly attended on the inpatient consult service for our cardiology fellows, and I must admit that I have learned something from every such interaction, even when the consult would have been deemed unnecessary. There is no reason why our fellows cannot do the same. I never saw a patient that did not teach me something.

Finally, I fully agree that how a consultant conducts himself or herself and how effectively he or she acts during such encounters can play a prominent role in establishing a good reputation. After all, one good consult begets another. Consultation is a pivotal part of inpatient care and it serves its purpose when everyone wins.

REFERENCES

