MEDICAL CONSULTATION

The Internist on Surgical, Obstetric, and Psychiatric Services

Second Edition

Co-Editors

William S. Kammerer

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Accurate indications, adverse reactions, and dosage schedules for drugs are provided in this book, but it is possible that they may change. The reader is urged to review the package information data of the manufacturers of the medications mentioned.

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Foreword to the First Edition

When thou arte call'e at anye time,
A patient to see;
And doste p. .eave the cure too grate,
And ponderous for thee;

See that thou laye disdeyne aside,
And pride of thyne owne skyll;
And thinke no shame counsell to take,
But rather wyth good wyll.

Gette one or two of experte men,
To help thee in that nede;
And make them partakers wyth thee,
In that worke to procede.

—John Halle, M.D. (1529–1566)
From *Goodlye Doctrine and Instruction*

The practicing internist is often called on to provide advice to colleagues. The time devoted to this endeavor during medical residency training varies from program to program but in general is not consonant with the need. A busy general internist may spend up to 40% of practice time providing consultations. The error made in most training programs is the assumption that, if a physician is competent to care for the diabetic on a medicine service, then he or she is competent to manage the diabetic through delivery or a surgical procedure. In fact, to give valuable service the consultant needs to understand the exigencies of anesthesia, the surgical procedure, the dynamics of pregnancy, labor, and delivery, and the disposition of colleagues.

The general internist is often in the best position to understand and work with these multiple variables. By virtue of their usual practice mix, general internists are faced daily with "interface medicine." Multiple medical problems in the same patient are the rule in general internal medicine, and the proper care of such patients requires knowledge of the effects of one disease on another, the hazards of polypharmacy, and the importance of the larger picture of health and disease.

Because these considerations and techniques are not the province of traditionally oriented textbooks, the editors felt the need to present this information in a composite form. Although chaptered and indexed in usual organ or disease entity ways, the information stresses the effects of surgery or pregnancy on a disease process or, conversely, the effects of a disease or pregnancy on the outcome of surgery. Further, the editors and contributors provide specific practical management advice designed to minimize these effects.

Before launching into the specific portions of this text, we would offer some general recommendations regarding the conduct of consultations which experience has taught us are worth bearing in mind as you make your appointed rounds.

KNOW FOR WHOM YOU ARE PROVIDING THE SERVICE. Different services may be looking for different kinds of advice. So, too, some individual physicians may routinely call for specific types of assistance.

KNOW WHY YOU ARE BEING CONSULTED. In general terms the request may be: "Help! What do I do now?"; "Come argue with another consultant"; or "Come see what a nice job I've done." More specifically, try to elicit the exact question being asked.

BE BRIEF—ALLOW FOR SELECTIVE READING OF YOUR NOTE. Long notes are not read. You should title sections of your note so that areas of interest for different readers will be readily identified. If you wish to record information for your own future review or to help a covering consultant, separate it from the rest of your text.

BE SPECIFIC WITH RECOMMENDATIONS. Therapeutic measures should be spelled out with respect to drug, dose, route of administration, desired effect, and toxicity.

SUPPORT YOUR RECOMMENDATIONS AND IMPRESSIONS. Your text should include the data to warrant a diagnosis and the indications for diagnostic and therapeutic recommendations.

TEACH THE READER. You have been asked to provide a special service. This is an admission that the requestor seeks information. Your experience with similar cases and pertinent points from the literature are appropriate.

FOLLOW-UP. It is a rare consultation which should involve one visit. If that is the case, you should indicate that you will not return unless requested. Your note should include what progress you expect and should provide the opportunity to change your problem list as the data base expands. Flow sheets which you can initiate might be a worthwhile venture. The follow-up visit is your best learning device.

BE CHARITABLE. You do not help the patient when you shame or anger his doctor.

ATTEMPT PERSONAL COMMUNICATION. This is a courtesy which allows you to amplify your note and reinforce your recommendations.

BE HONEST. You have been called in as an expert. Do not suggest diagnoses which are not supported by the data. Get help when you need it or recommend other consultants who can deal adequately with the situation.

The editors and contributors to this volume are from two training programs that endeavor to stress consultation skills as important educational components. All have wide experience in both providing and teaching consultations. Their contributions contain the science of the discipline and the wisdom of having done it many times.

J. W. Burnside

Preface to the Second Edition

Plus ca change, plus c'est la meme chose

The central theme of the second edition remains the same: a well-prepared general internist with a special interest in consultation medicine will best serve the interests of patients with medical problems on nonmedical services. Recent changes in insurance and hospital regulations, philosophy, training programs, and knowledge base are markedly altering medical consultation. Increased emphasis is being placed on elective outpatient evaluation; more than one-half of all evaluations are now being performed on an outpatient basis, a marked change that has occurred in a little more than 5 years. The general internist is ideally qualified to perform outpatient evaluations, but these require even more attention to proper communication and efficiency.

The increased number of surgical patients with multiple problems or in intensive care units is consuming greater proportions of physicians' time, changing the way physicians practice, and altering training programs. The amount of information to be collected and the therapeutic interventions available expand on an almost-daily basis. Under these conditions, it has been the well-trained general internist committed to patient care who has been called upon to care for the "whole patient" again, to coordinate multiple (and, occasionally, conflicting) strategies of subspecialty consultants, and to function effectively and efficiently in the absence of all the data that would ideally be available. For effective consultation, both communication skills and a command of an expanding knowledge base are required.

To meet these changing conditions, this edition has been expanded by the addition of new chapters on general medical evaluation of the preoperative patient, evaluation of the presumably healthy patient, evaluation for outpatient surgery, invasive cardiovascular monitoring, and the oncology patient requiring surgery. Most chapters have been extensively expanded based on new developments.

We welcome several new authors (J. Ballard, J. Field, B. Ford, R. Simons) who have given this edition "new blood." Although we are aware of many new concepts and techniques in various disciplines, we have not included every new idea reported if it is untested or too "subspecialized" (e.g., intraoperative EEG monitoring). We have used the same criteria for adding new references. In an effort to assist the reader, we have highlighted key concepts and information throughout the text.

This text selectively emphasizes information on medical problems of surgical, obstetric, and psychiatric patients that is *different* from that for the usual medical patients. We have not tried to reproduce another textbook of general medicine; this would necessitate the reader plucking what was "different" in the nonmedical patient from a mass of general medical knowledge. The precise focus of this text is to highlight these differences. Likewise, the amount of literature available varies tremendously, from the massive number of articles in cardiology, to relatively few in gastroenterology. This makes uniformity in style difficult. The editors have again decided to allow individual chapter authors wide latitude in order to best present their material. Whereas this decision yields variation in editorial uniformity, we believe it best achieves our goal of presenting the field of medical consultation in a clear, practical manner.

This book was conceived as an equal effort between the two editors and their general internal medicine faculties. They bring to this edition varied and complementary interests, skills, and experience.

There remain many gaps in knowledge in this field and in the bibliography. We

hope this text will stimulate our readers to fill these gaps with careful clinical research. As before, we welcome suggestions or corrections from readers for future editions.

Our goal continues to be providing the consulting internist with practical information for the care of our sickest and most complex patients.

William S. Kammerer
Richard J. Gross

Preface to the First Edition

"Operating on someone who has no place else to go."
—Dr. John Kirklen, quoted by Dr. C. B. Mullins, with permission.

What would motivate one to put together a multiauthored text on a subject traditionally learned through years of trial and error at the bedside and hours of labor in the library? We felt that, by bringing together the views of experienced internist consultants and a widely scattered literature, we could provide a nidus for an effective teaching program for residents, as well as a reference for continuing self-education for the practicing internist. Because medical consultations to non-medical services make up a large part of an average working day for practicing internists and medical residents, most training programs now include a rotation on a general medical consultation service. However, teaching on such services is hampered by the lack of reference material and the experience is often haphazard, isolated, and unsupervised. Many medical residents thus come to dread this activity and feel it is irrelevant and unscientific.

By categorizing the lessons learned from personal experience and the thinking of experienced internists, we hope that the prolonged floundering of trial and error learning will thereby be shortened and given direction. Consultation medicine is one of the few remaining areas in a subspecialty world where the venerable concept of the general internist as a master diagnostician of all ills "from the skin in" can come alive and allow the full utilization of all of his/her skills.

Recognizing that even the most complete general internist tends to become more proficient in one area than another, we felt a multiauthored approach, representing several institutions and styles of practice, would best serve the goals of this book. With few exceptions (e.g., anesthesiology, mechanical respiratory support, and dermatology) dictated by special skills and knowledge, all of the contributors are practicing general internists.

Undoubtedly, some subspecialists will find omissions or generalizations in the text which are unacceptable to them. However, rather than attempting an encyclopedic subspecialty reference text, our goal is to provide an approach as practiced by experienced general internists to specific perioperative problems and to medical problems in pregnancy and psychiatry. This approach emphasizes clinical decision making and practical management techniques rather than extended discussions of medical, surgical, and anesthetic pathophysiology. Due to the complex interrelationships at the interface of medical, surgical, and anesthetic problems and to the rapid changes in their relative importance through the pre-, intra-, and postoperative periods, pathophysiologic generalizations are often impossible to apply to the individual patient. Thus, we place the majority of our emphasis on clinical decision-making based on well-designed empirical studies and extensive personal experience. However, in areas where a general understanding of current surgical or anesthetic pathophysiology cannot reasonably be expected of the general internist, it is incorporated in the appropriate clinical discussions. Obviously, this approach assumes a general familiarity with a wide range of medical and surgical problems.

While attempting to keep the general structure and organization of all sections reasonably uniform, the remaining diversity in styles tends to reemphasize the need for versatility and practicality in the approach to medical consultations to surgical and non-medical services.

Discerning readers will note that the

bibliography occasionally appears dated, or even absent, for common consultation problems. Perhaps this observation will provide a stimulus to our readers to fill these gaps.

We hope the book will serve the needs of both medical residents and the consulting general internist and prove practical, educational, and stimulating.

W. S. Kammerer, M.D.
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The authors and editors, however, take responsibility for the final choice of content and for any errors.

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General Medical Consultation Service: The Role of the Internist

Richard J. Gross and William S. Kammerer

Little formal attention has been directed to the role of the internist as a consultant. Most authors have concentrated on a brief list of responsibilities or ethical constraints to prevent patient stealing or fee splitting. A few of the major figures in American medicine in the early 20th century commented briefly on the consultant's role, but none elucidated their philosophy in detail. The purpose of this chapter is to outline the consulting internist's role in relationship to the patient, the problem, and the consulting physician.

The opinions and reports of the Judicial Council of the American Medical Association contain the most comprehensive list of consultant responsibilities (1). The AMA document lists nine ethical principles of consultation:

1. One physician should be in charge of the patient's care;
2. The attending physician has overall responsibility for the treatment of the patient;
3. The consultant should not assume primary care of the patient without the consent of the referring physician;
4. The consultation should be done punctually.
5. Discussions in consultation should be with the referring physician and only with the patient with the prior consent of the referring physician;
6. Conflicts of opinion should be resolved by a second consultation or withdrawal of the consultant; however, the consultant has the right to give his opinion to the patient in the presence of the referring physician.*

A consultation should be differentiated from a referral, although these two terms are often used interchangeably. A consultation is strictly defined as requesting another physician to give his opinion on diagnosis or management. Referral means to request another physician to assume direct responsibility for a portion or all of the patient's care. A referral may be for a specific problem or total care of the patient.

We have conceptualized the role of the consultant as outlined below, based on clinical experience, discussion with other internists, and review of available literature. The performance of a consultation involves the phases of initial contact, completion of the consultation report, and follow-up (Table 1.1).

*The other three principles involve responsibilities of the referring physician for obtaining consultations. 1) Consultations are indicated "upon request," in doubtful or difficult cases, or when they enhance the quality of medical care. 2) Consultations are primarily for the patient's benefit. 3) A case summary should be sent to the consulting physician unless a verbal description of the case has been given.