

Letter from . . . Chicago

Consultants and consultoids

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The medical consultation has long been an exercise steeped in tradition and an occasion for a little showmanship. Readers of nineteenth century novels may well remember Sir Omicron Pie and other distinguished personages regularly coming down on the London train to bolster the confidence and confirm the diagnoses of country apothecaries and general practitioners. Veterans of the Chicago medical scene still recall the great Dr Sippy of the famous diet arriving by horse and buggy to prescribe his alkaline powders for the ulcers of the pre-cimetidine era. Later, as the horse gave way to the automobile, many illustrious consultants would be making their rounds in expensive cars or chauffeur driven limousines. Some of the better models would be pretty fast, even 20 years ago, as I discovered when I was taken along by my chief to an isolated house in a remote part of northern Wales, to accompany him on a Sunday morning consultation. I waited for an hour in the lounge while the chief consulted in the bedroom, then I was called in to confirm the palmar erythema and hepatomegaly in this obvious case of cirrhosis. The fee was some 20 or 50 guineas, and then the great man told the patient to also "give the lad £5."

Most of the recent writing on the mechanics of the medical consultation comes from America's teaching hospitals, as "newly developed sections of general medicine have struggled to define their mission in academic centers"—which could mean fighting for a piece of turf when everything has been pretty much divided up. As we read that "only few have stressed the importance of the consultant-level general internist,"¹ we remember that once most consultants were generalists and few were subspecialists and that the rules of how a consultation was to be carried out were pretty explicit. The general practitioner would walk in first and introduce the consultant, who would then ask questions and examine the patient, then the two would return to discuss the case before announcing the verdict. It must be that kind of thing that Dr Lepreau had in mind when he described in a recent surgical journal how the requesting doctor should have the chart and x ray films available, the family on site, and other consultants alerted.² The consultant examines the patient (in private by this set of rules), has a "frank discussion with the referring physician," makes recommendations to the family, and returns to the bedside to "give his opinion in simple reassuring language." He must never be Olympian in his manner, should admit that he has been known to make mistakes, and might want to explore if the doctor wants to keep the patient or get him off his hands. In the latter event he must be sure that everybody remains informed of what is going on.²

The last bridge

Yet to acquire these skills the prospective consultant needs to be trained. And the recent discovery that not all consultants must be subspecialists has led to considerable writing on the subject. Thus we read about the "last bridge," designed to link "well rounded, in-hospital tertiary care training" with "increased provision for ambulatory care experience." Without this bridge (the general medical consultation) we are in danger of training doctors incapable of rendering "total service to patients, hospitals, and other physicians"—which boils down to having a general medical service going around the hospital advising the specialties.³ Likewise "the new sections struggling to define their mission" have also instituted a general consulting service for surgeons and obstetricians and have found that they were called most often to manage patients with hypertension, diabetes, and angina who were about to have surgery.¹

They found that the referring doctors were pleased with the opinion given; the consultants themselves had a good time; but the house officers traipsing along with them experienced "learning lethargy," and presumably would have been happier reading about prostaglandins or learning to do colonoscopies. But the authors, in a further publication, have concluded that the most popular consultations are those in which initial recommendations are limited to five or fewer.⁴ They also suggest a neat way of writing consultations, using the four headings of, (a) reason for consultation, (b) problems, (c) recommendations, and (d) discussion.¹

Another study of the mechanics of consultations, also from a teaching hospital, emphasises that misunderstandings arise when the reason for calling the consultation is not clear.⁵ Thus the consultants on a case of jaundice and tuberculosis wrote lengthy notes on the differential diagnosis of liver disease when in fact the service wanted to know if prophylaxis with potentially hepatotoxic antituberculous drugs was indicated.⁵ In that hospital, as elsewhere, the consultations making the highest impact and causing least misunderstanding were those requested to obtain procedures, such as biopsies.⁵ But then we are also reminded, by some of the same authors, that a competent consultant has other commandments to obey⁶: he must determine if the consultation is urgent or elective; he may want to gather extra information himself (such as looking at old charts or phoning doctors at other hospitals); he should be specific in his recommendations and provide appropriate therapeutic options; and he should learn to communicate with tact and not write notes that might embarrass the referring doctor.⁶

Communication between colleagues

One contributing cause to a lack of communication, fortunately rare, is when a senior physician's request for a consultation is answered only by junior house officers. In the

worst cases the senior consultant never sees the patient, though he may discuss him in a conference in his office. On the ward, then, the attending physician has a patient with a recurring arrhythmia and is still waiting for the word on whether verapamil is better than digoxin or propranolol. True enough, the student on cardiology has already written a note recapitulating what was already known; and his senior, the cardiology resident, an intern six weeks ago but now rotating through cardiology, has also come. There are three pages of notes on the chart, but the information on verapamil is nowhere to be found.

There remains the option of picking up the phone and trying to contact the chief. This may be difficult if the great man is in the lab with his rabbits, in conference with his fellows, or in conclave with his typist trying to fit an abstract into the prescribed square for the next meeting. A little perseverance will detach him from the object of his preoccupations, and his tone will be controlled but clearly irritated, as if to suggest, though not necessarily to say, "haven't my boys seen this case already?" But then it could also happen that this is the week of the prestigious Nebraskan Congress of Cardiology, when everybody who deals in hearts is out of town except for the intern consultant and the student who is doing such a superb job.

So much for the occasional irritations of the rarified atmosphere of the teaching hospital. Things are somewhat different in private practice, where there should rarely be any difficulty in obtaining adequate consultations. If the consultant is late, doesn't follow through, gives a bad opinion, orders too many tests, or tells the patient that you are a silly old man, you need not call him again—you may even warn your colleagues. Referring doctors choose their consultants according to a whole host of criteria, including whether they want an opinion or someone to take over the case. Some referring doctors worry about losing the patient (though the consultant with a well developed sense of self preservation will avoid like the plague taking over the patient—or he may be his last). For overly concerned referring doctors, however, the solution is simple. They send their patients to a consultant many miles away, preferably in another state. No wonder the Mayo Clinic has maintained such a fine reputation as a referral centre. It enjoys a fine name—and it is a long way from home.

It follows from all this that the young consultant must learn to sense whether the referring doctor wants him to give an opinion, follow through, or take over management. Some doctors like to have several specialists write orders for their patient, limiting their role to an occasional social visit and to a note expressing their appreciation of the excellent care given. Other doctors, often from the old school, call for very few consultations, especially for patients whom they have known for years and wish to protect against aggressive treatment when the end is in sight. Some doctors use the consultation to further their education; others resent anything vaguely resembling a lecture, feeling that they are being talked down to.

Young consultants starting off in practice deserve special encouragement. They may be having a hard time, and established practitioners sometimes like to help and ask for a consultation when a second opinion is not absolutely necessary. By contrast, the referring doctor may desperately need help in an area where he feels out of his depth. The fledgling consultant needs to acquire a sixth sense to distinguish these two extremes, for where the referring doctor is out of his depth a direct call to him may be mandatory while it could be most irritating when a second opinion is less urgent. Nothing is more annoying than to be paged in a public place, perhaps in a restaurant or at a party, to have to locate a phone and find the right small change, perhaps to wait for another person to finish his call—only to be told ingenuously by a new consultant that the lady with the three years of chronic diarrhoea is doing fine and that he is well in control. Or to be given a lecture on the phone in a noisy club on the diagnostic work up of a hypercalcaemia that you could have treated just as well yourself. By the time you get back to your drink the glow will have worn off and the next time you will know better.

Referrals to surgeons

One reason to make a referral, perhaps to a surgeon, is to get off your back a cantankerous patient who has complained for years of his knee, bowels, or gall bladder, never letting you alone, and growing more disgruntled as the years go by. In a subconscious act of aggression such patients are sometimes sent to surgeons who will extirpate the offending organ or replace it with a plastic one, thus granting the referring doctor at least a few months of respite from complaints.

In the long run, however, the surgeon who betrays poor judgment or gets bad results will find his source of referrals drying up and his practice shrinking, however impressive his academic qualifications may be. The consultant who is competent but often unavailable, or does not follow through on his cases, may suffer a similar fate, for it is availability as well as performance that matter; and the consultant who is rarely seen in the hospital will probably not be called.

A successful consultant, then, is expected to work long hours, to be readily available, to come promptly when called, and consistently to give a sound opinion. He must never lose his humility, but he will be forgiven the occasional error. For in the practice of medicine everybody makes mistakes, a truth that medical students were explicitly taught in the past. But now some of their teachers have become infallible, like the severe members of Hazlitt's *Aristocracy of Letters*, who never put a word wrong because they never wrote one in the first place. Surrounded by a phalanx of students and house officers in their well ventilated conference rooms, these aristocrats of medicine may forget the odd reference, but they will never miss a spleen.

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A debilitated middle aged patient has a fungal infection of the throat which has persisted despite treatment with nystatin, fungilin, and gentian violet. What other treatment should be tried?

Fungal pharyngitis is almost invariably caused by infections with the yeast like fungus *Candida albicans*. The description "debilitated" is a rather general term, which alone might be considered an inadequate reason for acquired fungal pharyngitis in the middle aged. In such patients a careful clinical appraisal should be made to ascertain the presence of an underlying cause requiring specific treatment, in particular untreated diabetes. Chronic alcoholism may also be a predisposing factor. The condition is also quite common in patients with asthma who use local steroids administered by nebuliser. The initial treatments listed here are the correct first line of treatment. It is unusual for them to fail but common for the condition to relapse when treatment is discontinued. In such relapsing cases a 10 day to three week course of one of the recently introduced oral antifungals, such as ketoconazole, would be indicated at a dose of 200 mg every eight hours.¹ A second course may be necessary if the first fails to eradicate a persistent infection. If the infection is associated with the local use of steroids these will almost certainly have to be discontinued, probably for all time.—J H DARRELL, reader in clinical bacteriology, London.

¹ Hay R. Ketoconazole. *Br Med J* 1982;285:584-5.