

Consultation Etiquette Challenges Palliative Care To Be on its Best Behavior

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THE MOST COMMON MODEL for the growing number of palliative care programs introduced into U.S. hospitals in recent years is the consultation service, typically a multidisciplinary team that may include physicians, nurses, social workers, pharmacists, and/or chaplains. The palliative care service responds to requests from physicians and other colleagues for assistance with pain and symptom management, establishment of goals of care and associated treatment decisions, advance care planning, and other issues related to living with serious illness.

Working with consultants is familiar to most physicians, with a range of medical specialists commonly called upon to offer advice on how to deal with a variety of patient care issues. Consultations may be specific to organ (e.g., pulmonology), disease (oncology), or age of the patient (geriatrics). Palliative care, by contrast, is defined by its attention to the whole person and family, with a focus on comfort, symptom management, goal setting and associated decision-making, and quality of life for the seriously ill patient. But the consultation role in palliative care in its fundamental structure is exactly the same as for other specialties: the client of the palliative care team is the referring physician.

The rules of consultation are known as consultation etiquette: a set of unwritten but important standards that define how the consultant is expected to behave in response to requests from attending physicians, with consequences in terms

of loss of future referrals when the rules are breached. Palliative care consultants must recognize that the requesting physician is their primary customer, that the scope of their involvement is determined by the requesting physician, and that they are not in control over what happens to the patient or even whether their recommendations get followed. Palliative care nurses and social workers may not conform to these unwritten rules as readily, because they were not trained or acculturated in consultation etiquette, but they, too, need to learn and follow the rules.

Working palliative care consultants contacted for this paper suggest that they face particular challenges and frustrations in the consultant's role, even as they realize that following the rules of consultation etiquette is essential for gaining the trust of referring physicians and influencing the culture and practice of medicine within their institutions.

WHAT ARE THE RULES?

The classic view of the consultant's role in palliative care is offered by Dr. Charles von Gunten, director of the Center for Palliative Studies at San Diego Hospice and Palliative Care in San Diego, California, and Editor-in-Chief of this *Journal*. First of all, von Gunten says, it is important to be clear on the language of consultation, since that shapes understanding of the role.

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"The managing service requests a consultation. The patient belongs to the managing service, and it is the managing service that asks the question to be answered by the consultant," von Gunten explains. The consultant should clarify exactly what the managing service is asking for help with, and should provide no direct care unless this is specifically requested or negotiated. It is not the consultant's role to address patient care issues not on the agenda of the referring team. "This is a fundamental cornerstone of consultation etiquette," von Gunten says. Physicians create problems for themselves when they abrogate this basic principle—at least until they are familiar enough with the local medical culture and the referring physician to know when it can be safely abridged.

If the consultant understands this defined role, there need be no adversarial relationship because responsibility for the patient remains with the requesting physician, von Gunten adds. If the consultant has questions about the care the patient is receiving, he or she would naturally raise them with the attending, not with the patient and family.

Abiding by the rules of consultation is often challenging in palliative care, because many patients and their physicians are confronting the failure of modern medical care to cure their disease, and often are at turning points in treatment. "But if you set yourself up as a Don Quixote-like person who is galloping in there to 'save' these patients from their doctors, you should be aware that this attitude will quickly end consultation to your service. This problem is not unique to palliative medicine. Many other doctors feel the same way about their own expertise and whether their recommendations get followed," he says. But other specialty consultants have had to learn the same lessons about their role. Being able to work collegially and collaboratively as a consultant is an essential part of the growth and maturation of a subspecialty.

Dr. David Weissman, director of the Palliative Care Leadership Center at Medical College of Wisconsin in Milwaukee, spelled out the basic principles of consultation etiquette in a recent audio seminar presented by the Center to Advance Palliative Care.¹ Weissman outlined 10 principles (Table 1), adapted from a seminal 1983 journal article by Goldman and Lee,² and emphasized that success as a consultant is defined by meeting the needs of the stakeholders, principally the re-

TABLE 1. PRINCIPLES OF CONSULTATION ETIQUETTE

1. Determine the question (How can I help you in your care of patient X?).
2. Triage urgency (emergent vs. urgent vs. elective).
3. Gather your own data (thorough history and focused physical examination).
4. Brevity (focus your consult notes on assessment/recommendations).
5. Specificity (goal-oriented recommendations).
6. Plan ahead (contingency plans for anticipated future problems).
7. Honor turf (be careful to address the problem for which you were called).
8. Teach—with tact (viewing every consultation as a teaching, and marketing, opportunity).
9. Personal contact (directly to the requesting physician).
10. Follow-up (including your ongoing role and knowing when to sign off).

Source: David E. Weissman, Medical College of Wisconsin, adapted from Goldman L, Lee T, Rudd P: Ten commandments for effective consultations. *Arch Intern Med* 1983;143:1753–1755.

questing physician. He recommended using a standard format and a consultation reporting form that looks like those used by other specialists.

"I'll make an editorial comment here—I have made every mistake on this list," Weissman told the audio conference audience, adding that effective communication is the answer to many of the problems that come up in the consultant's role. When the consultant fails to ask the requesting physician what is the focus of the consultation, for example, there is likely to be miscommunication. A good leading question is, "What are you most concerned about with this patient?" or, "How can I help you in the care of your patient?"

WHERE'S THE RUB?

Is consultation really that simple? Or do palliative care consultants, as committed agents of change in the health care system, and as advocates for coherent goals of care for patients with life-threatening illnesses, bring special attitudes and expectations to the consultant's role? Of course, the answer is yes. How, then, can palliative care leaders balance this commitment to patient care with the diplomacy of a good consultant?

The 10 principles are steps to being more effective as a consultant, Weissman responds, ac-

knowledging that there will be some tension in the role. “We don’t want to stifle your passion. Every case is different—every referring physician is different. You have to read the situation and decide when and if to take your stand.” The challenge is to find a workable balance between honoring the consultant’s role and serving as the patient and family’s advocate.

“Be self-aware. Recognize yourself and where your emotion is being ignited,” Weissman says. A well-functioning palliative care team can point out when a team member, through zealous patient advocacy, is breaching the rules of consultation etiquette. Regular team meetings and discussions about these tensions help its members take the long view and recognize that they cannot fix every problem and every patient.

Some of the areas where conflict in the palliative care consultant’s role may arise include:

- When the referring physician requests help with specific symptoms but orders the consultant to stay away from sensitive topics such as prognosis;
- When the patient or family specifically and insistently brings up those same topics or asks for help with questions not covered in the scope of the consultation request;
- When emergent symptom management issues arise during the consultation;
- When communication problems or barriers between the patient/family and primary physician emerge as a major focus of the patient’s needs and concerns; and
- When the consultant has concerns about the requesting physician’s management of the case, for example, a failure to order adequate levels of analgesics or apparent unwillingness to provide realistic prognostic information.

It is also important to recognize that there will be variation in the stringency of the rules of consultation based on a range of factors: prior relationship between referring and consulting physician; differences in consultation etiquette on different services (for example surgical versus medical floors); local cultural patterns of physician consulting practice; age and penetration of the palliative care consultation service into the work of the hospital; acceptance by the physician community; and how the interdisciplinary team functions in provision of consulting support to referring services. In some settings the palliative

care team is asked to directly order pain medications and other treatments, while in other hospitals these would be considered violations of consultation etiquette. Some consultants accept referrals from anyone in the hospital (families, nurses, social workers, in addition to the primary physician), while others require initiation of the request from the managing physician.

“JUST COME AND DO WHAT YOU GUYS DO”

Some physicians will call for a consultation without a clear question or task for the consultation service. They may be unable or unwilling to articulate their personal distress and need for help breaking bad news, acknowledging that the treatment did not work as well as hoped, or helping patients and families understand their situation and arrive at treatment choices that best meet their values and goals. These are challenging tasks for any health professional and they may be difficult to articulate clearly in the consultation request. In these cases, the palliative care team should assess the patient and the situation and then get back to the primary attending with impressions and recommendations, leaving the authority to decide in the consultant’s hands.

Some referring doctors view palliative care as a direct path out of the hospital or to another service such as hospice, and will assume that a referral to palliative care means a thorough discussion of difficult goal-setting issues. Other differences may be found between academic and community hospitals or in settings where the palliative care service works closely with the hospital ethics committee.

One key question for any palliative care service is whether it is ever willing to take over medical management of patients from the requesting physician—or does it insist on remaining in a consulting role only? Dr. Robert Arnold of the Institute to Enhance Palliative Care at the University of Pittsburgh suggests that assuming primary management may create ethical risks through patient or family perception of abandonment by the primary physician.³ Arnold recommends that palliative care services take over such primary management responsibilities only after explicitly negotiating the transfer with the patient and family as well as the primary physician.

EXPERIENCES FROM THE FRONT LINES

Dr. Philip Santa-Emma, palliative care physician with the Mount Carmel Health System in Columbus, Ohio, stresses the importance of knowing the referring physician and his or her expectations. "In our system, when I get the consultation, I usually have a pretty good sense of what the physician is expecting. Sometimes we are asked to see the patient for symptom burden—but are told not to talk about goals of care or treatment planning. You respect that request, but you ask what they are concerned about or what they think might happen," he explains.

"I think you have to be very aware of your job as consultant. The goal is to give the best care to the patient that you can," Santa-Emma says. "We all bring our own personal beliefs to our work, but our goal is to set aside those personal beliefs and empower patients to make their own decisions. The real frustration comes when we're not able to empower the patients to make their best decisions."

Dr. Jean Youngwerth, associate program director of the Colorado Palliative Medical Fellowship at the University of Colorado Health Sciences Center in Denver, Colorado, has worked both sides of the consultation relationship as a palliative care physician and as an internal medicine attending who refers cases to palliative care. "In theory, a palliative care consultation should be the same as any other, but there are important differences and specific things you need to know," she says.

One of these is how to align yourself with the referring physician. "As a medical consultant asked to give preoperative clearance to a diabetic patient, for example, it is easy to limit my role to the specific task asked of me. In palliative care, it's a more sensitive subject, especially since you are addressing big picture social, psychological and spiritual issues. You can easily offend the referring physician," Youngwerth relates. "We also help facilitate communication between the patient/family and the medical team, and act as advocate for the patient and family if there is a conflict. If we see that the team is not following our recommendations, we will talk to them and try to understand why," she says.

"When we get a palliative care referral, I make sure I speak directly with the referring physician first, before seeing the patient. I ask, 'How can I help?' I get their perspective on the case. Right

there we are starting to align with them. I also invite someone from the primary care team to attend the family meeting, if not the attending, then a fellow or the chief resident." Family meetings can take a long time, Youngwerth adds. "So I invite the attending to come at the beginning, when I elicit the patient and family's goals of care."

She describes a recent case of a young woman with cancer, whose surgeon thought she should have a do-not-resuscitate order and a referral to hospice, which the patient resisted. "The patient clearly told us in the family meeting why she didn't want to be in hospice at this time. But her surgeon had problems with that, saying, 'You guys are pretty useless. You didn't get her into hospice.' We had to carefully explain why the patient did not feel that hospice was in line with her goals at this time, despite her clear understanding of her medical situation and prognosis."

Some surgeons only refer their most complex and long-stay cases to palliative care, and only when they go badly, Youngwerth adds. They may view palliative care primarily as a means of reducing demands from angry and upset family members. "Finally, they sometimes consult us because of pressure from nursing staff or other team members, but they don't always want to hear our input. They may not respect the patient's changing goals of care, and often will not attend family meetings, which makes communication more difficult," she relates. "That's where you need to act as patient advocate, using all of your social skills to explain how you came to your recommendations. We don't say, 'This is what you need to do,' or 'You're wrong.' We try to validate their viewpoint, show respect, and not put ourselves on the opposing side, because that won't work."

THE NEED FOR HUMILITY

Robert Arnold believes that the palliative care consultant's role is not an either/or dichotomy between respecting the rules of consultation versus advocating for the patient. "The real question is how can I be considerate of the attending's perspective and advocate for the patient. A related issue is the need for humility and recognition that we aren't always right and that the attending may know things about the patient that we don't," he says. (Arnold recommends a helpful reference in this regard: Patterson K, Grenny J, McMillan R,

Switzler A. *Crucial Conversations: Tools for Talking When Stakes Are High*. McGraw-Hill: 2002.)

“As a consultant, if I don’t make my primary customer happy, I won’t get much business. But there are some cases where I need to argue and push my colleagues and their comfort level a bit. The learning point is how to listen respectfully, assume they know something about the patient, and be humble in my suggestions,” Arnold says. “We need to be as kind to our primary clients, the referring physicians, when they don’t do what we think they should, as we are toward patients and families who make different choices than we would. If I can ask myself why a smart, hard-working doctor would want to do things differently than I would, I can be a better advocate for the patient and help the doctor provide better care for that patient.” Being a consultant is not necessarily a skill doctors are born with, but it can be taught, he says.

What if Arnold believes the referring physician is making a mistake? “My first question would be how serious is this mistake? If they’re really wrong, I can tell them.” There are other ways to address these issues, he adds, but the mistake has to be really significant, either medically or ethically, to discuss the mistake and/or to go over their head. “I only do that if I cannot negotiate with them, and in those rare cases it means going to their boss or a higher-up in the hospital.” Other cases that he believes may lead to less-than-optimal care might be addressed by trying to change hospital practice through education or policy.

Dr. David Giansiracusa, palliative care educational program director at Memorial Sloan-Kettering Cancer Center in New York City, says it is not uncommon for him to be given “[F]airly sharp boundaries of what the referring physician wants us to do or not do, such as not talking to the patient about dying. There is a way to respond to that order while showing respect to the physician,” he says.

If the patient brings up the taboo subject, the consultant can acknowledge its importance and engage in the topic, “not so much to give information as to elicit their concerns—i.e., to listen, which is always acceptable—while not divulging information that the primary physician should be the one to share. I may say, ‘This is not something your doctor asked me to address, but I can see it’s very important to you. I can share your concerns with your physician. I think it would be valuable for you to talk with your physician, but either he or I will get back to you about that,’” Giansiracusa relates.

Patients and families sometimes have a hard time bringing up these subjects with their doctors. “I can coach them in how to talk to their primary physician. What’s interesting is how often these patients and families share things with us instead of with the referring physician, and how we have to reflect the information back to the primary in a way that respects the doctor and supports his or her relationship with the patient and family. I may say to the doctor, ‘I think it’s important to share with you what the patient said. This was not an area of chief inquiry by me, but these are issues you may want to respond to, and I’d be happy to work with you on them.’”

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