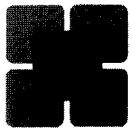

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Introduction: the internist as consultant

INTERNISTS OFTEN play an important role in the treatment of surgical patients by performing preoperative evaluations and managing perioperative complications. This issue of the *Cleveland Clinic Journal of Medicine* contains a special symposium exploring a variety of common problems that confront internists in their role as perioperative consultant, and makes recommendations on how internists can be most effective in that role.

The internist acting as a surgical consultant faces a wide range of possible medical problems. Approximately 60% of surgical patients have symptoms or signs of concurrent systemic disease, and the prevalence is even higher in the elderly. The most common comorbid conditions are cardiovascular, respiratory, or metabolic.

The effect of consultation on patient care in the perioperative setting has not been rigorously evaluated, although some studies have measured compliance with consultants' recommendations. For example, one study found higher compliance with consultants' recommendations in community hospital settings than in university settings.[1] Another study in a university teaching hospital found that consultants made many new diagnoses during preoperative assessments, but it did not examine the impact on outcome.[2]

Few studies have examined the effect of consultation on patient outcome. Studies in Veterans Affairs medical centers did show that preoperative consultations decrease length of stay and use of laboratory and radiographic services,[3,4] but these findings may not be relevant to the private sector, where most patients are evaluated as outpatients. There is obviously much to be learned concerning the effectiveness of perioperative consultation and how it affects patient outcomes.

HOW TO BE MORE EFFECTIVE

Goldman[5] has suggested "Ten Commandments for Effective Consultation," advising consultants to: (1) clarify the question, (2) determine the urgency of the consultation, (3) gather data independently and not rely only on that previously obtained, (4) be brief and avoid recapitulation, (5) state the differential diagnosis concisely and be specific in all recommendations, (6) anticipate potential problems and provide therapeutic options, (7) honor the roles of other care-givers, (8) teach with tact, (9) maintain direct contact with the referring physician, and (10) follow up with periodic notes and recommendations. Adherence to these principles increases the probability that the consultant's recommendations will be followed. Effective consultation requires collaboration between the consultant, surgeon, and anesthesiologist. It is important to clarify roles in order to ensure the best patient outcomes.

Along the same lines, we advocate the following guidelines for effective consultation:

Determine the question and respond to the question asked. Any additional problems that are uncovered should be pursued later, unless they will affect surgery.

Respond promptly. This will increase your effectiveness and help decrease length of stay.[6]

Avoid any criticism of the referring physician. Criticism increases resistance to your recommendations and decreases the effectiveness of care of other patients from the consulting physician.

Write a concise and specific note. We recommend the following format: reason for consultation, impression, subjective findings (pertinent history), objective findings (pertinent physical findings, laboratory or radiographic results), recommendations,

discussion, and plans for follow-up. A brief and well-organized note will lead to better compliance with recommendations.

Coordinate the advice of multiple specialists. When there are multiple consultants, the internist can serve a valuable role in setting priorities and negotiating differences among them.

Talk to the surgeon. Personal communication can enhance the effectiveness of the consultant. When your consultation is likely to lead to a significant change in the direction of care, a direct communication can make the shift go more smoothly. The surgeon should always be contacted if you recommend a delay or cancellation of surgery.

SPECIAL CONSULTATION ISSUE

In this special issue, Dr. Merli reviews the use of low-molecular-weight heparins in preventing deep venous thrombosis in surgical patients. Drs. Jones and Isaacson present their recommendations for routine preoperative testing. Drs. Gewirtz, Kottke-Marchant, and Miller assess the usefulness of the preoperative bleeding time test. Drs. Bronson and Halperin discuss preoperative assessment of cardiac risk. Drs. Hayden, Mayer, and Stoller discuss the perioperative management of pulmonary disease and complications. Dr. Miller summarizes the special considerations in the perioperative care of geriatric patients. In addition, two internal medicine board review cases are presented by Drs. Isaacson and Anderson.

We want to thank our colleagues who have contributed to this special symposium and hope that you, the readers, will find the articles informative and useful in your care of patients.

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