Optimizing the GI Consult Process: Jointly Bridging the Gap

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Introduction

There are positive outcomes in mortality, readmission, and length of stay in early involvement of consultants. (1, 2) While medical house staff consult multiple services, many training programs may be limited in formal teaching on the art and etiquettes of proper consultation.(3) Oftentimes, this trial-and-error learning leads to inefficient consults, particularly with heavily-utilized services like gastroenterology. (3)

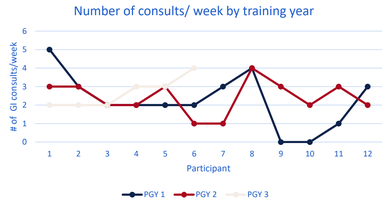
The literature for effective consultation, such as Salerno's Ten Commandments for Effective Consultation, modified from Goldman in 1983, states 1) determine your customer, 2) establish urgency, 3) look for yourself, 4) be as brief as appropriate, 5) be specific, thorough, and descend from the ivory tower to help when requested, 6) provide contingency plans and discuss their execution, 7) thou may negotiate joint title to the neighbor's turf, 8) teach with tact and pragmatism, 9) talk is essential 10) follow-up daily.(2,4) These commandments were modified based on interactions between different medical specialties such as, general internists, family medicine physicians, general surgeons, orthopedic surgeons, and obstetricians/gynecologists. The commandments were mainly focused on consultants with some pearls for the individual requesting the consult. However, no information was reported addressing the interaction between general internal medicine and gastroenterology teams.

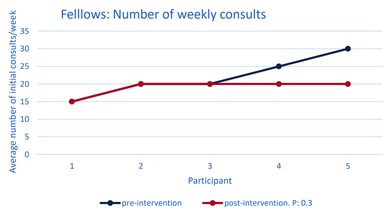
In this study, the we focus on bridging the gap and improving communication during the consultation process between internal medicine residents and gastroenterology fellows in a teaching hospital.

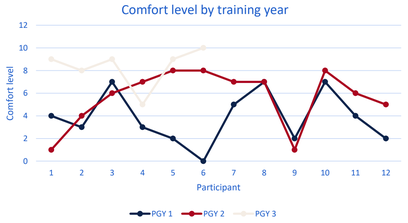
Methods

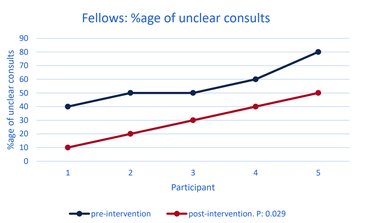
To identify current conditions and areas of improvement for the consult process, a survey was sent to residents and fellows. To residents, we asked their training level, formal training regarding consults, comfort level in calling GI consults, and the average number of GI consults per week. To fellows, we asked the average number of consults received during general GI consults, their estimated percentage of "unclear" consults and consults more appropriate for a different service. Working with a chief GI fellow, medicine residents jointly developed a primer of most common GI consult questions to aid in framing the question, work-up, and management. After 1 month, both residents and fellows were polled again. Responses were anonymous and analyzed via paired, two-tailed t-tests.

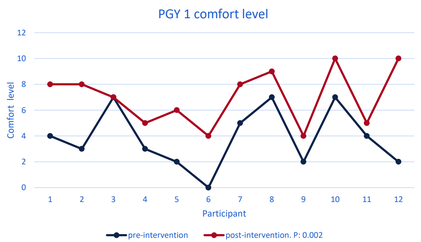
Results

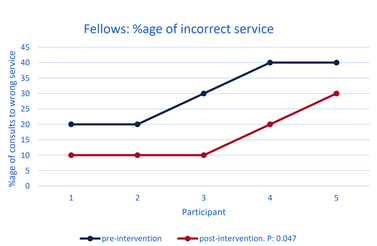


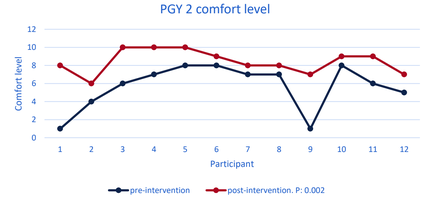


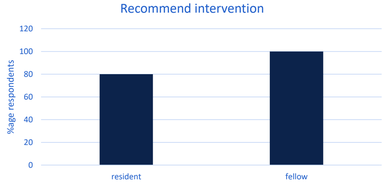












Discussion

Among the 32 pre-intervention resident responses, we had 6 PGY-3, 13 PGY-2, and 13 PGY-1. Of the 26 post-intervention resident responses, no PGY-3 responded; we had 13 PGY-1 and 13 PGY-2. The mean number of GI consults called per week was 2.4 per resident. There was a clear lack of formal training on calling consults (93% reported no formal prior education), yet 80% respondents wished for further teaching. Interestingly, there was no significant difference among the comfort level in calling consults between PGY-1 vs PGY-2 ($p=0.07$); unlike PGY-1 vs 3 ($p<0.01$) or PGY-2 vs 3 ($p=0.03$). This may be due to experience. Our interventions led to significant improvements in comfort/confidence levels in calling the GI service among PGY-1 and 2 ($p= 0.02$), with 80% respondents saying they would both use the primer in the future and recommend to colleagues.

Among our GI consultants, we had 5 fellows respond to the pre and post survey. Although there was no significant difference in the number of consults received per week, the number of unclear consult questions and incorrect consult service request significantly reduced after the intervention. This suggests the quality of the consult question improved and the appropriate services were utilized. Similar to 80% of our residents, 100% of the fellows also recommended its continued use.

Our study is limited by several factors. The sample size from both the residents and especially the fellows (although there are only 8 fellows at our institution), underpower this study. Fortunately, attrition bias was limited to 6 PGY 3 residents who we hypothesize were already comfortable and experienced in the consult process. The subjective nature of our survey invites recall bias which we aimed to minimize with standardized sampling methods. Future studies may design longer-washout periods with a larger sample size to improve upon ours.

The gastroenterology consult service is busy. Meeting the need and desire from both residents and fellows to bridge the knowledge/ communication gap, from lectures and step-wise guides, is crucial to optimizing the consult process and patient care.

Disclosures

The authors have no disclosures to report.

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