Medical Consultation for Surgical Cases in the Era of Value-Based Care

Gulshan Sharma, MD, MPH

Dr William Mason described the limitations of individual physician practice to provide the best care in the era of complex diagnostic and treatment algorithms in 1929. He explained medical consultation as a medium by which to secure ideas and the opinion of physicians with diverse medical expertise for patients segregated by specialized service units. An open and effective communication is necessary between surgeons and medical specialists for proper management of the patient with a complex medical history. Fast forward to 1983. Goldman and colleagues provide explicit instructions for effective consultation, labeled as “Ten Commandments for Effective Consultations.” These include the following: determine the question asked; establish the urgency of the consultation; gather primary data; communicate as briefly as appropriate; make specific recommendations; provide contingency plans; understand one’s role in the process; offer educational information; communicate recommendations directly to the requesting physician; and provide appropriate follow-up. This listing describes the traditional role of a consulting physician. However, significant specialty-specific differences exist for the involvement of a consultant. Hence, it is important that the medical consultant clarify the level of involvement with the requesting physician to avoid “turf battles.”

Over the past 20 years, the role of the medical consultant for surgical patients has transformed substantially, from consultant to comanager. Whereas a medical consultation used to be requested predominantly for preoperative risk assessment, management of complex comorbidities, or for postoperative complications, the role of a “comanergial physician” includes daily assessment of patients, writing orders, addressing comorbidities and any acute medical issues that arise, communication with surgeons, and assistance with the care transition process. This arrangement is common and differs from traditional relationships in which the consultant writes recommendations and the surgeon executes them. This transformation to some extent is driven by increased focus on quality and cost, allowing surgeons to spend more time in the operating rooms; the growth in aging population with complex comorbidities; and duty hour restrictions limiting the ability of house staff in teaching hospitals to provide preoperative and postoperative care.

Our study in 2010 found that one-third of the patients hospitalized for a common surgical procedure are now comanaged by medicine physicians (generalist physicians or internal medicine subspecialists). The largest increases during the study period were seen in patients hospitalized for an orthopedic procedure. The potential benefits of comanagement (mostly studied in orthopedic patients) include increased prescribing of evidence-based treatments; reduced time to surgery; fewer transfers to an intensive care unit for acute medical deterioration; fewer postoperative complications; increased likelihood of discharge to home; reduced length of stay; improved nurse and surgeon satisfaction; and a lower 6-month readmission rate. Recent studies suggest that comanagement facilitates effective rescue among medically complex surgical patients and explains the differences in outcomes of high-volume and low-volume surgery centers.

While medical consultation has many anticipated benefits, there are downsides as well, including the potential for confusion when multiple opinions are sought; the challenge of decision making when multiple decision makers are included; lack of ownership when problem arises; and the costs associated with soliciting additional input. In this issue, Chen et al shed light on this issue by examining the use of medical consultation for fee-for-service Medicare patients who underwent colectomy or total hip replacement (THR) between 2007 and 2010. Half of the patients were seen by a general medicine physician, and up to a third were compliant. Two-thirds of the patients with colectomy and over half of those with THR had 2 or more comorbidities, supporting the notion that these patients are medically complex. Medicine subspecialty consultation was sought in 56% for patients undergoing colectomy. Patients with colorectal cancer require multidisciplinary input from a gastroenterologist and an oncologist for management. By contrast, patients with THR are less complex, and 24% of them had medical subspecialty consultation, the most common being physical medicine and rehabilitation physicians consulted in 11% of the patients.

Medical consultation in patients with complications was high and did not vary by acute care hospitals. In contrast, there was large variation in the use of medical consultation in patients without complications. Does this pattern reflect an effort to increase surgeon efficiency or to reduce complication rates by actively intervening in a timely fashion? Risk-adjusted 30-day mortality and complication rates were higher in hospitals at the highest quintile use of medical consultation compared with hospitals at lowest quintile use of medical consultation. Are these findings all attributed to limitations (eg, selection bias, inappropriate adjustment of severity of illness, simultaneity bias) of descriptive studies, or is there a potential harm associated with medical consultation? Does routine use of medical consultation in low-risk patients avoid poor outcomes? Information on quality of care, use of comparative effectiveness research methodology to address issue of selection bias, and cost associated with consultation (especially in low-risk patients) are important but should not underscore the findings of the present study. It raises concern for potential inappropriate use in the health care system.
I agree with the Chen et al.\(^7\) that understanding the “value” of medical consultation is an important next step, especially in low-risk patients undergoing elective surgery. For surgical procedures, hospitals and surgeons are paid a set amount. Any additional consultation is an added cost to the health system billed under Medicare Part B for physician services. Each organization is different. The “value” of medical consultation is heterogeneous and lies in the eye of the beholder. For example, a surgeon with a high case volume may also have high use of medical consultation, producing “value” to the health system by improving efficiency that may offset the “value” lost through the additional consultations. Alternatively, there is the downside of injecting risk into patient care with multiple consults from additional physicians.

There is no one fit for all. Decisions on routine use of medical consultation for highly reimbursed procedures should be driven by institutional data on quality and cost. Some health systems may mandate comanagement of all surgical patients; such practice should be discouraged. During preoperative evaluation, patients with comorbid conditions and those at significant risk of postoperative complications should be considered for medical comanagement. As we move toward bundled payment for major surgical procedures, the role of medical consultation and comanagement will evolve further. A robust system to provide real-time clinical and financial information is needed to engage all parties. A significant amount of work is still needed on equitable distribution of monies among health care teams under bundled agreements. Transparency and trust are key for an integrated payment model to be successful. Until then, our responsibility as health care practitioner is to align resources to provide the best value for our patients and the health system.

### ARTICLE INFORMATION

**Author Affiliation:** Division of Pulmonary Critical Care and Sleep Medicine, University of Texas Medical Branch, Galveston.

**Corresponding Author:** Gulshan Sharma, MD, MPH, Division of Pulmonary Critical Care and Sleep Medicine, University of Texas Medical Branch, 301 University Blvd, JSA - 5.140, Galveston, TX 77555-0561 (gulshan.sharma@utmb.edu).

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### REFERENCES


