There's not a damn thing wrong with my bedside manner!
Consultation Etiquette

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Objectives

1. Describe how principles of consultation etiquette can be used to maximize advocacy for unmet palliative care needs.

2. Practice communication phrases that maximize the potential for meeting unmet palliative care needs.

3. Complete a self-assessment of consultant to clinician communication style.
Principles of Consultation Etiquette

1. Determine the question
2. Triage urgency
3. Gather your own data
4. Brevity
5. Specificity
6. Plan ahead
7. Honor turf
8. Teach with tact
9. Personal contact
10. Provide follow-up
A common source of tension for the palliative care team is when \textit{their patient care values conflict with those of the referring clinician}. Examples include:

– \textit{Timing and amount of opioids for pain control}

– \textit{Timing of sensitive communication regarding prognosis}

– \textit{Use of life-prolonging treatments, especially artificial feeding, antibiotics and mechanical ventilation}

How the palliative care team approaches these conflicts impacts:

– Their sense of frustration vs. accomplishment

– Their reputation among referring clinicians and other staff

– The outcomes of your team’s work: clinical care, readmission, cost avoidance.

Patient Advocacy vs. Respectful Consultant
Concerns Particular to Palliative Care Consults

- Specific request versus global needs of patient
- Requests to avoid certain issues
- Patient and family bring up topics outside scope of consult
- Current treatment plan does not reflect the patient’s priorities
- There is no consensus regarding goals of care among the healthcare team and/or patient and family
Consultation Tension

GOAL: to effectively combine both strong patient advocacy & be a respectful consultant.

Strong patient advocate

- Potential for more conflict
- Greater sense of personal value/accomplishment vs. emotional cost of conflict
- Greater respect from peers

Respectful consultant

- Easier to "get along"
- Lower sense of personal value/accomplishment balanced cost against less emotional "cost" of conflict
- Less respect from peers/others
Consultation Tension

Clash of Values

Recognize that the source of tension is usually about values, rather than facts.

Values are personal, reflecting deeply held attitudes. Values often have an emotional component—thus, they resist change through rational argument.

Examples:

- I’m afraid I will kill my patient with morphine.
- Chemotherapy for cancer patients with low PPS is wrong.
- My peers will view my action to refer a CHF patient to hospice as “giving up too soon”.


Role Play “the rest of the story”
Consultation Styles

Full Contact

– Strong patient advocate
– Honest communication with referring clinician
– “Tell it like it is”

Just Touch

– “Get-along” attitude
– Conflict avoidant—fear of upsetting referring clinician
Self Assessment

1. How do I decide for any given case whether to lean more towards the ‘full contact’ or ‘just touch’ side of consult interactions?

   Level of personal comfort with the referring clinician.
   Specialty of the referring clinician relative to my primary training.
   Level of energy/fatigue as the day progresses.
   Discomfort with conflict.
   Urgency of the clinical situation.
Self Assessment

2. How well does my practice style meet the needs of patients and families?

Are distressing symptoms met in a timely fashion?
Are key discussions taking place to meet patient and family needs?
Are patients and families asking important questions that are going unanswered?
Self Assessment

3. *Does my practice style lead to frequent problems that might be ameliorated by a shift in practice?*

- Prolonged hospital or ICU length of stay?
- Poorly managed symptoms?
- Frequent readmissions due to failure of advance care planning and goal setting?
- Frequent team conflict about how best to manage conflict with the referring clinician?
Case 1

Referral from a cardiologist:

75 y/o man with CHF, hospitalized for two days with fatigue, nausea, dyspnea and chest pain.

Consult request for assistance with pain and nausea control.

Six hospitalizations in the past year, most recently two weeks ago.

Gradual loss of function over the past year.

Pre-admission function was bed-to-chair, 15 pound weight loss over the last 3 months.

The cardiology PA calls saying: “Dr. X asked me to call and let you know that she has additional treatments to offer, please do not discuss prognosis or hospice
# Palliative Performance Scale

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity and evidence of disease</th>
<th>Self-care</th>
<th>Intake</th>
<th>LoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal activity; no evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Normal activity; some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80</td>
<td>Reduced</td>
<td>Normal activity with effort; some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Unable normal job/work; some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Unable hobby/ housework; significant disease</td>
<td>Occasional assistance needed</td>
<td>Normal or reduced</td>
<td>Full or confused</td>
</tr>
<tr>
<td>50</td>
<td>Mainly Sit/Lie</td>
<td>Unable to do any work; extensive disease</td>
<td>Considerable assist needed</td>
<td>Normal or reduced</td>
<td>Full, drowsy or confused</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in Bed</td>
<td>Unable to do any work; extensive disease</td>
<td>Mainly assisted</td>
<td>Normal or reduced</td>
<td>Full, drowsy or confused</td>
</tr>
<tr>
<td>30</td>
<td>Totally Bed Bound</td>
<td>Unable to do any work; extensive disease</td>
<td>Total Care</td>
<td>Reduced</td>
<td>Full, drowsy or confused</td>
</tr>
<tr>
<td>20</td>
<td>Totally Bed Bound</td>
<td>Unable to do any work; extensive disease</td>
<td>Total Care</td>
<td>Minimal sips</td>
<td>Full, drowsy or confused</td>
</tr>
<tr>
<td>10</td>
<td>Totally Bed Bound</td>
<td>Unable to do any work; extensive disease</td>
<td>Total Care</td>
<td>Mouth care only</td>
<td>Drowsy or coma</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>---</td>
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</tbody>
</table>
Case 2

Consult from a hospitalist:

55 y/o woman with pulmonary fibrosis, hospitalized for functional decline.
Consult request is for assistance with goal setting and possible hospice referral.
The patient is DNR/DNI. Her PPS is 20

When you enter the patient’s room she is sitting on the edge of the bed gasping for breath, unable to talk. The patient’s nurse tells you that the breathing worsened in the last two hours.

The hospitalist was notified and ordered 0.5 mg sq morphine, administered 60 minutes ago with no effect.
References


Meier D, Beresford L: Consultation etiquette challenges palliative care to be on its best behavior. JPM 2007; 10: 7-11.

The End