Consultation Etiquette in Palliative Care
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There are generally agreed upon rules for consultation (just as there are in social life) that may have profound consequences if they are breached. For those just starting to provide consultation services, it is wise to follow the rules until you develop enough familiarity to know when they can be abridged. Particularly since palliative care is a new field, and it deals in areas that make referring services feel uneasy, it is all the more important to pay careful attention to etiquette, which is at its core, about putting people at ease.

You are a consultant to the managing service. Although the focus of the consultation is a patient/family issue, your responsibility is to the attending physician and/or managing service that has requested the consultation.

Be accessible. A referring physician or service needs to know how to reach you easily. He or she will be put off if they can’t reach your service. Indicate how you can be reached in your consult note.

Be responsive. Acknowledge receipt of the request within a few hours of receiving the request to see the patient. See the patient and offer initial advice on the same day, or within 24 hours at the maximum.

Call the Referring Service. Before you see the patient, call the referring service to acknowledge that you received the request and to clarify the nature of the request. No matter what is written in the chart, the real story exceeds what is written. With experience and familiarity with frequent referrers, this step may be skipped. But, the chance for missed information is increased. Particularly for palliative care consultations, this has an important secondary importance. In telling you about the patient, the service will receive emotional support in telling the story. Be quiet and actively listen. Acknowledge the underlying distress.

Cultural Corollary: The rank of the person calling should match or exceed the rank of the person called. Strictly applied, an attending speaks to an attending or anyone else. A resident can call a resident or medical student or other hospital staff, but not the attending. Nurses call nurses or other staff.

Rank is an elusive quality. Some nurses and other health care professionals earn the rank and esteem of senior physicians, but this is specific to individuals. Also, some staff do not require this. For example, some attending physicians respond well when the medical student on the service calls. However, when in doubt, following the cultural corollary connotes respect.

Clarify the nature of the request. Determine what questions the managing service wants answered and be sure to answer them. If they are asking you to help with discharge planning, do not just focus on symptom control. Determine if there are areas that are “off-limits”. Common requests are not to use the "hospice" word or the "death" word, at least initially. Clarify what you will do if the patient/family ask about these issues. Clarify the patient/family constellation. Who needs to be there? With whom should the consulting team speak?

See the patient. This includes talking with the nursing staff and others, reviewing the medical record, pertinent laboratory and diagnostic tests, interviewing the patient and family, examining the patient, and offering information and counseling if that was part of the nature of the request.

Call the Referring Service. Before you write in the chart, call the referring service back with what you found, and what you advise. With experience and familiarity with frequent referrers, this step may not be necessary.

An important secondary role is to commiserate and give support about the challenging nature of the case. Remember the cultural corollary—it is probably more important here than for the initial call. It shows respect to the referring attending for the consultant attending to call back with recommendations and to discuss the case.

Discuss the recommendations with the Managing Team. Find or call other important consultants, housestaff, nursing staff, therapists, social workers, chaplains, etc who are working with the patient. Discuss your findings and recommendations. This is a key educational and marketing step for your consultation service. Remember the cultural corollary.

Negotiate roles. Many referring physicians and teams will want the palliative care service to play an ongoing role in the management of the patient and family. This may range from providing information and counseling, to managing symptoms, to assuming principal care for the patient and family. Others will want the palliative care service to maintain a strictly consulting role while the managing service implements recommendations.

Reference