How to nail your first consultant phone call!

Calling in consults is a bit of an art and can be an anxiety point for new clerks (and honestly residents and attendings as well depending on the consultant). Let's go through some tips on how to make this go well. This approach is adapted from articles on RebelEM, Maimonides EM, Canadiem, BoardVitals, and my own personal experience on both ends of the phone.

Before you call

1. Do you understand what the **consult question** is? "My resident told me to call" won't cut it!
2. Have you sat down with the chart for a few minutes to **review the history of the problem you're consulting for, relevant investigations and management, and response to that management?**
3. Can you articulate the urgency of the consultation? Are you asking for them to see tomorrow, or does staff need to run over?
    - Consider urgency before picking up the phone overnight/end of the day – do you need consultant recommendations to advance care appropriately/for safety reasons, or can this wait until the morning?

When you call

Try this format (it's evidence based – Kessler et al 2012)

1. **Contact**
   - Confirm if appropriate person on the phone
   - Your name
   - Your level of training
   - Your service and attending
   - Is this a new consult or is the patient known to them already?

Hi there, is this Dr. Byrne on call for Gastroenterology today? Is this an ok time to call you? I'm Alex Monaghan, second year resident on CTU Red with Dr. Laura Kuyper. I'm calling to get your help with a new patient.

2. **Communicate**
   - Patient's name/MRN/location
   - *The consult question**
   - Pertinent clinical details
   - Pertinent labs
   - Interventions and response
   - "Other details that you know the consultant will ask for right away" - you will learn these as you do more medicine

The patient is Mr. Smith, 70 year old male, MRN ######### on 10C bed 320-4, admitted under CTU. He is a patient with presenting with likely upper GI bleed, for your consideration of scope. He presented with hematemesis, melena, and anemia with hemoglobin drop to 50. He is currently vitally stable after 2 units of blood and 1L fluid bolus, and incremented appropriately with blood transfusion. We have initiated pantoprazole IV bolus and infusion. He has no prior bleeds or known liver disease, but is on DAPT with no PPI. He is still passing melena. He last ate at 0830 this morning.

3. **Core Question**
   - Reiterate the main consult question/task and the timeframe

The patient is stable now but is still frankly bleeding, so we are hoping for your assessment and plan for potential scope this afternoon Is there anything you would like me to get done before you assess the patient?

4. **Collaboration**
   - Offer to put in orders/prepare supplies/whatever else they may need to move things along

Thanks for your time, we'll see you shortly. In the meantime I'll make the patient NPO and print you a consent form. My call back number is ######### in case you need to reach us sooner.

5. **Close the loop**
6. **Follow up, debrief if needed**
   - Ideally your senior resident will be around for the first few calls you make, but please do debrief with them if you feel a call didn't go well. This is a skill that needs to be developed, and that means some of your calls will be rough until you develop the skill.
   - Follow up on the consult recommendations and incorporate recommendations into the care plan!

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6 reasons why consultant calls can go badly (adapted from Dr. Nadim Lalani)

1. **Caller is not ready**: We need to have our ducks in a row when the consultant returns our call. This means having our ‘one liner’ introductory sentence to hook the listener and having all relevant and accurate patient data readily available.
2. **No clear question**: We need to know what we need from our consultant. If we don’t know what we want, it will be hard for our consultant to know what we want. “I am calling for assistance with outpatient follow up,” vs “I am calling to admit this patient onto your service.”
3. **No previous contact**: In a large hospital system it is not unusual to have never interacted with the consultant. Making good first impressions will help tremendously. Having a goal of only calling for appropriate reasons will also endear your consultants to you.
4. **System is overloaded**: Any time a consultant receives a call it will typically mean more work for them. Making an efficient and factually correct call will make your consultants day smoother. It also takes time to build rapport with a consultant through multiple interactions, but only one bad interaction to lose their trust.
5. **Known difficult consultant**: Medicine is full of great people but sometimes people are angry and short, and it has very little to do with you. The only good way to deal with this is to exude professionalism, courtesy, and to not sink to their level if the conversation deteriorates.

6. **Lack of skills/training**: Relatively less time tends to be spent teaching residents and students in the best way to call a consult (vs how to round well, how to do a consult).