

ACOG COMMITTEE OPINION

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Seeking and Giving Consultation*

Committee on Ethics

Reaffirmed 2019

ABSTRACT: Consultations usually are sought when practitioners with primary clinical responsibility recognize conditions or situations that are beyond their level of expertise or available resources. One way to maximize prompt, effective consultation and collegial relationships is to have a formal consultation protocol. The level of consultation should be established by the referring practitioner and the consultant. The referring practitioner should request timely consultation, explain the consultation process to the patient, provide the consultant with pertinent information, and continue to coordinate overall care for the patient unless primary clinical responsibility is transferred. The consultant should provide timely consultation, communicate findings and recommendations to the referring practitioner, and discuss continuing care options with the referring practitioner.

Physicians have a long history of working together and with other health care professionals to provide efficient and comprehensive care for the patients they serve. Achieving these goals sometimes requires that physicians or other care providers seek consultation from or provide consultation to their colleagues (1). The basic principles of consultation for obstetrician–gynecologists are summarized in the “Code of Professional Ethics of the American College of Obstetricians and Gynecologists” as follows (2):

- “The obstetrician–gynecologist’s relationships with other physicians, nurses, and health care professionals should reflect fairness, honesty, and integrity, sharing a mutual respect and concern for the patient.”
- “The obstetrician–gynecologist should consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients.”

Often, these relationships among clinicians lead to professional dialogue. In professional dialogue, clinicians share their

opinions and knowledge with the aim of improving their ability to provide the best care to their patients. Such dialogue may be part of a clinician’s overall efforts to maintain current scientific and professional knowledge or may arise in response to the needs of a particular patient.

In professional dialogue, a second clinician is typically asked a simple question and he or she does not talk with or examine the patient. For example, questions might be asked regarding the significance of an irregular blood antibody or the follow-up interval for an abnormal cervical cytology result. The second clinician does not make an entry in the patient’s medical record or charge a fee, and the first clinician should not attribute an opinion to the second clinician.

Professional dialogue does not constitute a formal consultation or establish a patient–consultant relationship. Sometimes, however, professional dialogue does lead to a formal request for consultation. If, for example, a physician is asked to provide an opinion regarding a patient’s care and believes an examination of the patient or her medical record is necessary to answer the question appropriately, he or she should ask to see the patient for a formal consultation.



**The American College
of Obstetricians
and Gynecologists**
*Women’s Health Care
Physicians*

*Update of “Seeking and Giving Consultation” in *Ethics in Obstetrics and Gynecology*, Second Edition, 2004.

Although consultation usually is requested in an efficient manner that expedites patient care, situations occur in which the relationship between practitioners or between institutions and practitioners results in an inefficient, less-than-collegial consultative process that may not be in the best interest of the patient. For example, a patient and a consultant may be put at serious disadvantage when consultation is requested late in the process of care or is not accompanied by sufficient background information or the reason for consultation is not clearly stated. Conversely, those seeking consultation may be denied assistance on arbitrary grounds.

This Committee Opinion outlines the purpose of consultation and referral, states the underlying ethical foundations that govern consultation and referral, and elaborates specifically the responsibilities of those who seek and those who provide consultation. The Committee Opinion is directed to physicians but it should be recognized that nonphysician practitioners also may be involved in consultation.

The Purpose of Consultation and Referral

Typically, a patient first seeks care from her primary caregiver, who should be aware that the patient's needs may go beyond his or her education, training, or experience (2–4). Various levels of consultation may be needed to make correct diagnoses, provide technical expertise, and recommend a course of action (see the box). Occasionally, consultation or referral may be indicated when a patient's request for care is in conflict with her primary caregiver's recommendations or preferences. Finally, a patient may seek consultation with another caregiver to obtain a second opinion or explore other options for care (5). In all of these types of consultation, the interests of the patient should remain paramount (3).

Ethical Foundations

Ethical principles require that the consultative process be guided by the following concepts (2, 6):

- The welfare of the patient should be central to the consultant–patient relationship (beneficence).
- The patient should be fully informed about the need for consultation and participate in the selection of the consultant (respect for autonomy).
- The patient should have access to adequate consultation regardless of her medical condition, social status, or financial situation (justice).
- Practitioners must disclose to patients any pertinent actual or potential conflict of interest that is involved in a consultation relationship, including financial incentives or penalties or restrictive guidelines (truth-telling).

In addition, both practitioners with primary clinical responsibility and consultants must respect the rights of

Definitions: Levels of Consultation

Consultation is the act of seeking assistance from another physician(s) or health care professional(s) for diagnostic studies, therapeutic interventions, or other services that may benefit the patient. There are several levels of consultation: single-visit consultations, continuing collaborative care, and transfer of primary clinical responsibility. Their descriptions are as follows:

- **A single-visit consultation** involves examination of the patient or the patient's medical record and performance of diagnostic tests or therapeutic procedures. The findings, procedures, and recommendations of the consultant are recorded in the patient's medical record or provided to the practitioner with the primary clinical responsibility for the patient in a written report or letter, and a fee may be charged. The subsequent care of the patient continues to be provided by the referring practitioner. Examples of such consultations are confirming the findings of a pelvic examination, performing a specific urodynamic procedure on a patient with urinary stress incontinence, and interpreting an electronic fetal monitoring tracing or imaging studies. In the latter two cases, the tracing or other output can be transmitted electronically, allowing for the performance of a single-visit consultation without personal contact between the patient and consultant.
- **Continuing collaborative care** describes a relationship in which the consultant provides ongoing care in conjunction with the referring practitioner. Thus, the consultant assumes at least partial responsibility for the patient's care. An example is a high-risk obstetric patient with a medical complication of pregnancy who is periodically assessed by the consultant, whereas the referring practitioner is responsible for the day-to-day management of the patient.
- **Transfer of primary clinical responsibility** to the consultant may be appropriate for the management of problems outside the scope of the referring practitioner's education, training, and experience or in cases in which the patient must be transferred to another facility. Examples are the transfer of care of a patient in preterm labor from a birth center to a consultant in a perinatal center or referral of a patient with ovarian cancer to a gynecologic oncologist. In many of these situations, patients will eventually return to the care of the referring practitioner when the problem for which the consultation was sought is resolved.

the patient and also the rights of their respective professional colleagues.

Responsibilities Associated With Consultation

Seeking Consultation and Requesting Referral

Consultations usually are sought when practitioners with primary clinical responsibility recognize conditions or situations that are beyond their level of expertise or avail-

able resources. Historically, these practitioners acted as independent agents who decided when consultation was appropriate, determined the level of consultation, and were free to choose particular consultants. More recently, as a result of recognition of the importance of respect for patient autonomy, practitioners now inform patients of the need for consultation and discuss options with them. The quality of the consultation often is improved by this collaborative relationship between practitioners and patients.

Today, this practitioner–patient partnership operates under new conditions that may affect the process of consultation. Health care guidelines and protocols used by certain types of managed care arrangements may limit the freedom of the practitioner to provide complete care or to request consultation (7). These guidelines may include instructions about specific situations or medical conditions in which consultation, second opinion, or referral is mandated (8). Examples include abnormal labor that may require operative delivery or chronic uterine bleeding that may require hysterectomy. Other guidelines may require that practitioners seek consultation when patients develop signs and symptoms of severe preeclampsia or if ovarian cancer is discovered. Such arrangements and guidelines may be designed to ensure a high level of care for patients by requiring that consultants be involved appropriately in certain clinical problems.

Conversely, practitioners may find themselves in situations that create disincentives to medically appropriate consultation or that mandate the use of a consultant panel that is not adequate to support appropriate patient care. The policies that lead to such situations involve potential conflicts of interest (9) and may have a negative effect on the patient's medical needs, thus limiting her autonomy and her right to informed choice. Under all conditions of practice—solo or group, fee for service, or managed care contract—consultation and referral should be carried out in the patient's best interest and obtained with the patient's consent after full disclosure of limitations and potential conflicts of interest.

It is in everyone's best interest—practitioners with primary clinical responsibility, consultants, patients, and health care plans—that the criteria for consultation be mutually agreed on in advance and stated clearly in writing. Financial incentives or penalties for consultation and referral that exist either overtly or covertly under many managed care contracts are sources of serious conflicts of interest. Practitioners must be free to inform patients of the best medical practice or options of care, even when the mandate of directed referrals under contracted care does not include these alternatives. Ethical responsibility for patients' best interests demands that practitioners disclose any proscriptions to serving as patients' advocates. Practitioners have a responsibility to provide patients with their best medical judgment and serve as advocates for patients if recommended care is denied. It then becomes the patients' responsibility to decide whether to

abide by insurance plan restrictions, challenge them, or seek care outside the scope of coverage.

Giving Consultation and Accepting Referral

Physicians generally provide consultations or accept referred patients in the interest of providing excellent care for patients and promoting good relationships among colleagues. Open communication and established professional relationships facilitate effective consultation and referral. However, at times a consultant may be called on unexpectedly, inconveniently, and sometimes inappropriately to be involved in or to assume the care of a patient. In these situations, a physician is only ethically obligated to provide consultation or assume the care of the patient if there is a contractual agreement or a preexisting patient–physician relationship or if there is a severe medical emergency, in which there is no reasonably available alternative caregiver (10). Hospital or departmental guidelines for consultation and referral may prevent such confrontations.

Practical Recommendations

Providing optimal care demands a good working relationship with a number of other physicians and health care professionals. Consultation may be needed by the practitioner with primary clinical responsibility regardless of specialty designation or level of training. Ideally, the referring practitioner–consultant relationship has been established before the need for consultation or referral arises, and the referring practitioner–consultant relationship should be ongoing.

One way to maximize prompt, effective consultation and collegial relationships is to have a formal consultation protocol. This may be especially advantageous for family physicians who provide obstetric or gynecologic care and for collaborative practice between obstetrician–gynecologists and nurse practitioners, certified nurse–midwives, and other health care professionals. Such protocols create pathways that anticipate difficult or complex situations. The level of consultation should be established by a dialogue between the referring practitioner and the consultant that results in mutual agreement (see the box on the previous page).

Electronic means of communication, such as e-mail, may be used as long as the consultant and referring physician agree to use such media and have established systems to confirm receipt and transfer of reports to the medical chart. Electronic communication must be done in a manner that protects patient confidentiality.

Responsibilities of the Referring Practitioner

The responsibilities of the referring practitioner can be outlined as follows:

1. The referring practitioner should request consultation in a timely manner, whenever possible before an emergency arises. A good working relationship

between the referring practitioner and the consultant requires shared concern for the patient's needs and a commitment to timely and clear-cut communication.

2. The referring practitioner is responsible for preparing the patient with an explanation of the reasons for consultation, the steps involved, and the names of qualified consultants.
3. The referring practitioner should provide a summary of the history, results of the physical examination, laboratory findings, and any other information that may facilitate the consultant's evaluation and recommendations (11).
4. Whenever possible, the referring practitioner should document in the medical record the indications for the consultation and specific issues to be addressed by the consultant.
5. The referring practitioner should discuss the consultant's report with the patient and give his or her own recommendation based on all available data in order to serve the best interest of the patient.
6. A complex clinical situation may call for multiple consultations. Unless authority has been transferred elsewhere, the responsibility for the patient's care should rest with the referring practitioner (3). This practitioner should remain in charge of communication with the patient and coordinate the overall care on the basis of information derived from the consultants. This will ensure a coordinated effort that remains in the patient's best interest.

Responsibilities of the Consultant

The responsibilities of the consultant can be outlined as follows:

1. Consultants should recognize their individual boundaries of expertise and provide only those medically accepted services and technical procedures for which they are qualified by education, training, and experience.
2. When asked to provide consultation, the consultant should do so in a timely manner and without regard to the specialty designation or qualifications of the referring practitioner.
3. The consultant should effectively communicate findings, procedures performed, and recommendations to the referring practitioner at the earliest opportunity (12).
4. A summary of the consultation should be included in the medical record or sent in writing to the referring practitioner.
5. The extent to which the consultant will be involved in the ongoing care of the patient should be clearly established by mutual agreement of the consultant, the referring practitioner, and the patient. At times it

may be appropriate for the consultant to assume primary clinical responsibility for the patient. Even if this is only a temporary circumstance, the consultant should obtain the referring practitioner's cooperation and assent, whenever possible.

6. When the consultant does not have primary clinical responsibility for the patient, he or she should try to obtain concurrence for major procedures or additional consultants from the referring practitioner.
7. In all that is done, the consultant must respect the relationship between the patient and the referring practitioner, being careful not to diminish inappropriately the patient's confidence in her other caregivers (3).
8. The consultant should be cognizant of the referring practitioner's abilities, and the consultant and referring practitioner should discuss who can best provide the agreed-upon care. Reliance on the referring practitioner's abilities may increase convenience to the patient, limit transportation needs, and ultimately result in more cost-effective care. In other cases, however, it may not be possible for the consultant's recommendations to be addressed adequately by the referring practitioner.
9. If the consultant believes that the referring practitioner is not qualified to provide an appropriate level of continuing care, the consultant should recommend to the referring practitioner and, if necessary, to the patient that the referring practitioner transfer care of the patient.

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