



Called to serve as a consultant in the OR?

WHAT TO DO

by

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At some time, most surgeons have been approached by another surgeon asking for advice or operative assistance due to unexpected problems or questions in the operating room. Regardless of whether we find these requests flattering or annoying, they should be regarded as calls for help from our colleagues. As surgeons, our social contract with patients and colleagues dictates a prompt and professional reply.

The unplanned nature of the intraoperative consultation and communication errors regarding the nature and degree of assistance required can potentially lead to confusion and inappropriate care. As surgical care becomes increasingly subspecialized, the frequency of these interactions will probably increase. We suggest some guidelines for approaching the intraoperative consultation.

What's your role?

Some operative consultations are of such an urgent nature that the consultant must rapidly enter the operative field for direct surgical assistance without an opportunity to review the pertinent data; such instances commonly involve uncontrolled hemorrhaging. In all other situations, the consultant should take sufficient time to review the patient's medical history, preoperative workup, and relevant radiologic studies. The first goal should be to identify the nature of the consultation by determining: (1) exactly what the surgeon wants from the consultant; (2) whether the problem is medical, social, intellectual, or technical; and (3) whether the preoperative diagnosis is correct.

Identification of the information or expertise the primary surgeon needs, while seemingly straightforward, is the most important part of the interaction. In many cases, surgical or technical advice is sought. A senior surgeon may be able to offer suggestions on how to proceed with a difficult operation.

In other cases, a primary surgeon may seek out a more experienced colleague for assistance in decision making. For instance, when faced with an unusual or unexpected finding on frozen section examination of a specimen, a primary surgeon may ask a colleague for data on the natural history of this condition. Some surgeons, particularly when operating on a malignancy that appears unresectable, seek the solace of a colleague who might reinforce this opinion. Other surgeons may not require technical advice or data but, nonetheless, seek the support of a senior member of their

department when an operation becomes far more extensive than anticipated. The consultant's primary role here may be to validate what the primary surgeon already knows. Most of these consultations require little, if any, direct operative involvement and minimal patient responsibility.

Nature of request

The consultant should determine whether the nature of the request is primarily medical, social, intellectual, or technical. Consultations of a medical nature typically involve an intraoperative judgment regarding whether to proceed with an operation or how to respond to an unexpected finding. Similarly, these questions may be of a more intellectual nature, where a surgeon seeks experiential knowledge to guide further operative management. Queries may be purely technical, although often the raising of these so-called technical issues is really a search for surgical guidance or judgment in disguise. Technical, intellectual, and medical questions may require a consultant to briefly scrub in on a case to get a better sense for the operative field, but usually do not require direct surgical involvement.

Consultations may be of a more social nature as well; a surgeon might call in a subspecialist when he or she believes the consultant's "turf" is involved. In other circumstances, "social" consultations might reflect an obligation of the primary surgeon to involve another specialist if unforeseen complications arise. Additionally, when faced with a difficult case that seems likely to result in legal action, some surgeons will solicit early support from colleagues. In general, these so-called social concerns require minimal if any direct involvement on the consultant's part, but do imply the assumption of some responsibility by "blessing" the procedure.

Direct operative assistance is sometimes requested. For instance, unexpected bowel involvement may be discovered during attempted resection of a pelvic mass, prompting a general surgery consultation. In such cases, it is essential for the consultant to clarify in advance which parts of the procedure he or she is expected to perform, and also which aspects of postoperative care each team will be responsible for. In precisely defining roles, the consultant surgeon acts much like a subcontractor for the operation. It is entirely appropri-



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ate that a consultant have access to specialized or personal surgical instruments and, occasionally, a surgical team from his or her own specialty.

Sometimes a surgeon finds that the complexity or details of an operation are sufficiently outside his or her area of expertise that complete operative management by another surgeon would be more appropriate. This situation calls for an intraoperative transfer that would require the consultant to assume full responsibility for patient care after the operation. For any degree of operative assistance, the consultant also is responsible for judging the appropriateness of the requested intervention. It may be impossible to perform the requested procedure with the incision and exposure provided by the consulting team. In some cases it is appropriate to discuss elements of the case with available family members, or even to elect to perform the operation at a later date after a full discussion of options with the patient.

Assessing preoperative diagnosis

Finally, it is crucial for the consultant to assess the preoperative diagnosis and judge whether it was correct. When operative findings show that a working diagnosis is incorrect, the consultant's potential for involvement in the case can range from advice to operative management and postoperative care. If the preoperative diagnosis is correct, however, the role of the consultant is generally much more limited, as the primary surgeon presumably is able to handle the issues and technical maneuvers associated with that diagnosis.

Surgeons performing intraoperative consultations should be aware that reimbursement is different than for office or inpatient consultations. Although reimbursement guidelines vary between states and insurance plans, intraoperative consultations of an intellectual nature often are not reimbursed. Brief, informal consultations may be considered a professional courtesy between colleagues. More extensive consultations may be billed as an inpatient consult, provided that full documentation is provided. Surgical "standby" services, in which a consultant scrubs in for an operation to offer advice but does not perform the procedure, are generally nonbillable and unpaid services.

Despite the time and expertise required, rarely may a consultant collect a fee for "standby" ser-

vices in the absence of a prior negotiation or agreement between surgeons and their facility. For operative assistance, payment may be sought as an "assistant" if the procedure performed is one in which assistance is permitted by a given insurance plan or Medicare policy, and if resident assistance is unavailable. Alternatively, a consultant may bill as "co-surgeon" with the primary surgeon; however, such arrangements require an agreement between the surgeons and their facility regarding the percentage of fee to be collected by each surgeon. A consultant may bill separately for operative services if such services are associated with a new or different diagnosis (for instance, when consulted for an open biopsy of a new liver lesion detected during laparotomy performed for a gynecologic problem).

The acute nature and breadth of potential scope of intraoperative consultations can lead to miscommunication and confusion regarding roles. By precisely defining the question at hand, the nature of the consultation, and, if necessary, the specific operative or technical assistance requested, the consultant surgeon can help to maximize appropriate patient care. □

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