Learning to Be a Consultant

What Should Be Taught

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consultant: “a hospital doctor of the highest rank who is an expert in a particular area of medicine”

As noted in earlier articles and editorials in this series on education and training in pathology and laboratory Medicine, we look more and more for evidence as to what should be taught, how it should be taught, and when it should be taught. Education and training are entering a new era that is driven by better research, careful analysis of research findings, and new approaches for applying those findings. One of the most important parts of this new approach is the issue of what should be taught. Although it may seem obvious that students and trainees should be taught what they need to know to advance in the next stages of their careers, most content has been focused on preparing students and trainees to complete their education or training; there has been much less emphasis on career development. More recently, resident training has seen a major shift towards standardization, primarily through efforts of the Accreditation Council for Graduate Medical Education (ACGME) and individual residency review committees for each medical specialty. But many gaps remain: the long-lamented lack of education and training in the business aspects of health care, formal training in informatics, and so forth. A less obvious gap that only recently is being addressed is the idea of the training needed to enable individuals to make the transitions that occur as a natural part of careers. One of those is the subtle transition for becoming an expert consultant.

Consultation is one of the most challenging and rewarding activities of physicians. Consultants by definition provide expertise and services beyond what general practitioners provide. As a result, there are higher expectations for consultants and for the expertise that they provide. Not surprisingly, most consulting activities require expertise and experience available from attending physicians: junior trainees simply do not possess the knowledge, skills, or experience to provide adequate consultative services. One might fairly ask how does one know when a trainee or junior attending has attained those attributes that are necessary for effective consultation? How are the necessary skills taught? At what point in training should they be taught? And perhaps, most importantly, what should be taught?

There is no simple answer to the first question. To date, we have no objective way to assess the career development of individual physicians once they complete training. Maintenance of certification, ongoing medical education, and similar efforts make a positive contribution to ongoing professional development, but none of these is designed to provide an assessment of progress. Given the variability in career paths, jobs, and other factors, it is unlikely a simple, standard assessment tool will ever be developed. For now, the decision as to when a trainee or junior attending is ready for true consultative activities is largely a subjective one.

Regarding the second question, teaching consultative skills has traditionally been through the method of direct observation and role models, with all the benefits and drawbacks to that approach. It is a positive approach because trainees can observe directly how effective consultations are done. It is a negative approach due to the lack of standardization, the unavoidable fact that not all role models are good ones, and there is no way to assess the effectiveness of the method. Clearly we need better methods.

When should consultative skills be taught? If one keeps the traditional approach the answer would be throughout training. If a new method were adopted the answer likely...
would be completely different: it would be taught when it is most effective. It seems intuitive that trainees would benefit from formal training in consultation after they have attained more skills and experience, rather than trying to teach individuals an advanced skill at a point in their career when they have yet to master basic skills in their specialty. On the other hand, not everyone progresses at the same rate, so selecting an arbitrary point in a residency or fellowship also is likely to be ineffective. What may better guide this type of training is a competency-based training program where advanced skills are taught when the trainee is ready.

The final question, what should be taught, also may seem intuitive, but there is remarkably little information about this in the literature. For most of the recent past the effort has largely been one of trying to teach everything within reason. The pitfalls of this approach do not need description. What is needed is evidence to guide educators in selecting topics that are the most relevant, important, and have the highest “return on investment.” For this reason, the article by Schmidt and colleagues in this issue of the Journal is important and should be studied closely by educators. Knowing who asks for consultations is critical because consultants need to understand the context in which questions are being asked. Knowing why a consultation is being requested is equally important: one can’t answer a question effectively without understanding why it was asked. Knowing the specific topics of questions being asked is important, yet the technical expertise to answer questions is built into most training programs. Moreover, this information can be looked up readily and quickly once one knows what is being asked and why.

In contrast, understanding who is asking a question and why they are asking it is not something one can find in a textbook or on-line resource. Performing consultations is more than just providing technical answers: it requires an understanding of the needs of the person asking for the consultation. Different individuals may ask the same question for different reasons. The answers should not be the same.

References