



## ASSUMING THE ROLE OF CONSULTANT: WHEN A RESIDENT BECOMES A FELLOW

**Q:** As an internal medicine resident, you requested consultations to guide your care of patients. When you become a fellow, you switch roles and become the consultant specialist. Is that transition difficult?

**A:** While it may be at first, said several ATS members for whom the transition is fresh in their minds, it quickly becomes easier. “The first few months of fellowship you’re learning on such a steep curve,” explained Annette Esper, M.D., who just finished her fellowship at Emory University and has since joined the faculty there, “that you soon become comfortable providing your professional opinion.” Even before then, there is an easy way not to get stressed about your new role as pulmonary expert. “It’s perfectly okay to say you don’t know and want to confer with a senior fellow or an attending physician before answering,” added Renee Stapleton, M.D., M.Sc., assistant professor of medicine at the University of Vermont.

**Q:** Beyond the need to acquire knowledge rapidly, are other changes necessary to successfully transition from primary care doctor to specialist?

**A:** Former ATS President Sharon I. S. Rounds, M.D., chief of medical service at the Veteran’s Administration Medical Center in Providence, Rhode Island, believes one of the mistakes fellows make is becoming too involved in the management of another physician’s patient. “Fellows need a broader, more nuanced and complicated perspective,” said Dr. Rounds. “The primary care physician or surgical resident, for instance, is usually looking for the common things. As a consultant, you have to consider less common causes of a patient’s symptoms.”

**Q:** Is a consultant’s interaction with patients also different?

**A:** Fellows also need to keep their new role in mind when interacting with patients. After her residency, Sushma Cribbs, M.D., a third-year fellow at Emory, spent a year in an asthma clinic, where many patients asked her questions that would be better asked of their primary care doctors. “It’s reasonable for patients to ask any medical questions, but it’s important not to take over the primary care doctor’s role and to educate patients about the difference.” This is also practical, she noted, because you don’t have time to be the patient’s primary care doctor. Of course, if you uncover something critical—whether or not it’s related to why the patient was sent to you—you should contact the patient’s physician yourself.

**Q:** Do you ever feel that your recommendations are not taken seriously because you may be younger than the physician requesting the consult?

**A:** “The interaction between a young doctor and an older one can sometimes be difficult

for both,” said Dr. Cribbs. “Even though the older doctor may have 30 additional years of experience on you, they’ll usually recognize that you are on a pathway to learning something they haven’t.” If not, you can bring in an attending physician for support.

**Q:** How do you deal with a senior doctor who doesn’t?

**A:** Whether a primary care or other doctor has confidence in your opinions or not, everyone agrees that communication is the key to being a successful consultant. “Communicating your advice and rationale is important, and occasionally, for a variety of reasons, you may have to be persuasive,” said Ken Kunisaki, M.D., assistant professor at the University of Minnesota. “You want to keep lines of communication open. They probably won’t know as much about a rare disease as you, so it’s an opportunity to educate, as well as advise.”

**Q:** What kind of communication is best?

**A:** For outpatient consultations of relatively uncomplicated cases, members agree that a well-written note or e-mail is sufficient. For more complicated situations, a call is usually necessary. Do not, however, cautioned Dr. Stapleton, mimic the “grouchy” tone of many doctors on service. “In an academic environment, you can get away with being grouchy, because who’s on service is on service and those who need your advice don’t have other options. But community physicians do have options, so be professional—always.”

For in-patient consults, most members interviewed prefer a face-to-face or phone conversation. This is essential in emergent situations. Many senior fellows use these face-to-face meetings, especially with residents and medical students, as opportunities to teach, and will therefore spend more time discussing their recommendations and their rationale.

**Q:** How does being a fellow change your role in the ICU?

**A:** The members interviewed for this column agreed that in the ICU, the fellow’s role is similar to that of a primary care physician. Often, you are calling upon specialists to provide their opinion. There is an important difference, though, from being a resident in the ICU, said Dr. Esper. Instead of being responsible for, say five patients, you may find that you’re responsible for twenty. “To manage that number of patients, you have to teach residents what things are most important for day-to-day management,” she said. “You’ll have to trust the residents, so that you can focus on those patients who are most critically ill.”