Panconsultitis, an Epidemic

Fellow
The piercing sound of my pager echoes against the hospital hallways, alerting me to my next consult. Instinctively, I call back to receive report. It is 3:00 PM and my 20th day on the consult services. I am fatigued. My body is drained from the repetition of rounds, the sleepless nights spent anticipating a 2:00 AM page, the office practice follow-ups, grand rounds, nephrology journal club, and life itself. I want nothing more than to retreat to the comfort of my own home. My mind wanders aimlessly, dreaming of the day that consult services are done. I arrive at the hospital desk and begin the tedious task of reviewing the patient’s chart. A straightforward case of a man in his 60s with end-stage kidney disease on hemodialysis who presents with fever and diarrhea... needs to be scheduled for dialysis. This I can do almost in my sleep. I speak briefly with the patient and complete my examination. My consult is done and I am on my way. I have survived another day.

On day 2 of this patient’s hospital stay I arrive to examine the patient and review his chart. Immediately, I am struck by the chasm that has formed, overnight, between the patient I saw and the chart on the computer screen. I ask myself, “Could this possibly be the same patient who I saw yesterday?” (Fig 1). I turn to my peers to discuss, and what results is the discovery of a new syndrome born from a health care system of excess: “panconsultitis,” in which providers are encouraged by patients and families to “do everything” and for which treatment is limitless.

As I review the cascade of notes, I realize that what started as an admittedly complex patient seeking care and reassurance became a distorted reflection of the state of health care delivery in the United States. There was no need for this arsenal of medical resources; this was just an older patient with an acute illness and a long history of kidney disease who needs to be scheduled for dialysis. For which treatment is limitless, and more is always better. For which “providers,” not physicians or healers, are encouraged by patients and families and relative value unit counters to “do everything.” For which treatment is limitless, and more is always better. In such settings, we have normalized the practice of referral to specialists regardless of need because time spent thinking is less valued than time spent consulting others.

Dealing with “consultitis”, I hereby mark the emergence of a new syndrome in our health care system, caused by excess consumption and characterized by bloated charts: panconsultitis. For which “providers,” not physicians or healers, are encouraged by patients and families and relative value unit counters to “do everything.” For which treatment is limitless, and more is always better.

As nephrologists empowere to function as captains and consciously seek to create a work ethic that promotes appropriate examinations and the rote questions, each one asking from his or her preplanned list. Yet somehow, as the questions and examinations and explanations go on, I find I can’t remember a thing any of the doctors have been telling me. Who was that last set of doctors who came in and what was their plan for me? Who knows? I feel there is no final answer and it seems that none of them know what the other is planning to do. No one is in charge! For 9 hours they come one after another, leaving me no rest even when the pain subsides. And I begin to wonder, why did I even come to the hospital in the first place?

Nephrology Attending
Dear apprentice, you may be mastering nephrology, but unfortunately there is a larger illness emerging within medicine. I hereby mark the emergence of a new syndrome in our health care system, caused by excess consumption and characterized by bloated charts: panconsultitis. For which “providers,” not physicians or healers, are encouraged by patients and families and relative value unit counters to “do everything.” For which treatment is limitless, and more is always better.

In such settings, we have normalized the practice of referral to specialists regardless of need because time spent thinking is less valued than time spent consulting others. A glance at the chart (Fig 1) alerts us all to monitor the American health care system for panconsultitis.

As physicians, nurse practitioners, physician assistants, and nurses (not just providers!), we need to consider the medical and ethical implications involved in overuse of health care resources. But we should also consider how panconsultitis can degrade patient trust and impede, rather than improve, quality of care. Eradication of this syndrome will demand that in certain situations (such as for dialysis patients or kidney transplant recipients), nephrologists may have to serve as leaders to begin the process of educating patients and professionals. Nephrologists and hospitalists should work to engage and activate others to balance the demand for medical excess with judicious referral patterns that allow nephrologists to deliver care that is timely and practical.

In both academic and community settings, time spent in the hospital setting by nephrologists is precious. Time spent on a consult that in actuality did not require a nephrology consultation takes away more time that nephrologists could have spent on a complex intensive care unit patient, a complex diagnostic dilemma, teaching our fellows and students, or providing more thoughtful care. Hospitalists should be empowered to function as captains and consciously seek to create a work ethic that promotes appropriate...
consultation and distributive justice. Additionally, the psychological, emotional, and financial implications that this syndrome can bring to the patient should be addressed as we seek to find ways to minimize the outbreak of panconsultitis. This will undoubtedly contribute to system-level changes that minimize medical excess and ensure the appropriate use of medical resources for patients with kidney disease.

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