THE "CURBSIDE" CONSULT AND WHAT IT MEANS FOR YOU

Who in psychiatric practice has not been faced with a challenging or troublesome situation and wished that they could run the situation by a colleague or mentor? Who has not secretly yearned for guidance from their residency director?

Medicine is a collegial profession, both in theory and in practice, and physicians consult with one another regularly. Indeed there is an expectation of consultation, particularly when faced with a situation beyond one's usual area of expertise.

Consultation with a colleague can be formal or informal.

Formal Consultation: For a formal consultation, the treating physician refers the patient to another physician, often a specialist, in order to obtain formal guidance on some aspect of the patient's care and treatment.

The consultant performs the evaluation –in-person or by reviewing treatment records, studies, test results, or other pertinent information– and documents the evaluation either in the patient's record or by providing a written opinion or report. The consultant does not write orders, write prescriptions, or take any other kind of action regarding treatment.

The consultant typically is paid for this work.

Informal Consultation: Informal consultations are sometimes referred to as "curbside", "hallway," "elevator," or "sidewalk" consults. Curbside consults are a desirable, well-accepted part of medical practice.

For a curbside consultation, the treating physician seeks informal information or advice about patient care or the answer to an academic question from a colleague. Often the colleague has a particular expertise or talent that can be brought to bear.

Curbside consults typically are based on the treater's presentation of the case or by posing direct questions. The colleague-consultant does not see the patient or review the chart.

The colleague is not paid for the consultation.

Professional liability is minimal.

Physicians occasionally voice concern about the professional liability risks associated with providing curbside consults. While it is true that liability risk exists in any professional undertaking, including providing curbside consults, it is important to maintain a realistic perspective.

To begin with, providing a consultation –whether formally or informally– is an extremely low risk undertaking. Both the Program's experience with managing malpractice claims and reports in the literature demonstrate that curbside consultants are very rarely included in a lawsuit. This limited risk is related to the concept of control in the therapeutic relationship.

Generally speaking, the degree of professional liability risk exposure inherent in a professional relationship is directly related to the degree of control, either real or perceived, that the psychiatrist exercises over patient care decisions. In other words, the greater the degree of control, the greater is the liability risk exposure. This makes sense as liability derives from the physician-patient relationship and the subsequent duty of care owed to the patient.

A true consultative relationship involves providing an opinion and nothing more. The treating physician requesting the consult is entirely free to accept or reject –in whole or in part– the opinion and recommendation of the consultant. Therefore, it is the treating physician who retains most of the liability risk. The curbside consultant often is viewed as providing a service to the physician seeking consultation rather than to the patient. In fact, a patient may not even know if or when her or his physician obtained a curbside consult.

Even if a professional relationship were to be found by a court to exist between a patient and a curbside consultant, in order to prevail in a lawsuit, the plaintiff would have to prove that the consultation was negligently done *and* was a direct/proximate cause of her or his injury. This is a fairly challenging undertaking considering that the physician seeking the curbside consult remains free to exercise her or his own professional judgment in accepting, rejecting, or otherwise relying on the consultant's advice.

Lest anyone decide that the risk of obtaining a curbside consult is still too great, bear in mind that seeking consultation from a colleague is one of the best risk management strategies available. Seeking curbside consults with colleagues when appropriate shows thoughtfulness by the treating physician, and without doubt, patient care benefits when physicians are able to obtain informal consultation.

One concern regarding curbside consults is that an informal consultation might be sought when a formal consultation would be more appropriate. Whether a formal consultation would be more appropriate is a matter

of judgment for both the treating and consulting physicians. Some factors to consider, among others, when deciding whether or not to obtain a formal or information consultation are listed below.

Low risk for an informal consultation	Consider a formal consultation
Academic questions for the general education of the person seeking the consult	When you need to examine the patient to give good advice
Does not involve making or confirming a diagnosis	The situation presents complex issues or multiple variables to sort out
No detailed discussions or complex advice are required	When the patient requested the consult or knows of your consultation
No need to review patient records or history	If it becomes clear to you that your colleague will suspend his or her own professional judgment to substantially rely on your advice
No need to examine the patient	When you are consulted because of your specialization or expertise in an area
Questions about whether to order laboratory tests, studies, etc.	You are billing for your advice
Amenable to short, simple answers; in general terms; little complexity/few variables to the case; non-specific advice	
To ascertain whether a formal consultation is needed	

Documentation remains the exercise of professional judgment.

There is no consensus about how to approach documentation of informal consults. While this lack of clear guidance can be anxiety provoking, the up-side is that it gives physicians significant leeway about whether and how to document such encounters. In other words, you have significant discretion to exercise your professional judgment.

From a risk management perspective, documentation of informal consults can be an important risk management action. When deciding your overall approach to documentation, try to be consistent. For

example, try to be consistent about what kind of information is documented and how that documentation is maintained.

Informal consultation as a volunteer with a professional organization

Some professional organizations, such as some APA District Branches, have developed programs in which members provide informal consultations to primary care physicians.

These programs have been initiated to help address the shortage of psychiatrists and the lack of access to psychiatric care for patients in many areas of the country. If you participate in one of these programs, you should understand the essential requirements and the policies and procedures of the program and abide by them. Furthermore, you should understand the limits of your role as a consultant and continually evaluate whether or not a formal consult is required.

As previously stated, documentation of the consultation can be an important risk management action. Note that some programs have standards regarding documentation.

When seeking a curbside consult . . .

When seeking a curbside consult, consider whether the advice or input that you seek might be more appropriate for a formal consultation.

Avoid documenting the name of the colleague from whom you obtained an informal consult unless you have obtained the colleague's permission to do so.

When giving a curbside consult . . .

When asked for a curbside consult, first, make sure you understand exactly what is being asked of you. Have a low threshold for suggesting a formal consultation.

Remember that the treating physician controls patient care. If you direct care (for example, order laboratory tests, write prescriptions, adjust medications, etc.) you will almost certainly be establishing a professional relationship with all the attendant obligations and liability risks. Couch your response in terms of giving advice and make clear that you are relying on the facts as presented by the physician requesting the curbside consult.

If the advice you give is academic and solely for the education of the provider seeking the consult, then typically it should not be necessary to document the encounter. If the advice that you give is more patient-specific, consider creating a note of the encounter that details the advice that you gave. In the highly unlikely event that you are named in a lawsuit, such contemporaneous documentation would serve to bolster your defense. If documentation of a curbside consult becomes lengthy, it is probably best to suggest a formal consultation.

Finally, offering a specific diagnosis via curbside consult is risky. The foundation of successful treatment is an accurate, well-founded diagnosis. It is at the point of diagnosis that the decision tree branches into multiple, potentially erroneous courses of action. Diagnostic formulation probably should not be entrusted to a curbside consult. Because of the potential stakes, the same likely holds true for most admission or discharge decisions. Diagnosis and admission or discharge decisions in most cases should be the subject of formal consultations rather than curbside consults.

Resources

”Broadsided by the Curbside Consultation: What Constitutes a Physician-Patient Relationship?” Michael A. Chabraja, JD and Monica C. Wehby, MD. *AANS Bulletin*. Vol. 15, No. 4, 2006

“Minimizing the legal risks with ‘curbside’ consultation.” Ray Kreichelt, JD, Mary Lou Hilbert, MBA, LHRM, and Deidre Shinn, MSN, MBA. *Journal of Healthcare Risk Management*. Vol. 28, No. 1, 2008.

“Physician use of the curbside consultation to address information needs: report on a collective case study.” Cathy M. Perley, PhD. *Journal of the Medical Library Association*. Vol. 94, No. 2, 2006

“Malpractice Liability for Informal Consultations.” Robert S. Olick, JD, PhD and George R. Bergus, MD, MAEd. *Family Medicine*. Vol. 35, No. 7, 2003.

Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists. APA Reference Document, 2009

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