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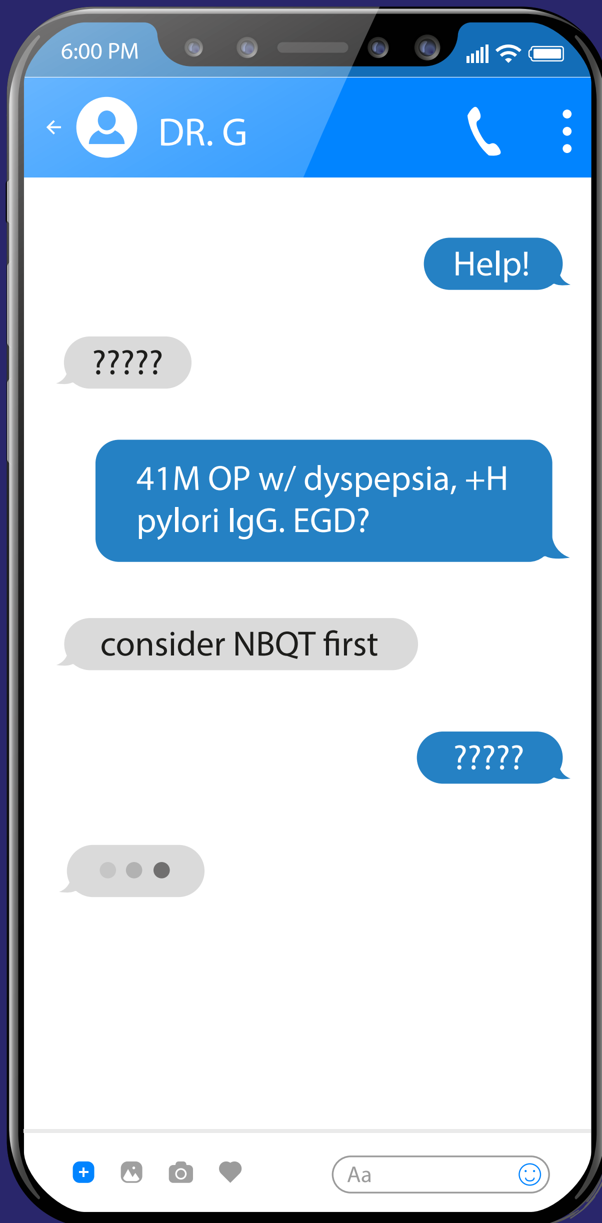


Curb Your Risk:

Best Practices for Safe Curbside Consults in the Digital Age

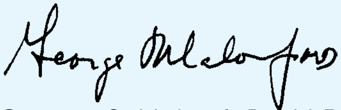
find out...

- What is a curbside consult?
- What are the benefits and risks of curbside consultations for both the treating and consulting Physician?
- What are best practices for curbsiding via electronic communications?

A NOTE FROM THE CHAIR OF THE BOARD

Dear Colleague:

Informal Physician-to-Physician consults are a traditional part of the practice of medicine. However, technology poses new risks and challenges to this exchange of information and advice. In this issue of *Doctors RX*, we will explore what a curbside consult is and what it is not, examine the risks of curbside consults in the digital age, and provide practical recommendations for both treating and consulting Physicians.



George S. Malouf, Jr., M.D., FACS
Chair of the Board
MEDICAL MUTUAL Liability Insurance Society of Maryland
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ISSUE HIGHLIGHTS

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DOCTORS RX

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CURB YOUR RISK:
BEST PRACTICES FOR SAFE CURBSIDE CONSULTS IN THE DIGITAL AGE

Informal Physician-to-Physician consults — also known as "curbside," "hallway" or "elevator" consults — are an integral part of the practice of medicine. In one peer-reviewed survey study, 70.4% of primary care Physicians and 87.5% of subspecialists reported participating in at least one curbside consultation during the previous week.[1] Primary care Physicians reported obtaining an average of 3.2 curbside consults, and subspecialists reported receiving an average of 3.6 requests for curbside consults during the prior week.[2] A prospective one-year study in a large teaching hospital found that curbside consults comprised 17% of the clinical work value of the infectious diseases service.[3]

Like most aspects of the practice of medicine, curbside consults have been transformed by the digital age. To illustrate this transformation, consider the contrast between the following fictitious scenarios starring a friendly gastroenterologist, Dr. G:

SCENE NO. 1 — Some time before smartphones. The setting is a Physicians' lounge. Dr. G is catching a break between rounds. He sits down and starts reading a newspaper.

A colleague settles nearby and casually queries Dr. G. regarding treatment of dyspepsia in patients with H. pylori infection. The question leads to a brief exchange on the pros and cons of dual therapy versus quadruple therapy. The colleague thanks Dr. G for the input and resumes rounds. Dr. G returns to the newspaper.

SCENE NO. 2 — Present day. The setting is a busy hallway on a hospital medical-surgical floor. With an EHR tablet on one hand and a smartphone on the other, Dr. G "thumbscrolls" through patient charts as he weaves through an obstacle course of stretchers, housekeeping carts and IV poles while enroute to the next consult.

The smartphone vibrates with the arrival of a text message from Dr. P, a primary care Physician who frequently texts questions to Dr. G: "Help! 41M OP w/ dyspepsia, +H pylori IgG. EGD?" While walking into the next patient room, Dr. G. hurriedly thumbs a response: "consider NBQT first." A flurry of short, acronym-laden text messages ensues between Dr. G and Dr. P throughout the day that delve into treatment alternatives, indications and contraindications, and the patient's reticence toward endoscopic procedures. The patient is never referred to Dr. G.[4]

Curbside consults are as prevalent today as ever. As Dr. G's present-day experience also shows, technology has infused new risks and challenges into this time-honored tradition. In this article, we will explore what a curbside consult is and what it is not, examine the risks posed by curbside consults in the digital age, and provide practical recommendations for requesting and providing effective informal consults while minimizing risks to both patients and Physicians.

German A. Rodriguez is a partner at Armstrong, Donohue, Ceppos, Vaughan & Rhoades, Chtd.
His practice concentrates on the defense of Physicians, nurses, hospitals, and other healthcare providers facing medical malpractice claims in state and federal courts, as well as professional licensing issues before state licensing authorities.

Note

In an age when medical malpractice litigation is commonplace, consulting Physicians often worry about the possibility of being named in lawsuits filed by patients they never treated.

WHAT IS A CURBSIDE CONSULT?

According to the *Journal of the American Medical Association* (JAMA), a curbside consultation is an informal process whereby a Physician obtains information or advice from another Physician to assist the treating Physician in the management of a patient. Thus, in contrast with a formal consultation, the consulting Physician's recommendations or comments are based almost entirely on information provided by the treating Physician seeking advice, rather than from the patient record.[5]

BENEFITS OF CURBSIDE CONSULTS: SHARING THE KNOWLEDGE

When properly understood and deployed, curbside consults can offer significant benefits for Physicians and patients alike. For treating Physicians, these consults allow quick access to useful independent information and promote the exchange of practical knowledge between specialties. For patients, these exchanges can streamline and expedite care and improve patient outcomes. These informal exchanges can help treating Physicians quickly determine whether a formal consult is needed and serve as efficient catalysts for necessary formal consults.

RISKS OF CURBSIDE CONSULTS: ALL ABOUT THE RELATIONSHIP

Inappropriate curbside consults can present risks to both treating Physicians and patients. The risks of misunderstood and misused curbside consults are intimately intertwined. Patient-specific decisions made based on general advice rendered upon incomplete information can lead to poor patient outcomes or patient injury. In turn, poor patient outcomes can trigger legal, credentialing and licensing issues.

The risk of professional liability is a common concern surrounding curbside consults. In an age when medical malpractice litigation is commonplace, consulting Physicians often worry about the possibility of being named in lawsuits filed by patients they never treated.

The issue of Physician civil liability in the context of a curbside consult has not been specifically addressed by the highest appellate courts in Maryland, Virginia and the District of Columbia. However, the foundational element of Physician liability under the law of medical negligence in these three jurisdictions — and in most jurisdictions in the United States — is the existence of a patient-Physician relationship.[6] Absent a patient-Physician relationship, a consulting Physician generally does not owe legal duty and cannot be held liable to a non-patient.

This prerequisite to liability suggests that the legal risk presented by curbside consults can be mitigated by conducting them in a way that avoids creating a patient-Physician relationship. However, there is no bright-line test or defined rubric to determine whether a patient-Physician relationship exists in any particular situation. Indeed, a patient-

Physician relationship "may arise by implication where the Doctor takes affirmative action to participate in the care and treatment of a patient."[7]

MITIGATING THE RISKS OF CURBSIDE CONSULTS

Although there is no precise test for determining — and avoiding — the creation of a patient-Physician relationship, Physicians engaging in curbside consults can mitigate the risks associated with curbside consults by properly delineating the limited scope of the consult and the specific roles of the consulting and treating Physicians. In addition, the treating Physician needs to be clear with the consulting Physician as to whether or not this is a formal or a curbside consult. The following guidelines can help delineate these boundaries.

For the Consulting Physician:

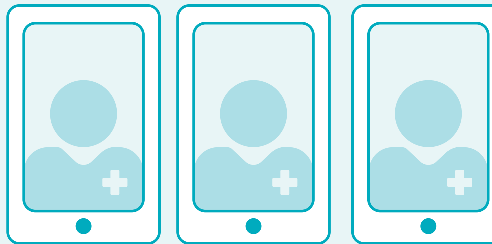
- The consulting Physician is not given the name of the patient.
- The consulting Physician does not examine the patient.
- The consulting Physician does not communicate directly with the patient.
- The consulting Physician does not review the patient's medical records, including imaging or labs.
- The consulting Physician does not document in the patient's medical records.
- The consulting Physician has no obligation for formal consultation — e.g., on-call obligations.
- The consulting Physician receives no payment for services.
- The consulting Physician gives opinions and advice solely to the treating Physician.

For the Treating Physician:

- The treating Physician is free to accept or reject the consulting Physician's opinions and advice.
- The treating Physician remains in control of the patient's care and treatment.[8]

Our opening scenes illustrate the practical application of these guidelines. Dr. G's discussion with his colleague in Scene No. 1 is strictly hypothetical and not patient-specific. The discussion is only verbal. In contrast, Dr. G's involvement in Scene No. 2 becomes increasingly more patient-centered. Dr. G receives and considers patient-specific information, even drifting into patient-specific treatment preferences. There is a long text message thread recording the breadth and depth of Dr. G's involvement. Although there is no clear-cut patient-Physician relationship in either scene, it will be far easier for the patient in Scene No. 2 to successfully argue that there was a patient-Physician relationship with Dr. G in the event of a lawsuit.

PRIMARY CARE PHYSICIANS REPORTED OBTAINING AN AVERAGE OF **3.2** CURBSIDE CONSULTS, AND SUBSPECIALISTS REPORTED RECEIVING AN AVERAGE OF **3.6** REQUESTS FOR CURBSIDE CONSULTS DURING THE WEEK.[2]



REFERENCE: Curbside Consultation Practices and Attitudes Among Primary Care Physicians and Medical Subspecialists, JAMA.

Effective mitigation of the risks involved in informal consults also requires awareness of common scenarios and circumstances that are not informal curbside consults. Requests for guidance from residents to attending Physicians, questions from mid-level providers to delegating Physicians, or inquiries directed to department or section chairs are not curbside consults — they are part and parcel of those supervisory roles for which the supervisory Physicians are responsible. Similarly, on-call specialists should construe any requests for information or advice — even if seemingly informal — as formal consults which may establish a relationship with the patient at issue.

Inquiries to consulting providers who have or previously had an established relationship with the affected patient can be challenging.

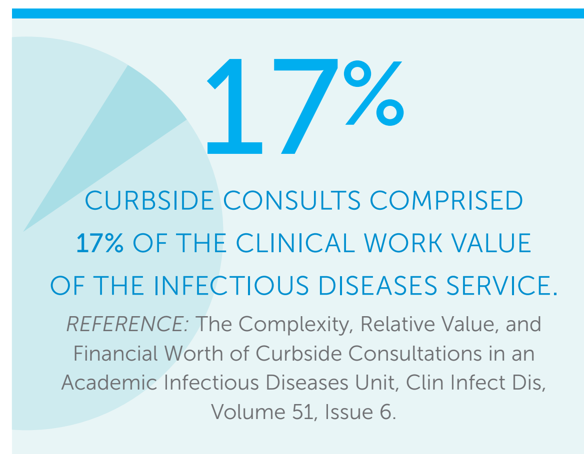
Did you know?

The foundational element of Physician liability under the law of medical negligence in Maryland, Virginia and DC is the existence of a patient-Physician relationship.

Electronic Curbsiding

Curbside consults conducted in writing over email and other electronic means expose Physicians to additional risks when compared to casual hallway conversations. Emails and text messages create a permanent, time-stamped record of the interaction.

These situations can be particularly risky when the inquiry is not directly related to the scope of care of the responding provider, when there has been a significant lapse of time since the last contact with the patient, or when the patient's condition has materially changed in the interim. The risks can be compounded when — like in our present-day opening scenario — requests for advice or opinions are communicated informally via text message, email or a brief phone call. Before offering advice as a consulting Physician, the most prudent course of action would be to consider the inquiry as a part of the patient's care continuum, communicate and document accordingly, and request a formal consult or office visit to reestablish care before offering advice or opinions.



REFERENCE: The Complexity, Relative Value, and Financial Worth of Curbside Consultations in an Academic Infectious Diseases Unit, Clin Infect Dis, Volume 51, Issue 6.

CURBSIDING IN THE DIGITAL AGE: SPECIAL CONSIDERATIONS

In today's digital age, Physicians regularly communicate with each other by email, text messages and instant messaging apps. These asynchronous electronic communications offer speed and convenience and avoid the frustration of coordinating face-to-face or phone interactions.

However, curbside consults conducted in writing over email and other electronic means expose Physicians to additional risks when compared to casual hallway conversations. Emails and text messages create a permanent, time-stamped record of the interaction. This record can implicate the informal consultant in litigation. A written back-and-forth exchange of specific patient information (i.e., lab values, or other test results) can also unintentionally suggest a greater degree of involvement in the patient's care than the consultant actually intended at the time of the consult.

Text and instant messaging present unique risks due to their brevity and informal nature. Abbreviations, acronyms, and shorthand in hastily sent and read messages can easily be misunderstood, leading to potential patient harm. Even known and accepted abbreviations can have ambiguous meanings.[9] This well-recognized danger has ushered in the "Do Not Use" List and standards for health information management systems governing the use of abbreviations.[10] However, informal communications on Physicians' personal mobile devices sidestep these important safeguards.

Text messages also invite senders to rely on acronyms or shorthand commonly used within their specialty but that may not be readily understood by the recipient. Dr. G's cryptic use of "NBQT" — a common gastroenterology abbreviation denoting non-bismuth quadruple therapy — in Scene No. 2 likely was not readily familiar or even understandable to his family practice colleague. Such communication problems can easily devolve into clinical problems. The lack of context and clarity typical in text and instant messages only increases the potential for miscommunication.

Email, text messages, and instant messaging apps also make it easier to engage in an ongoing written discussion about a particular patient situation. This fluency increases the consultant's degree of involvement in the case and can quickly blur the line between curbside and formal consults. As illustrated above in Dr. G's present-day curbsiding experience, multiple and progressively granular question-and-answer exchanges after an initial email or text message may unwittingly implicate the consultant in the patient's care. The ease of engagement may also quickly lead the treating provider to abandon their independent clinical judgment and rely on the informal consultant instead without the safeguards of a formal consult.

Given the particular risks raised by emails and text messages, Physicians should be cautious and exercise special care in requesting or responding to curbside consults through these mediums.

STAYING ON THE CURB:
BEST PRACTICES FOR SAFER CURBSIDE CONSULTS

Maximizing the knowledge-sharing and synergic benefits of curbside consults while minimizing the clinical risks to patients and legal risks to Physicians requires both the treating Physician asking the question and the consultant providing the answer to understand and respect the limitations of curbside consults. This can help the consulting Physician stay on the proverbial consultant's "curb" and off the potentially perilous "roadway" of affirmative participation in the patient's care. With this goal in mind, we recommend following these practical "dos and don'ts" when it comes to curbside consults.

DO NOT ask or answer questions that cannot be properly answered without having a detailed history; having hands, eyes, and ears on the patient; reviewing laboratory results; or evaluating multiple variables or compounding issues.

DO NOT ask or answer questions that would direct or have the potential to direct care for a specific patient — e.g., advice regarding admission, diagnosis, or discharge.

DO NOT ask for or offer curbside consults for rapidly deteriorating patients, patients in active labor, patients who are critically ill, or any other cases in which timely formal consultation and/or specialist intervention may be critical.

DO NOT include the curbside consultant's name in the patient's medical record; a formal consult should be requested whenever listing the consultant's name in the chart would be desirable or necessary.

DO NOT consult the patient chart or conduct independent research to respond to the inquiry.

DO maintain patient privacy and confidentiality by excluding protected health information from informal consults.

DO consider whether the question can be answered based on the quantity and quality of the information provided.

DO consider what information may be missing from the question/scenario.

DO ask for a formal consult without offering informal advice if appropriate under the circumstances, such as those listed above.

DO make it clear that the opinion or advice is general, not patient-specific, and based strictly on the limited information provided by the treating provider.

DO consider limiting the narrative to general medical information, and not include anything specific about the patient.

CONCLUSION

When properly understood and used, curbside consults can benefit both requesting Physicians and patients. Informal curbside consults, however, should not be used as shortcuts or workarounds in situations that require a formal specialist consultation or direct involvement with the patient. Additionally, be cautious of what modes of communication you use when advising colleagues and, as always, request a formal consultation when necessary.

Consider

A written back-and-forth exchange of specific patient information (i.e., lab values, or other test results) can unintentionally suggest a greater degree of involvement in the patient's care than the consultant actually intended at the time of the consult.

Remember

When properly understood and used, curbside consults can benefit both requesting Physicians and patients.

Got Questions?

ASK A RISK MANAGEMENT SPECIALIST

Sometimes it's just easier to talk to someone. Insureds of MEDICAL MUTUAL/Professionals Advocate can call 410-785-0050 or 800-492-0193 to speak to a highly qualified risk management specialist anytime 8 a.m.- 4:30 p.m., Monday-Friday. No matter your specialty, if you have a practice-related question or concern, we're ready to listen and offer guidance to help you identify and reduce your liability risk exposure. Please note, however, that any advice given from MEDICAL MUTUAL/Professionals Advocate should not be construed as legal advice.

references

[1] Kuo D, Gifford DR, Stein MD, Curbside Consultation Practices and Attitudes Among Primary Care Physicians and Medical Subspecialists, JAMA. 1998;280(10):905–909. doi:10.1001/jama.280.10.905. PMID: 9739975.

[2] Id.

[3] Grace C et al., The Complexity, Relative Value, and Financial Worth of Curbside Consultations in an Academic Infectious Diseases Unit, Clin Infect Dis, Volume 51, Issue 6, 15 September 2010, Pages 651–655, https://doi.org/10.1086/655829

[4] These fictitious scenarios are adapted from Lin M, Pappas SC, Sellin J, El-Serag HB, Curbside Consultations: The Good, the Bad, and the Ugly, Clin Gastroenterol Hepatol. 2016 Jan;14(1):2-4. doi: 10.1016/j.cgh.2015.09.026. PMID: 26698231.

[5] Kuo D, Gifford DR, Stein MD, Curbside Consultation Practices and Attitudes Among Primary Care Physicians and Medical Subspecialists, JAMA. 1998;280(10):905–909. doi:10.1001/jama.280.10.905. PMID: 9739975.

[6] For Maryland, see Sterling v. Johns Hopkins Hosp., 145 Md.App. 161, 164, 802 A.2d 440, 441 (2002); Rivera v. Prince George's County Health Dept., 102 Md.App. 456, 649 A.2d 1212 (1994). For Virginia, see Prosise v. Foster, 261 Va. 417, 417, 544 S.E.2d 331, 331 (2001). For the District of Columbia, see Gilbert v. Miodovnik, 990 A.2d 983, 984 (D.C. 2010).

[7] Sterling v. Johns Hopkins Hosp., 145 Md. App. 161, 187, 802 A.2d 440, 455 (2002).

[8] Olick RS, Bergus GR, Malpractice liability for informal consultations, Fam Med. 2003 Jul-Aug;35(7):476-81. PMID: 12861458.

[9] Institue for Safe Medication Practices, Medical Abbreviations That Have Contradictory or Ambiguous Meanings, https://www.ismp.org/resources/medical-abbreviations-have-contradictory-or-ambiguous-meanings

[10] The Joint Commission, Managing Health Information: Use of Abbreviations, Acronyms, Symbols and Dose Designations - Understanding the Requirements, https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/information-management-im/000001457/

CME TEST QUESTIONS

1. True or False: A curbside consultation is an informal process whereby a Physician obtains information or advice from another Physician to assist the treating Physician in the management of a patient.

   A. True B. False

2. True or False: A curbside consult, if properly understood and deployed, can offer benefits to only the treating Physician and not the patient.

   A. True B. False

3. True or False: The issue of Physician liability in the context of a curbside consult has not been specifically addressed by the highest appellate courts in Maryland, Virginia and DC.

   A. True B. False

4. True or False: Absent a Physician-patient relationship, a consulting Physician in a curbside consult does not owe legal duty and cannot be held liable to a non-patient.

   A. True B. False

5. True or False: A treating Physician doesn't need to be clear with the consulting Physician on whether a discussion is a formal or curbside consult.

   A. True B. False

6. True or False: The treating Physician remains in control of the patient's care and treatment after a curbside consult.

   A. True B. False

7. True or False: One example of a curbside consult is when an attending Physician receives requests for guidance from residents or mid-level providers.

   A. True B. False

8. True or False: Conducting curbside consults over email and other electronic means can expose Physicians to additional risks when compared to hallway conversations.

   A. True B. False

9. True or False: After being consulted in a curbside consult, as the consulting Physician, it is OK to access the patient's chart to see what else you can help with.

   A. True B. False

10. True or False: It is best to limit the narrative to general information and not include anything specific about the patient when providing information to the consulting Physician during the curbside consultation.

    A. True B. False

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Read the articles contained in the newsletter and then answer the test questions.

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CME EVALUATION FORM

Statement of Educational Purpose

Doctors RX is a newsletter sent twice each year to the insured Physicians of MEDICAL MUTUAL/Professionals Advocate.®
Its mission and educational purpose is to identify current health care-related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) Gain information on topics of particular importance to them as Physicians
2) Assess the newsletter's value to them as practicing Physicians
3) Assess how this information may influence their own practices

CME Objectives for "Curb Your Risk: Best Practices for Safe Curbside Consults in the Digital Age"

Educational Objectives: Upon completion of this enduring material, participants will be better able to:
1) Understand what constitutes a curbside consultation.
2) Learn the benefits and risks of curbside consultations for both the treating and consulting Physician.
3) Learn best practices for curbsiding via electronic communications.

Part 1. Educational Value:	5 (Strongly Agree)	4	3	2	1 (Strongly Disagree)
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

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Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature:________________________________ Date:________________________

Part 4. Identifying Information: Please PRINT legibly or type the following:

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TECHNOLOGY CAN HELP REDUCE CLINICIAN BURNOUT

In a recent American Medical Association survey, 49% of nearly 21,000 health care professionals reported at least one symptom of burnout. To combat this, more Physicians are using care management tools to increase their efficiency, accuracy and well-being. There are a variety of applications to help you access the right patient data, coordinate care, combat alert fatigue and provide outreach support. For more information and stress management tips, visit **mmlis.com/content/wellness** or **professionalsadvocate.com/content/wellness.**

MEDICAL MUTUAL and Professionals Advocate offer a variety of online tools and resources that are specially designed to help Doctors identify and address preventable issues before they escalate into potentially serious legal action.

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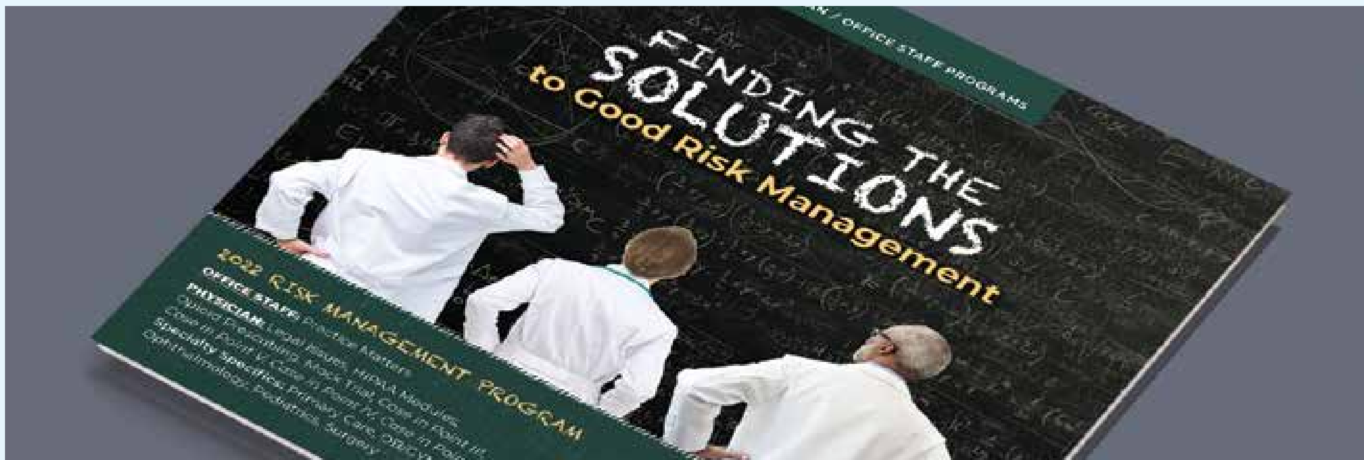

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