

Curbing the Curbside Consult - A Risk Management Perspective

How often has a colleague asked you for your opinion about the condition of a patient whom you've never examined and without requesting a formal consultation? Curbside consultations, as they have been labeled, are widespread in medicine.

According to one study of 413 primary-care and subspecialty physicians in Rhode Island, 70 percent of the primary-care physicians and 68 percent of subspecialists were "curb-sided," participating in at least one informal consult in the previous week. These consults were most often used to select diagnostic tests or initiate treatment, determine the need for a formal consultation or to help interpret laboratory or radiology results.¹

Despite the shortcomings of this type of information exchange, many believe the curbside consult is essential for maintaining positive relations with physician colleagues. Other perceived advantages include quick access to current medical information, ease of initiation and convenience, lack of paperwork, and the promise of future formal consultations. However, the curbside consult also poses liability risks to both attendant and consultant physicians if boundaries dividing an informal from a formal consult are not appreciated and respected.

In general curbside consults are only appropriate for basic questions that do not require the consultant seeing the patient. A risk-wise set of previously published guidelines² are summarized as follows:

1. Keep the curbside consultation brief and simple. If the case requires consideration of two or more confounding variables or a detailed discussion of the patient's history and physical examination, formal consultation should be considered.
 2. The attending physician should offer the option of a formal consultation as a courtesy if the complexity of a specific patient problem or the consultant's desire to formally see the patient is not clear. Similarly, the consultant should feel free to request to see the patient formally if he or she believes that the question is too complex to be handled by an informal discussion.
 3. Consider a formal consultation if contacted by a treating physician a second time concerning a particular patient.
 4. When a curbside consultation is obtained, the name of the consulting physician should not be recorded in the patient's medical record without the consultant's permission.
 5. Physicians who are given a financial incentive to keep referrals to the minimum should avoid the temptation of managing difficult patient care problems by seeking informal rather than formal consultations.
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¹ Washington School of Medicine: Risk Prevention and Control: Informal “Curbside” Consultations.
<http://aladdin.wustl.edu/risk/riskmgmt.nsf/00e6edf0d1cc3393862567f50051bbd9/2ab531e88d4ce369862567f5005e36f9?OpenDocument>

² JAMA, Vol., 275, No. 6, pp. 145-147. F.A. Manian M.D. and D.A. Jansen, M.D. Curbside Consultations: A Closer Look at a Common Practice

In addition to consulting colleagues in person or on the phone, a number of physicians are going to Internet-based discussion groups for advice from their colleagues. Although going online can be easier than tracking someone down in person or on the phone and may also help locate the best source of information for a particular case, experts advise special cautions. Online clinical discussion is by nature not a formally peer-reviewed or evidence-based resource. Credentials are more difficult to verify and financial interests harder to discern when you do not know a consultant personally. Physicians who use these resources agree that they do not use online recommendations as their sole source of information, but rather as a springboard to exploring new options or raising issues with colleagues whom they do know well³.

Informal or “curbside” consultations are a recognized component of medical practice. However, this practice can raise liability concerns. To minimize risks and provide quality care, the above discussion should be considered when participating in informal consultations.

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Thank You!

³ *ACP Observer*, January 1998, Chris Dyer, Medical Informatics Program Associate, medinfo@acponline.org

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