Insight

crico

March 2012

Communication Challenges

566

CRICO-insured physicians were named in malpractice cases that involved some form of miscommunication (from 2006 to 2010).

At CRICO, we devote significant resources toward in-depth analysis of medical professional liability claims in an effort to identify areas of highest risk. Part of our mission is to raise awareness among those of you who treat patients about such risks—especially those commonly associated with patient harm and allegations of malpractice. In this *Communication Challenges* issue of *Insight* we offer some actionable data, expertise, and personal perspectives to help you manage this ever-present area of concern. Thanks for reading, and we welcome your input.

Insight

Communication Challenges

For more information on *Communication Challenges*, visit our website.

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Can We Talk? Physicians Get Personal with Patients

Tom A. Augello, CRICO

My car trouble. Your daughter's terrible report card. Is it OK for clinicians and patients to share their personal issues with each other?

Yes, in fact it's necessary, say some CRICO-insured physicians.

Christopher Lathan, MD, is a thoracic oncologist at Dana-Farber Cancer Institute. During a recent conversation with a patient where she shared her difficulties at home with an adult son, Lathan shared with her that a member of his own family once got into similar trouble.

The patient learned that he understood her obstacles, and the interaction gave Dr. Lathan a professional advantage:

> "The more you know about your patients and where they are from, the more their actions can make sense to you."

"That's when you understand that noncompliance might not be noncompliance. Maybe it's a medical literacy issue. Maybe it's not noncompliance, but they are unsafe at home."

View more physician commentary on communication.

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Time is the enemy for primary care physician David Ting, MD, who sees patients at the Massachusetts General Hospital Everett Center. Even though he thinks he'd be a better physician if he had unstructured time to talk with every patient, his caseload does not allow it.

Still, his approach to his patients is,

"I want them to know me, and I want to know them."

Patients understand this need as much as anyone. "Suzanne," the mother of a former Dana-Farber patient, remembers how therapeutic it was to connect one night with an off-duty nurse as her daughter was dying.

"She came in, and she just sat, and we talked, and we talked as mothers," she says. "And we talked about things our kids did, and she told me how much she admired me and the way I was helping my daughter to live as much of a normal life as I could. That was one of the biggest gifts that she could have given me."

Another mother of a Boston patient with renal failure considered a lawsuit after her daughter died unexpectedly in rehab. But "Serena" didn't cast about to name every provider who treated her daughter.

During one of her child's many crises, one physician had earned her trust after she saw his tears of joy when kidney function returned to normal.

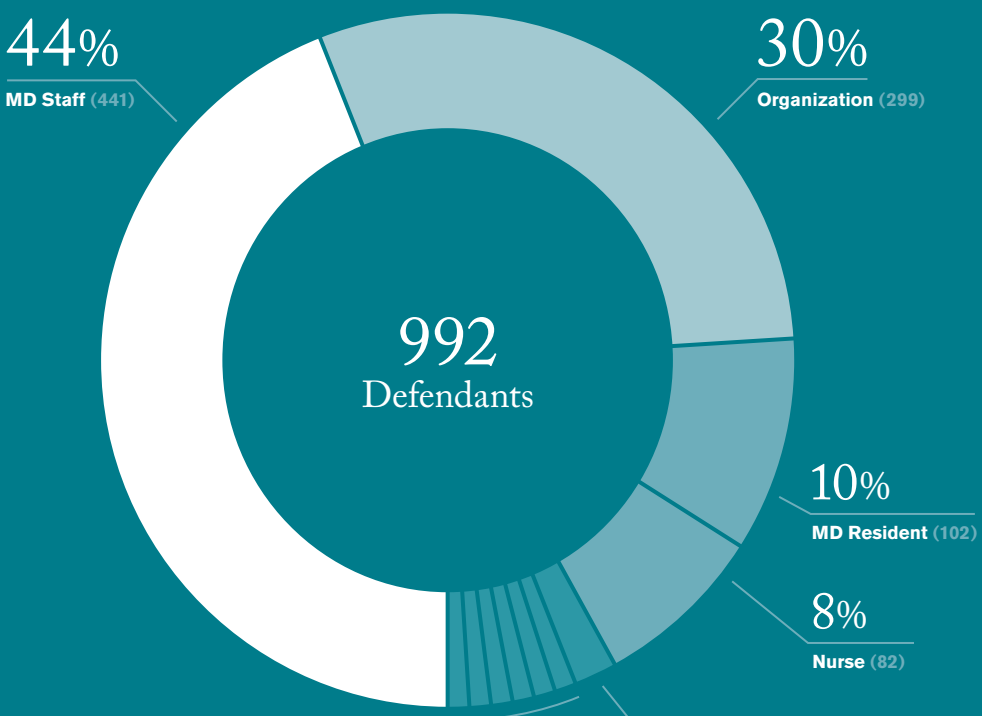
"I know you have to have a tough skin to a point or you get involved with every patient that you operate on," Serena says. "But when a family is hurting so much, I mean, I don't know how you can't just give them a hug. Just to show you're human and that you do care."

Dr. Ting says he understands the need for professional boundaries. Still, even during small, day-to-day interactions, "I'm not hesitant to tell patients about my kids and tell them if I'm having a bad day or struggling with something. I'm quick to apologize, if I've dropped something, just so they know I'm a real person and I'm human and that allows them to open up to me."

Tom Augello is CRICO's Multimedia Editor.

Communication Factors in Malpractice Cases

Jock Hoffman and Supriya Raman



Defendant Type

Defendants named in 484 CRICO cases with communication factors, 2006–2010

"What we've got here is failure to communicate."

That phrase, permanently co-opted by the acclaimed 1967 film, *Cool Hand Luke*, is the ubiquitous reasoning for almost every two-party mishap from marital discord to international conflict. While the human race is remarkably adept at developing and mastering languages, we much too frequently fall short in putting them to use during important situations—including those that involve a patient and medical professionals.

Effective and safe health care rides on the rails of effective communication. A patient who is able to clearly express his complaint, his symptoms, his history, and his comprehension is an equal partner with a physician or nurse who is trying to help. A clinician who can hear and grasp the patient's story—and share it with subsequent caregivers—is an invaluable part of the team responsible for guiding that patient to a timely diagnosis, appropriate treatment, and sustained follow up. An organization that values each strand of the communication web that supports safe patient care, is much less likely to see a "failure to communicate" played out in a malpractice trial.

From 2006–2010, 1,160 medical malpractice claims and suits were asserted against CRICO-insured clinicians and organizations (see Case Volume, right). When those cases were analyzed by the nurses who constitute CRICO's coding team—looking at the medical record, physician expert reviews, depositions, and other associated clinical or legal documents—42 percent reflected communication breakdowns. Half of those cases involved outpatients.

Each open CRICO case is assigned "reserved" dollars to cover the eventuality of an indemnity payment to the claimant. The value of closed cases is determined by any payment awarded by settlement, arbitration, mediation, or trial. For a set comprising open and closed cases, reserves and payments are mixed to calculate the "incurred losses" of that set. The incurred losses for CRICO's 484 cases from 2006–2010 coded with a communication issue is $264 million, 44 percent of all CRICO incurred losses for that time period (see Defendant Type, left).

Every assertion of malpractice alleges an injury caused by the defendant(s) not meeting the standard of care. CRICO assigns each case an injury severity rating based on the National Association of Insur-

Case Volume

CRICO cases, 2006–2010

484
Total cases with communication factors

1,160
Total cases

$264M
Total incurred in cases with communication factors

$598M
Total incurred in all cases

Communication Breakdowns: Provider-to-Provider

CRICO cases, 2006–2010

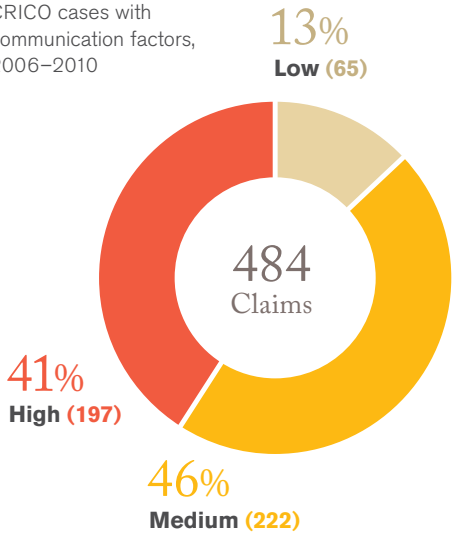
138
Regarding patient's condition

13
Failure to read medical record

10
Poor professional relationship/rapport

Case Severity

CRICO cases with communication factors, 2006–2010



Common Allegations

in cases alleging that the patient did not receive sufficient information from his/her clinician.

20% Inadequate informed consent for surgical/ invasive procedures

15% Poor rapport/ unsympathetic response to patient

10% Language barrier limited communication

6% Inadequate discharge instructions

5% Inadequate follow-up instructions

5% Patient/family education regarding risks of medications

ance Commissioners nine-point scale (1 = emotional injury; 9 = death). High-severity cases include death and permanent severe injuries. For the 484 cases from 2006–2010 coded with a communication issue, 197 (41 percent) involved a high-severity injury (114 deaths); 46 percent involved a medium severity injury. Typically in malpractice cases, high-severity injuries are associated with disproportionately higher dollar losses. Thus, while reflecting 41 percent of CRICO's communications-related cases from 2006–2010, the high-severity injuries account for 79 percent of the incurred losses for that case category (see Case Severity, above).

The plaintiff—a patient, or an agent acting on behalf of a patient (e.g., family member, estate)—asserting medical malpractice must name one or more defendants as responsible for the alleged substandard practice. Organizations (hospitals, practice groups) or individual physicians, nurses, or other employees can be named as defendants (after the initial filing of the case, the plaintiff may choose to add or drop selected defendants). CRICO's 484 communications cases from 2006–2010 named 992 defendants: 566 MDs, 82 nurses, and 45 other individuals…as well as 299 organizational defendants. The range of defendants exemplifies the fact that miscommunication in a health care setting reaches well beyond the doctor and patient in the exam room. In fact, many of the communication issues cited in malpractice cases don't directly involve the patient. Nearly 40 percent are triggered or exacerbated by breakdowns in communication between two or more providers: physician-nurse, attending-resident, PCP-specialist, or multiple providers somehow failing to properly give or receive vital patient information (see Communication Breakdowns: Provider-to-Provider, previous page).

Nevertheless, the most troublesome communication gaps are those between the provider and the patient. For CRICO, 69 percent of communication cases allege that the patient did not receive information that he or she needed to understand their health issues, make informed decisions about treatment options, or manage their long-term care. Of course, physicians and other caregivers are challenged to understand what a given patient hears, comprehends, and retains in the throes of a health crisis—and jurors are charged with determining a reasonable level of responsibility for the patient/plaintiff.

For the 532 communication-related cases CRICO closed from 2006–2010 (including some with assert dates prior to 2006) two-thirds of those cases were resolved without any payment. Most often, the plaintiff voluntarily discontinued his or her case in light of insufficient evidence of substandard care. For the remaining one-third of cases that ended with a payment to the plaintiff (via settlement or trial), the average payment was $768,000. By comparison, over the same time period, 33 percent of all CRICO cases closed with payment, and those payments averaged $625,000.

Chronology of a Malpractice Case

Your suit may be dropped or dismissed shortly after the original filing, or it may take years to go through the entire trial and appeal process. In Massachusetts, the majority of suits take at least three years after the filing date to reach trial.

If you find yourself being named as a defendant in a malpractice suit, it may well be your first exposure to civil litigation. While you will probably wish it would just go away, you cannot ignore it no matter how you feel about the merits of the claim.

Every case follows its own path to conclusion, but this illustration depicts common steps in the process. Understanding what your involvement is likely to be along the way helps strengthen your ability to cope with what can be a long and drawn out course of events. While you will face occasional spurts of activity related to your case, you may not hear anything new about the proceedings for extended periods of time. Of course, for case-specific information, contact your CRICO claim representative or defense attorney.

Physician Voice

I think the lawsuit probably took away some of the joy and put a little bit of fear in me. I would like to think I was still taking good care of my patients, but maybe in some ways my heart wasn't completely in it.

Wanda Gonzalez, MD,
defendant in a 2009 malpractice suit

“

I did worry.
Every angry patient, every tiny little missed thing, made me fearful. Every patient’s misinterpretation of what I said made me nervous.

Wanda Gonzalez, MD, practices pediatrics at Massachusetts General Hospital Chelsea Healthcare Center. Her patient population looks a lot like the people she grew up with in Spanish Harlem. She is fiercely dedicated to her patients, and recently returned to them after maternity leave for her first baby.

Dr. Gonzalez says the experience of being sued forced her to learn all over again that she’s a good doctor. Active participation in her defense helped her regain some sense of control.

View more of Gonzalez’s interview online. Scan or visit:

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Mistakenly Told Biopsy Normal

Christine Allen BSN, RN, CCM

CLINICAL SEQUENCE

A 53-year-old post menopausal female on hormone replacement therapy (>10 years) presented to her PCP and NP several times for vaginal bleeding and pain during intercourse. The patient was treated for vaginitis, and she was referred to her gynecologist for further evaluation. She presented to her primary gynecologist three times over a six-week period with complaints of vaginal spotting. A pap smear was normal. A pelvic ultrasound showed widening of the endometrial stripe. The patient had a 16 mm stripe (normal range < 4 mm, with > 8 mm suggesting hyperplasia). Due to the abnormal bleeding and abnormal ultrasound findings, the gynecologist recommended an endometrial biopsy.

The patient deliberated a few days before deciding to have the biopsy. A covering gynecologist did the procedure because the primary gynecologist went on vacation and the patient wanted it done before she herself left for a trip. After the biopsy was completed, the gynecologist advised the patient to follow-up with her primary gynecologist when she returned.

The pathology report noted blood, mucous, and scant endocervical epithelium, with immature squamous metaplasia and glycogenated squamous epithelium (normal cervical findings). However, the report also indicated there was no endometrium present (purpose of test was endometrial biopsy), indicating the tissue was insufficient for diagnosis.

Upon receiving the results, the gynecologist who performed the biopsy forwarded them to the patient's primary gynecologist without personally reviewing the contents. When the patient called urgently for her results prior to her trip, a nurse practitioner at the health center located the report; upon seeing "normal cervical findings," she interpreted it to mean the biopsy results were normal. The NP advised the patient of the "normal" result and documented it in the patient's chart. She also included the result and the patient communication in an e-mail summary for the primary gynecologist when he returned.

Upon his return, the gynecologist saw the message from the NP and did not personally review the pathology report itself, assuming the covering gynecologist who did the biopsy reviewed the formal report. As a result, the biopsy was not repeated, and both the provider and the patient pursued the symptoms no further than the differential diagnosis of uterine lesions.

A year later, the patient was at a well visit with the primary gynecologist, and she mentioned continued vaginal spotting, which she "got used to." Another pelvic ultrasound showed an endometrial stripe of 23 mm with bilateral ovarian masses. A repeat endometrial biopsy showed stage III adenocarcinoma of the uterus with metastatic ovarian cancer. The patient underwent a hysterectomy, bilateral oophorectomy, and omentectomy followed by chemotherapy and radiation therapy. She eventually developed pulmonary metastases and died from the disease.

CLAIM SEQUENCE

The patient's family sued the two gynecologists, her PCP, and the NP, alleging negligence for a two-year delay in diagnosing her endometrial cancer, leading to her premature death.

DISPOSITION

The case was settled for more than $1 million.

Lessons to be Learned

1

It was unclear who was responsible for review and follow-through once the pathology report was available; the primary gynecologist did not read the formal pathology report, and did not discuss the case further with the colleague who performed the biopsy.

A physician performing a diagnostic test is responsible for receiving and checking the results, as well as either following-up directly with the patient or with the referring provider. A referring physician who continues to follow a patient for the problem that gave rise to the referral, has a responsibility to read the full pathology report, not just a note in the chart by someone else. Lack of communication between providers can lead to confusion and misunderstandings as to who is responsible for coordinating the patient's care, which can lead to important findings falling through the cracks, and ultimately to missed or delayed diagnoses. Office practices need clear communication policies and procedures regarding handoffs with specialists or covering providers. These protocols should outline each provider's responsibilities so that outstanding issues don't get overlooked. In addition, reliable office systems to track and reconcile test results require ordering physicians to review the result before it can be filed.

2

The NP responded to an insistent patient, misinterpreted the pathology report, and told her the results of the biopsy were normal.

Physicians are increasingly pressed for time with ever-growing patient panels and the subsequent bombardment of studies. Many office practices have responded by trying to alleviate some of the burden, asking nurses within their practice to communicate many of the test results to their patients. Office practices need clear guidelines around these communications. These would include who should be designated to have these conversations, their necessary qualifications, when it is appropriate for nurses to take on this responsibility, etc. A distinction between routine and significant lab reports should be clear, and the threshold should be very low for putting formal pathology reports in front of the physician before communicating findings to a patient.

3

The biopsy was not repeated, and an assumption of a benign cause of the patient's abnormal vaginal bleeding and enlarged endometrial stripe was carried forward for more than a year without further evaluation.

Abnormal findings and continuing symptoms should be explored until a definitive diagnosis is made. Closer monitoring may be required in the mean time. Non-resolving symptoms are a cue for providers to reassess clinical indicators and laboratory findings or to pursue additional studies and consultations.

4

Experts for the defense could not support the care provided by the primary gynecologist, and reviews were mixed regarding the involvement of the covering gynecologist. The experts agreed that it was the primary gynecologist's responsibility to read the pathology results and schedule a repeat biopsy.

Juries tend to support physician defendants when presented with evidence that they did what any other qualified physician in the same specialty would do. Without supportive expert reviews, a monetary settlement with the plaintiff is more likely to be in everyone's best interest.

Christine Allen is CRICO's Taxonomy Specialist.

Linking Patient Safety *and* Communication

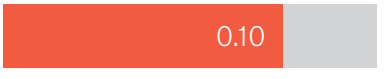
Michael Leonard, MD

When clinicians don't effectively communicate, the risk of something going wrong increases substantially. Adverse medical events are frequently the result of ineffective team communication: either not having enough information, losing it across the transitions of care, or one clinician having a different "picture" of what's supposed to be done than others caring for the same patient. Multiple people caring for a given patient need a systematic process to facilitate communication and keep everyone in the same "movie."

What gets in the way of more effective communication among clinicians is, first, the historical mindset that people have been trained to be expert individuals and act by themselves. They believe that if they're trying hard, they can manage any situation. Currently, the complexity of the care environment has evolved beyond the ability of any one person to keep track and manage all that information. The new reality involves learning in a different way, getting teams of people together—physicians, nurses, pharmacists, and others—and working with some fundamental techniques to enhance communication and to ensure that they're going to deliver the right care.

Of course, there are common limitations that affect clinicians as communicators. One is multi-tasking—look at the traffic accidents with people trying to drive and talk on cell phones, trying to do two things at once. Another limitation is short-term memory. An individual can mentally hold about five pieces of information, but think of a clinician during a busy day with the pager going off repeatedly, talking on the phone, multiple people tugging on his sleeve, trying to write in a chart, and the patients backing up. We're constantly exceeding the ability of our brains to manage and capture all that information. The game has rapidly changed around us and will continue to do so.

We also know fatigue has a huge impact on the ability to process complex information. Drew Dawson's data indicate that 24 hours without sleep is equivalent to a blood alcohol of 0.10.[1] But physicians routinely work after they've been on call all night, nurses work double shifts, et cetera. Since fatigue certainly does affect their performance—and their potential for error—we need to be wiser about our staffing and how we schedule people.



24 hours without sleep is equivalent to a blood alcohol of 0.10.

HOW CLINICIANS CAN MANAGE THEIR COMMUNICATION LIMITATIONS

Once we accept that we're working in an environment that often will surpass our individual capabilities, then we can create a safer environment where we can work collectively, talk together, and have a common vision.

Here's a simple example of setting the stage nicely before embarking on a clinical challenge. This was when we began doing endovascular aortic grafts, which involves putting a $20,000 graft inside a patient's aorta (instead of a traditional aortic aneurysm repair). It is a complex procedure with

1 Dawson D, Reid K. Fatigue, alcohol and performance impairment. Nature. 1997;388(6639):235.

Share your communication challenges

Add your voice by sharing a personal experience around common challenges and a best practice you've established to address these issues. We'll share your comments so everyone can benefit, as we strive toward the delivery of safer patient care.

Share your communication challenge. Scan here to email your comments.

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I want to be able to give patients the kind of care that I would want. I want to be able to talk to them in a way that they can understand.

If I can't do it, and somebody else can do it better, I want them to go to see that person.

Christopher Lathan, MD

15–20 people in the cardiac cath lab. When the chief of vascular surgery walked in the room, the first thing he said was:

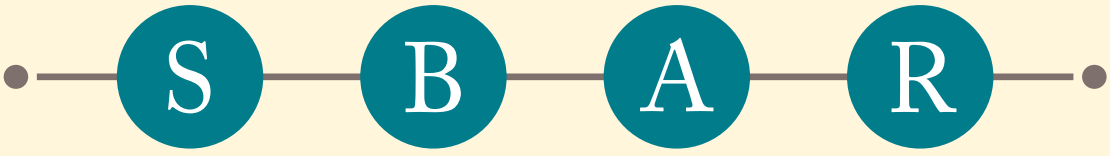
"I have no pride invested in this case. I just want to get it correct. If any of you see me doing the wrong thing, or if you have any ideas of how we can do this better, please speak up. We're all here to do the right thing. We're all learning, so let's work together."

He then introduced himself by his first name to every individual in the room. He flattened the hierarchy, established relationships, and created an environment in which it was going to be a lot easier for people to speak up.

Such transformations aren't automatic. Sometimes, we have to "sell" communication improvement to a clinician who is skeptical, or simply feels too busy. We show them that by investing a small amount of time up front in effective communication, building the team, and creating a common mental model, that their clinical day is going to be simpler, safer, and easier for all involved.

One example comes from briefings in operating rooms. When we first launched our briefings project in Kaiser Orange County [California], the surgeons were saying, "Why should I care? Why should I do this?" What we were talking about was a one- to two-minute focused conversation in the operating

SBAR. A common tool for individuals trained to communicate differently.



SITUATION
about which you are calling

BACKGROUND
information related to the situation

ASSESSMENT
of the situation

RECOMMENDATION

room before they started the operation. The "wake up" for the surgeons was the realization that the other OR staff frequently did not share the clear picture they had relative to the procedure, and through briefing—getting everyone on the same page—they were far more likely to have the correct equipment, people, and skills present to get the job done well.

The greatest upside to the surgeons—what won them over and made briefing "the way they do business"—was the realization that this small investment of time in effectively communicating with the team prevented about 90 percent of those magic moments in the middle of a case where things come to a screeching halt because something essential is missing and everyone has to wait while the equipment, supplies, or person is obtained. Briefings were effective because the people doing the work saw a significant return on the investment of their time to make sure everyone knew what the game plan was.

The surgeon, the anesthesiologist, the nurse, and the scrub nurse or technician all engaged in a one or two minute conversation about what were they going to do, what equipment they would need, what they would need from each other, and any special factors. The surgeon would go first and say, "This is what I need you all to know when I'm doing a case." And then it was everybody else's turn to say to the surgeon, "This is what we all need to know from you." The striking part here was the looks of interest and outright surprise on their faces. The surgeons had no idea that it's a big deal to the nurses whether the surgeon is on call (the nurses want to know if they're going to have to answer the surgeon's pager 45 times in the next three hours). Realizing that frequently the doctors did not know the names of the others they were working with, they also incorporated having everyone write their names on the board where they count the instruments and sponges, and the physicians agreed to use their names. Familiarity was the key: it's much easier to talk to somebody with whom you have a relationship.

PHYSICIANS AND NURSES COMMUNICATE DIFFERENTLY

This is true, and it's important to reconcile if doctors, nurses, and others are going to effectively communicate. Nurses are trained to be narrative and descriptive; the end result is that they describe things with broad brushes. Physicians, on the other hand, want the headlines: "What's the problem? What's the fix?" So what happens millions of times a day in American health care is that a nurse picks up the phone and starts to describe a situation with a patient, painting a broad narrative picture. Meanwhile, the physician on the other end of the phone is thinking, "What do they want? Tell me what the problem is and we'll fix it." That's the fundamental mismatch in how these people are communicating.

Listen to more from this interview with Michael Leonard.

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One tool we have used widely to bridge this difference is the Situational Briefing model, or SBAR (Situation, Background, Assessment, and Recommendation). SBAR is helpful for the nurses when they pick up the phone, because they know that after they describe the situation: "I've got Mrs. Jones, who is acutely short of breath; and the background: "She's got chronic lung disease, has been sliding downhill, and now she's suddenly worse"; then they have to get to the assessment: "I don't have any breath sounds on the left side of her chest. I think she's got a pneumothorax;" and finally, the recommendation: "I need you here now. I believe she needs a chest tube pronto."

SBAR not only ensures that everybody gets what they want, but also helps develop critical thinking: when people pick up the phone, they have this model in their mind of what they actually have to deliver. SBAR is an effective bridge for a group of people who interact all day long, but who are trained to communicate differently.

When you examine which particular skills influence clinicians' operating in a team structure, you see more commonality than diversity. Teamwork skills for people in medicine appear to be universally applicable across health care from open-heart surgery to the ICU to the outpatient clinic. One, which I've already discussed, is briefing: getting a group of clinicians to set the stage and communicate effectively. Another is assertion.

Assertion is usually not a big deal for physicians because they're at the top of the food chain, but it's a huge issue for people lower in the hierarchy. What we're talking about is how we can give less empowered people a mechanism for speaking up when they see something wrong. We don't want somebody standing in the room saying to herself, "This is a mistake," but unable to tell people.

A while back in my institution, an anesthesiologist and a circulating nurse took an awake patient to the operating room for shoulder surgery and proceeded to put in a nerve block on the wrong shoulder. The scrub nurse knew they were wrong, and started talking to them, but in an oblique way (nicknamed "hint and hope" in the aviation world)—which is quite typical. Their perception was, "We don't know what she's talking about. She's being a pain in the neck. We'll talk to her later." So they continued on and performed a successful procedure on the wrong side. Afterwards, the scrub nurse's version was "I told him he was doing the wrong thing, and he wouldn't stop."

Situational awareness is another universal team communication skill. How do we keep everyone on the same page, and what are the red flags that tell you that you're getting off in the margins? (For example: things are going sour with the patient, and it gets quiet, as opposed to enhancing and increasing the communication. Or you get the sense of "it doesn't feel right"—as an expert the pattern you are matching is telling you things didn't go well the last time you saw this.) Ideally, these skills tie together: everyone's on the same page, if someone sees (or senses) something that makes them uncomfortable, they have a standard way to openly communicate that to the rest of the team.

This article is excerpted from CRICO's interview with Dr. Leonard originally published by CRICO, in *Forum*, in 2003, when he was Kaiser Permanente's Physician Leader for Patient Safety. Currently, Leonard is a principal at Pascal Metrics, in Washington, D.C.

Are You Complicating Your Consults?

Michael D. Howell, MD, MPH

Recent studies show that—even among patients admitted to a general medicine service—almost half will receive a subspecialty consult.[1] In my medical center over one year, more than 1,000 inpatients had four or more specialties involved in their care during a single admission. For complex, acutely ill patients, the quality of a particular consult can make or break a case. Unfortunately, there is a startling lack

CALLING A GOOD CONSULT

1 Be specific.

Consultants are challenged to answer a question you didn't ask, and a vague question engenders a vague response. To get the help you are looking for, ask a specific question. Lee's seminal 1983 work showed that the consultant and the requesting team had totally different perceptions of the primary reason for consultation in more than 20 percent of cases.[11] When this occurred, requesting physicians were significantly more likely to perceive lower value from the consult. This does not appear to have improved over the subsequent 25 years: a 2009 study found that more than one in four consult requests did not contain a clear question.[12]

2 Be clear.

As a consultant, I need to know: Is your request for input about a particular clinical question? Do you want me to perform a procedure? Are we going to co-manage a problem? Should I write my orders in the chart? Shall I transfer the patient to my service? All of these levels of consultation occur fairly frequently.[13–15]

3 Inquire or explain.

If my consultation is clear but you don't agree, talk to me; if it's unclear, contact me.

The patient's attending physician is obligated to integrate incoming data, including consultants' recommendations, into a coherent whole. A consultant's job is to provide you with their best advice about the right way to proceed. If a consultant's recommendations do not make any sense: 1) he or she may not have understood the question you wanted answered; 2) his or her note is inadequate; or 3) he or she may have missed some salient feature of the case. Most often, a simple phone call can clear up the confusion. With the confusion cleared up, the consultant may have something meaningful to say that will change the course of therapy.

4 Don't wait until the end of the day.

Inconsideration, or bad timing, can be a barrier to good patient care. If possible, avoid introducing unnecessary delays into the process: if you know you need help from nephrology at 9:00 a.m., call before 9:00 a.m. Give the consulting team time to talk with your team members (and factor in that trainees have to leave by a certain time and the consultants may be unable to talk to the physician who admitted the patient). Finally, if the consultant is likely to recommend additional labs or imaging, a recommendation received after 5:00 p.m. may mean delaying these tests until the next day.

5 Don't ask for a curbside consult when you need a formal one, and vice versa.

Professional dialogue about individual clinical cases is ubiquitous and—when handled appropriately—helpful.[16–18] A mishandled informal consultation, however, can be medico-legally complex.[19]

If you seek a curbside consult, be clear to the consultant that a) your goal is to confirm your pre-existing clinical impression and, b) the consultation will not be part of the record. Consider, also, that those who are asked to provide curbside consultation often feel that there are important gaps in this type of communication that do not occur with formal consultation.[15,17]

of research into what differentiates a good consult from a bad one. Studies that have evaluated outcomes, costs, and utilization among patients who receive a particular specialty's consultation or management, generally, treat the exposure to one consult as identical to exposure to every other consult.[2–10] This implies that—like an aspirin tablet—the quality of consultation does not vary from dose to dose. Experience would argue that that is far from the case. In my pulmonary medicine and critical care practice experience, I have had the opportunity to both perpetrate and witness some spectacularly bad consultative episodes…and have learned to strive for better experiences.

References listed on page 20.

PROVIDING A BETTER CONSULT

1 Help.

A physician calling for a consult is, primarily, asking for one thing: help. Either I am calling an appropriate consult that legitimately needs your specialty expertise, or I am in over my head and don't know what to do. In either case, both my patient and I need your help. Don't disregard a consult request just because it's poorly articulated. Over the phone, a request may, at first, seem to have no relationship to your specialty—particularly when it comes from a cross-covering physician. On further investigation, however, most of these requests turn out to be quite reasonable.

2 See the patient now.

Heed the second of the Ten Commandments for Effective Consultations: "establish urgency."[20] If another physician is on the phone asking for your help right now, assume there is a good reason; accept that I truly am asking for help (even if you think I don't need it). Better to see a few cases early that could have waited than to delay seeing a time-sensitive disease too late to improve the patient's outcome. Embedded here is Goldman's third commandment: "look for yourself." Good consultants see the patient and review the data themselves.[20]

3 Answer the question I asked.

Although you will undoubtedly have other recommendations, please also address the specific reason we called. If we are really on the ball, we will have written this question in our note for the day ("Consult cardiology: would they recommend left heart catheterization in this patient who is unable to wean from the ventilator because of recurrent acute pulmonary edema?"). Good consultants always address the specific question asked, in addition to other issues that they uncover.

4 Ask me first.

It is my responsibility, as the patient's attending physician, to integrate all incoming data, including your recommendations, into a coherent whole—and to review this with the patient and his/her family. Thus, we need to talk before you act (excluding a few truly emergent procedures).[16,21] Similarly, transfer of the patient from my service to yours should happen only after we have spoken directly.

5 Communicate, communicate, communicate.

In consultation, more communication is better. If it is urgent or important, call me. Nothing is a substitute for direct, verbal communication between the consultant and the requesting physician.[15,20,22] Also, please write legibly, sign your name so that I can read it, and leave clear and specific recommendations in your note. All of these things improve the chances that I will follow your recommendations.[23]

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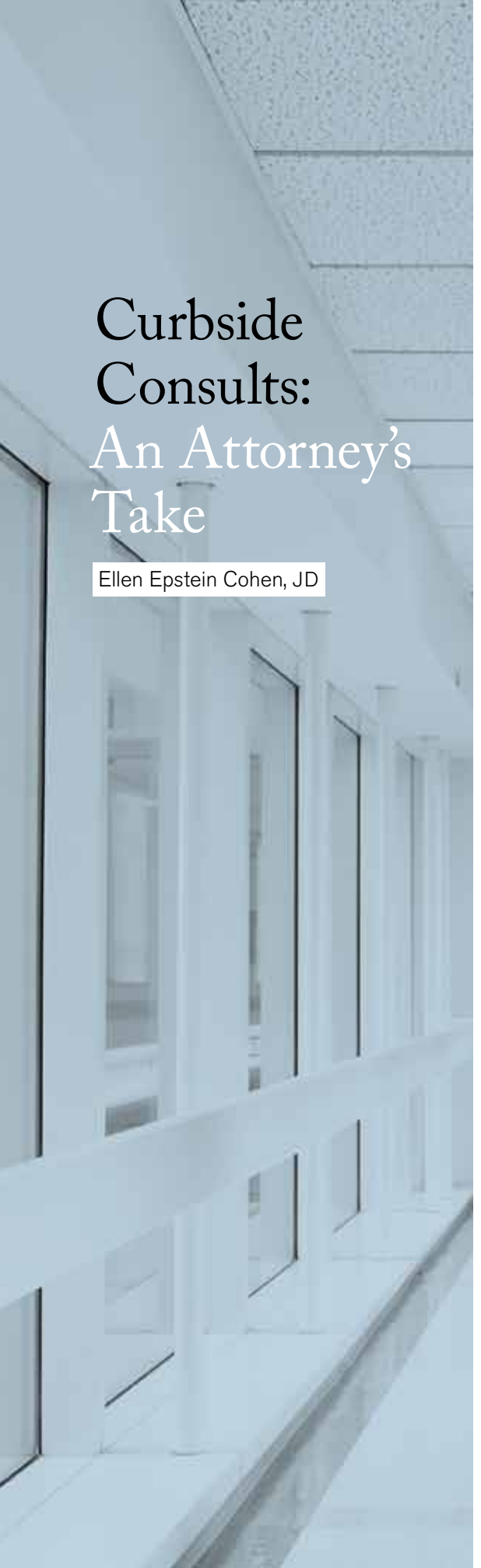

Curbside Consults: An Attorney's Take

Ellen Epstein Cohen, JD

CRICO **What is a curbside consult?**

ATTORNEY COHEN It is an informal interaction in which one physician asks another for advice or input on how to handle a particular patient issue, during which the person to whom the physician is speaking 1) is not in the presence of the patient, and 2) doesn't necessarily know or has never met the patient. It's an informal exchange between colleagues who are trying to make treatment decisions.

What if Dr. A sends Dr. B an e-mail about a patient's diagnosis or care?

If Dr. B receives an e-mail that asks her a specific medical question, she should make it clear that her answer is a general answer—not intended to apply to any particular patient. A limited amount of information is being presented to her, and she's providing a general answer without meeting, seeing, or examining the patient. She doesn't have the necessary medical history or personal information to render a medical opinion specific to that patient.

This kind of qualification—written by Dr. B in her response to the e-mail question—will serve her better than a quick, specific answer. This is especially important in case Dr. A decides to write in the patient's medical record that he or she consulted with Dr. B. Once her name gets into a particular patient's chart as someone who provided advice about any treatment decisions, Dr. B is then on the invitation list for ensuing litigation.

If Dr. A documents the contents of a curbside consult (including Dr. B's name) in a patient's record, and a medical malpractice suit is later filed, is there anything that Dr. A can do to protect Dr. B?

No. Once Dr. A makes the ill-advised decision to put Dr. B's name in the chart, he can't un-ring that bell. But the plaintiff in a medical negligence claim does have to prove that there was a physician/patient relationship established. So the defense for Dr. B would be: "I never met this patient, saw this patient, or examined this patient. Nor did I ever make a note in this patient's chart. I never had any information about who this patient even was. I didn't know this patient's name. I just remember Dr. A called me and asked me a question about this issue." The legal argument of Dr. B's defense would be that there was no physician/patient relationship and, therefore, no duty ran from the consultant (Dr. B) to the patient. But that doesn't mean Dr. B won't have to stay in the lawsuit and fight to prove her position.

What if Dr. A asks Dr. B to take a look at one of his patient's test results or imagings?

This is the next layer of establishing a physician/patient relationship. Now Dr. B knows who the patient is and something specific about him or her. That's the danger zone. Dr. B would be well-advised to include a standard, boilerplate statement (to use either in conversation or in her e-mail responses) that clarifies the limit of her consult. For example she could say: "I've looked at this [result], but it's not enough for me to render specific medical advice. At your request or the patient's request, I would be happy to become involved in evaluating [him/her] and get involved in the care," or "this image suggests [the following things] and should be followed up by the patient's treating team."

Would it be prudent for Dr. B to document what she actually told Dr. A during the curbside consult? Would that reduce confusion or misinterpretation if it should come to court?

That's probably not feasible for busy practitioners who want to communicate freely with their colleagues. The concept of asking for curbside consults is that patients receive the best quality of care by skilled physicians who have thought about their issues the most. If we begin telling physicians that they need to document every curbside consult, they may simply avoid doing them. Further, it is very difficult to think of a way that documentation of these informal consults could be maintained, as Dr. B has no chart for this patient because she has never seen her for any formal encounter.

Does the fear of being sued render some physicians more reluctant now to give curbside consults?

I do think that plays into people's minds… especially once you hear about someone who has been "burned." When you hear about how Dr. B's name got into the chart of a patient whom she never met or saw, and she ended up as a defendant in a lawsuit, it's memorable. But curbside consults are such an important aspect of communication between physicians, so deeply ingrained in their practice, that I hope we're not going to lose that as an essential element of high quality patient care.

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