Title: Medical Consultation Principles and Policy	
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Approved by: Assistant undersecretary of technical affairs	
Notes	

1.0 **Objective**

1.1 Physicians have a long history of working together and with other health care professionals to provide efficient and comprehensive care for the patients they serve. Achieving these goals sometimes requires that physicians or other care providers seek consultation from or provide consultation to their colleagues.

1.2 It is the objective of this policy to define the concept of medical consultation and ensure the principles and tenets of medical consultation are practiced ethically and professionally to ensure the best care for all patients.

2.0 **Definitions:**

2.1 **MRP**: Most Responsible Physician (MRP), or most responsible practitioner, generally refers to the physician, or other regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time.

2.2 **HCP**: Health Care Provider (HCP), generally refers to any individual; including but not limited to, physicians, nurses, physiotherapists, technicians, that in the course of their professional activities may directly or indirectly recommend, administer and/or determine the medical and/or related services for the patient.

2.3 **Attending Physicians**: A physician (specialist rank or above) who is responsible for the overall care of a patient in a hospital or clinic setting.

3.0 **Definition of a Consult:**

3.1 Consultation is the act of seeking assistance from another physician(s) or health care provider(s) (HCP) for diagnostic studies, therapeutic interventions, or other services that may benefit the patient.

3.2 It is a procedure whereby, upon a physician request, another HCP reviews a patient's medical history, examines the patient, and makes recommendations as to care and treat. The consultant/consulted service often is a specialist with expertise in a particular field of health care.

3.3 Consultations usually are sought when physicians with primary clinical responsibility recognize conditions or situations that are beyond their level of expertise or available resources, in doubtful or difficult cases, or when they enhance the quality of medical care; consultations are primarily for the patient's benefit.

3.4 The referring physician should consult, refer, or cooperate with other physicians, health care providers, and institutions to the extent necessary to serve the best interests of their patient.

4.0 **Ethical Foundations** Ethical principles require that the consultation process be guided by the following concepts:

4.1 The welfare of the patient should be central to the consulted service-patient relationship (**beneficence**). The management, transfer of care or takeover of the patients should be guided by this ethical principle.

4.2 The patient and or his/her representative/guardian should be fully informed about the need for consultation and maintains the right in the selection of the consultant/consulted service if deemed necessary or possible (**respect for autonomy**).

4.3 The patient should have access to adequate consultation regardless of his/her medical condition, social status, or financial situation (**justice**).

4.4 Physicians must disclose to patients any pertinent actual or potential conflict of interest that is involved in a consultation relationship, including financial incentives, penalties or restrictive guidelines (**truth-telling**).

5.0 **Responsibilities of the Referring/Consulting Physician**

5.1 The referring physician should request consultation in a timely manner, whenever possible before an emergency arises.

5.2 The referring physician is responsible for preparing the patient and or his legal guardian with an explanation of the reasons for consultation, the steps involved, if possible or deemed necessary.

5.3 The referring physician should provide a clear question/reason of consult, a summary of the history, results of the physical examination, laboratory findings, and any other information that may facilitate the consulted service evaluation and recommendations.

5.4 The referring physician contact information should be provided.

5.5 For urgent and emergent consultations, the consulted service should first be informed verbally, then a written official consultation should be issued with documentation of the time, date, name, job title and contact information of the recipient (and the referring physician) of the consult.

5.6 The referring physician should document date and time of issuing and communication of the consult (in the Health Information System -HIS- or patient's file).

5.7 The referring physician should document in the medical record the indications for the consultation and specific issues to be addressed by the consultant.

5.8 The referring/treating physician should discuss the consulted service proposed plan with the patient and give his/her own recommendation based on all available data in order to serve the best interest of the patient.

5.9 Complex clinical situations may call for multiple consultations. Unless authority has been transferred elsewhere, ***the responsibility for the patient's care should rest with the referring/treating physician (MRP)***. This (referring) attending physician has overall responsibility for the patient's treatment and should remain in charge of communication with the patient and coordinate the overall care based on information derived from the consulted service. This will ensure a coordinated effort that remains in the patient's best interest.

5.10 In case of emergencies (e.g., code blue), a nurse is authorized to seek appropriate medical consultation if the responsible physician couldn't be reached instantly.

6.0 Definitions: Levels of Consultation

6.1 There are several levels of consultation to be considered and documented by the referring physician: consultation only, consultation and management, single-visit consultations, continuing collaborative care, and transfer of primary clinical responsibility. Each involves different levels of patient care management and overall responsibility on the part of the consultant/consulted service.

Their descriptions are as follows:

6.1.1 **Consultation only** is ordered when the attending physician requests the consultant/consulted service to review the patient's records and pertinent findings to render an opinion and make treatment recommendations. The consultant/consulted service is **not** directly involved in patient management, does **not** place orders in the chart, or have overall responsibility for the patient's care.

6.1.2 **Consultation and management** is ordered when the attending physician requests the consultant/consulted service to place orders in the chart and participate directly in patient care management.

6.1.3 **A single-visit consultation** involves examination of the patient or the patient's medical record and performance of diagnostic tests or therapeutic procedures. The findings, procedures, and recommendations of the consultant/consulted service are recorded in the patient's medical record or provided to the physician with the primary clinical responsibility for the patient in a written report or letter. The subsequent care of the patient continues to be provided by the referring/consulting physician.

6.1.4 **Continuing collaborative care** describes a relationship in which the consultant/consulted service provides ongoing care in conjunction with the referring physician. Therefore, the consultant/consulted service assumes at least **partial** responsibility for the patient's care.

6.1.5 **Transfer of primary clinical responsibility** to the consultant/consulted service may be appropriate for the management of problems outside the scope of the referring physician's service education, training, and experience or in cases in which the patient must be transferred to another facility.

6.1.5.1 Once transfer of primary clinical responsibility/care is agreed upon to the consulted service from the treating service, it is the responsibility of the accepting consulted service to care for the patient, follow up and managed accordingly regardless of the location of the patient.

6.1.5.2 The exception would be if the accepting consulted service is in another health care facility, in which case the patient's care is the responsibility of the consulting/treating service until the patient is officially/physically transferred to that health care facility. (e.g., orthopedic trauma patient planned for transfer from hospital with no orthopedic service to Alrazi Hospital)

7.0 Responsibilities of the Consultant/consulted service

7.1 Consults **cannot** be refused once issued **without** patient assessment

7.2 Those who are consulted should recognize their individual boundaries of expertise and provide only those medically accepted services and technical procedures for which they are qualified by education, training, and experience.

7.3 It is the responsibility of all services, specialties and subspecialties in the MOH health care facilities in Kuwait to ensure that they maintain, progress, evolve, expand and upgrade the scope of services they are expected to provide for their patients.

7.4 If the consulted service decide that the consult is out of their scope and area of competency and expertise, the consulted service is still responsible to arrange assessments, consultation and or management by those with the expertise and competency of that same respective specialized service.

7.4.1 An example would be consulting a cardiologist not experienced in post cardiac transplant patients for heart failure in which case that consulted cardiologist is responsible to arrange care by a cardiac transplant specialist or a cardiologist with such competency.

7.5 When asked to provide consultation, the consultant/consulted service should do so in a **timely manner** and without regard to the specialty designation or qualifications of the referring physician. The response time of a consult should be as follows (refer to the attached table of response time for more details) **

7.5.1 In-hospital response time

7.5.1.1 STAT/Emergency consult, 3-5 mins

7.5.1.2 Urgent consult,15-30 mins

7.5.1.3 Routine consult, within 24 hours

7.5.2 Out-hospital response time

7.5.2.1 STAT/Urgent/emergency within 15-45 mins (these consults should be attended as soon as possible, and the extended time frame was given due to the logistic purposes).

7.5.2.2 Routine consult, within 24 hours

7.6 Services may set criteria and indications of consults (through their respective council) BUT it remains left to the responsible treating physician to consult that service(s) if deemed necessary/fit by him/her.

7.7 **Definitions:**

7.7.1 STAT/Emergency consult: is when the clinical condition in question **DOES** pose an **IMMEDIATE** threat to life if not diagnosed, or managed accordingly

7.7.2 Urgent consult: is when the clinical condition in question does **NOT** pose an **IMMEDIATE** threat to life but will have a significant effect (or threat) on life **in the near future** and a definite effect on the change of medical/surgical management.

7.7.3 Routine consult: is for **NON**-life threatening, **NON**-limb or organ threatening pathologies and clinical conditions that need assessment, plan and management during index admission, on discharge or follow up (e.g., ligamentous injuries, poorly controlled hypertension, reassessment of psychiatric medications etc.). It is generally for the stable patient with:

7.7.3.1 Clinical conditions that do NOT pose an IMMEDIATE threat to life but will possibly have a significant effect on health **in the future** and a definite effect on the change of medical/surgical management.

7.7.3.2 Clinical questions about patient care or fitness or follow up *e.g., clearance for preoperative elective surgery*

7.7.3.3 Clinical questions regarding management plans, optimizing medications, transfer of care or discharge planning of ***stable*** patients.

****refer to table of each specialty and time of Response to consult*

8.0 **Tenets of a consult should be met and fulfilled before a consult is declared to be completed. These tenets include:**

8.1 Attendance of the consulted service to the source of the consult and respective patient

8.2 Assessment of the patient by the respective consulted service

8.2.1 Assessment includes history review, physical examination, file review and follow up the results on ordered investigations (including laboratory and

radiological investigations) necessary to formulate the impression/final diagnosis and management plan.

8.3 Documentation by the consulted service of the impression, plan of management and disposition (e.g., admission, discharge or transfer of care to another service or follow up).

8.4 Cases being followed by a consulted service thereafter are expected to be provided with serial assessment, management plan and documentation until admission, discharge, or transfer of care to another service or completion of management is documented.

8.5 It is the responsibility of the consulted service to organize a plan of management and sign over between the members in their team to ensure continuation of care, especially during oncalls, weekends, and public holidays.

8.6 The consultant/consulted service should effectively communicate findings, procedures performed, and recommendations to the referring physician at the earliest opportunity.

8.7 A documentation of the consultation should be included in the medical record.

8.8 The extent to which the consultant/consulted service will be involved in the ongoing care of the patient should be clearly established by mutual agreement of the consultant/consulted service, the referring physician/service, and the patient. At times, it may be appropriate for the consultant/consulted service to assume primary clinical responsibility for the patient. Even if this is only a temporary circumstance, the consultant/consulted service should obtain the referring physician's cooperation and assent, whenever possible.

8.9 When the consultant/consulted service does not have primary clinical responsibility for the patient, he or she should try to obtain agreement for major procedures or additional consultants/consulted service from the referring physician.

8.10 In all that is done, the consultant/consulted service must respect the relationship between the patient and the referring physician, being careful not to diminish inappropriately the patient's confidence in his/her other caregivers.

8.11 The consultant/consulted service should be aware of the referring physician's abilities, and the consultant and referring physician should discuss who can best provide the agreed-upon care.

8.12 If the consulted service believes that the patient will receive the best continuing care service in their department, the consulted service should recommend transfer of care of this patient to his/her department.

8.13 Disputes regarding transfer of care should be raised from registrars to senior registrar to attending and so forth up to chairs of departments. Failure to reach an agreement at the level of chairs of departments maybe resolved by the chief medical officer (CMO) or designee by CMO (e.g., hospital director) of the hospital.

9.0 Patient ownership and the provision of the best of care should be aimed when adhering and following the above principles and policies.

10.0 Violations of the above (with or without resulting medical complications arising from such breach of code of conduct) may be reviewed in investigative committees and are subject to disciplinary actions.

11.0 Pending establishment of rules and regulations on telemedicine for medical consultation, the use of telecommunication/internet will be permitted to be accessed and used by some consulted specialties which cover all MOH healthcare facilities (e.g., neurosurgery and vascular surgery). That is to be able to access patient information (CT-scan etc.) to triage the consultation response and the ensuing care and management. However, they are still subject to abide by the principles of the consultation and attend, assess and manage the patient accordingly.

12.0 **Professional dialogue:**

12.1 Definition of professional dialogue:

12.1.1 When clinicians share their opinions and knowledge with the aim of improving their ability to provide the best care to their patients. Such dialogue may be part of a clinician's overall efforts to maintain current scientific and professional knowledge or may arise in response to the needs of a particular patient.

12.1.2 In professional dialogue, a second clinician is typically asked a simple question and he or she *does **not** talk with **or** examine the patient.* The second clinician does ***not*** make an entry in the patient's medical record, and the first clinician should ***not*** attribute an opinion to the second clinician.

12.1.3 Professional dialogue does ***not*** constitute a formal consultation or establish a patient–consultant relationship.

12.1.3.1 *Example: questions might be asked regarding the significance of specific blood antibody or the follow-up interval for an abnormal cervical cytology result.*

13.0 **Monitoring procedure**

13.1 MOH committee on hospital clinical services and polices will monitor the above policy.

13.2 A Senior doctor of the related team can email the above-mentioned committee, in case of any incidence.

13.3 The email address will be: policy.moh.kw@gmail.com

References:

- *ACOG COMMITTEE OPINION Number 365 • May 2007 Reaffirmed 2019*
- *American Medical Association (AMA) Principles of Medical Ethics: I,VI,VIII,X*
- *The role of the medical consultant*
  Steven L. Cohn,
  Clin N Am 87 (2003) 1–6

- *Principles of Effective Consultation*
  An Update for the 21st-Century Consultant
  Stephen M. Salerno, et al.Arch Intern Med. 2007;167:271-275
- *CMPA – visit the link*

Attachment

** Response time:

Specialty	STAT Response time	Emergency Response time	Urgent consult Response time	Routine consult Response time
General surgery	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Urology	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Orthopedic surgery	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Vascular surgery	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Thoracic surgery	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Internal medicine	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Cardiology	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Anesthesia	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Acute Pain Service	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Intensive care Unit	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Respirology	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Endocrinology	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Nephrology	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Neurosurgery	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Neurology	In Hospital: 3-5 min	In Hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Psychiatry	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Pediatric surgery	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Pediatrics	In Hospital: 3-5 min	in hospital: 5-15 min	In Hospital: 15-45 min	within 12-24 hours
Pediatric ICU	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours
Neonatal ICU	in hospital: 3-5 min out of hospital: 15-45 min	in hospital: 5-15 min out of hospital: 15-45 min	in hospital: 15-45 min out of hospital: 15-45 min	within 12-24 hours

OBGYN	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
Rheumatology	**In Hospital**: 3-5 min	**in hospital**: 5-15 min	**In Hospital:** 15-45 min	within 12-24 hours
Heamatology	**In Hospital**: 3-5 min	**in hospital**: 5-15 min	**In Hospital:** 15-45 min	within 12-24 hours
ENT	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
Opthalmology	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
OMF surgery	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
Dermatology	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	15-45 min	within 12-24 hours
Cardiac surgery	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
Plastic surgery	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**in hospital**: 5-15 min **out of hospital**: 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
Immunology	**in hospital**: 3-5 min **out of hospital**: 15-45 min	**In Hospital:** 15-45 min	**in hospital**: 15-45 min **out of hospital**: 15-45 min	within 12-24 hours
Infectious dx	**In Hospital:** 15-45 min	**In Hospital:** 15-45 min	**In Hospital:** 15-45 min	within 12-24 hours