Minimizing Risk During Curbside Consults

Segan’s Medical Dictionary 2011 defines a curbside consultation as “an informal and unofficial consultation obtained from a health professional by either a lay person or fellow health care professional.” Responding to a request for a formal consultation does not cause angst amongst physicians as the reason for the request and their response are clearly defined. In other words, the consulted physician examines the patient, documents findings in the patient’s chart and bills for the consultation. However, responding to a curbside consultation appears to bring up any number of issues for physicians. In this paper we will address those issues and provide examples of various state rulings in order to help you decide if your curbside consultation practice needs revising.

Curbside consultations were once a fairly straightforward issue with minimal liability risk. However, the level of risk associated with curbside consultations may be rising due to reasons such as increased social media use amongst health care providers, increased numbers of hospitalists and subspecialties, new rulings from the courts and changing state laws. However, that risk can be minimized by reviewing new information on what defines a curbside consultation, determining when curbside consultations are appropriate, and how to respond to requests for a curbside consultation.

Fundamental to a discussion regarding curbside consultations is the question of when is a physician-patient relationship formed? In Mead v. Legacy Health Sys., 352 Or. 267, 283 P.3d 904 (2012), the defendant was an on-call neurosurgeon who received a telephone call from a resident in the emergency department about a patient who had back pain. The resident reported that an MRI was taken and interpreted as showing a disk bulge. The resident also reported that the patient was neurologically intact and had normal rectal tone. Defendant understood that the resident was asking for his advice about whether the patient needed to be seen by a neurosurgeon. Defendant's advice was to admit the patient to the medical service for pain management because defendant concluded that the patient did not need a neurosurgery consultation at that time. There was also testimony that another emergency room physician called defendant and gave him more information about the patient's condition. The emergency room physician testified that she did not explicitly ask defendant to see the patient, but she believed that the request was implicit in her calling him in the first place. Defendant disputed that he ever spoke to the emergency room physician. It was later discovered that the patient was suffering from cauda equina syndrome. The patient alleged that the delay in diagnosis caused substantial neurological damage. The question before the court was whether a physician-patient relationship existed as a matter of law between the on-call neurosurgeon and the patient.

In deciding Mead, the Oregon Supreme Court set forth the standard for determining when a curbside consultation establishes a physician-patient relationship. The court held that the standard is whether a physician who has not personally seen a patient either knows or reasonably should know that he or she is diagnosing a patient’s condition or treating the patient. The court acknowledged that advising a colleague about the possible causes of a patient's illness or the proper course of treatment for a patient does not necessarily give rise to an implied physician-patient relationship. In other words, the fact that one doctor offers an opinion to a colleague about the colleague's patient does not necessarily mean that the doctor either knows or should know that he or she is rendering a diagnosis for the patient, as opposed to offering advice to a colleague. With regard to on-call physicians, the court explained that the obligations that flow from a physician's on-call status are not uniform. Those obligations can vary from one institution to the next depending on the institution's policies, if any; the terms of any agreement to serve as an on-call physician; or, in the absence of institutional policies or an agreement,
the customary practice in the relevant medical community. Therefore, such factors may be relevant in determining whether a physician-patient relationship exists. This will typically be a fact question decided by the jury after hearing evidence on the factors that apply.

The state of Idaho has also addressed this issue with specific statutes that protect curbside consults. “Title 54 Chapter 18 54-1821 No Physician-patient relationship for informal consultations. 1) No physician-patient relationship is created between a physician licensed under this chapter and an individual not otherwise a patient of that physician when a physician is contacted by another physician or licensed health care practitioner who is treating the patient for a consultation or advice, if: (a) the consulted physician does not examine the patient; and (b) such consultation or advise is given by the physician to the physician or health care practitioner treating the patient without expectation of compensation for providing such consultation or advice. (2) A consulted physician who does not have a physician-patient relationship with a patient by virtue of this section shall not be named on any special verdict form concerning care provided to the patient unless there is a basis of liability to the patient independent of the consultation.”

The Washington Physician’s Guide to Health Law, from the Washington State Medical Association, addresses the issue of when a patient-physician relationship is created, by stating “Generally, the physician-patient relationship is created when a patient consults a physician for the purpose of health care, including prevention, treatment, management of illness, and preservation of mental and physical well-being. It is not necessary for the creation of the relationship that the physician actually treat the patient. Whether a physician-patient relationship is created depends on whether the patient believes that the patient’s contact with the physician was for purposes of treatment.”

Victor R. Cotton, MD, JD, provides some guidelines to the curbside consultation situation. He advises that the liability is greatly decreased if the interaction is informal, if there is not a supervisory role between the two health care providers, if there is no pre-existing doctor patient relationship with the consultant, if there is no contract between the consultant and the patient, if there is no written report, if the consulted physician is not on call, and the consultant does not receive payment for his/her opinion.

On the other hand, liability greatly increases when you participate in a curbside consultation if the above conditions are not met and if: 1) it’s a complex situation, 2) the questions being asked are specific in nature versus general, 3) if you need to examine the patient to give good advice, and 4) you know your advice is being used to make or confirm a diagnosis, admission, or discharge decision.

We receive many questions related to the relationship of curbside consultations and being on call. The Mead decision in Oregon, and Dr. Cotton’s advice stated earlier in this article, certainly clarifies that on-call status does not lend itself to curbside consultations. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that an emergency department and its on-call physicians owe a duty of care to any person who presents with an emergency medical condition. Therefore, a physician-patient relationship is established between the patient and the physician for whom the consultation is being requested. (However, if the physician does not possess the necessary skills and experience to treat the patient, it is appropriate to refuse care of the patient even while on-call.)

Similar to being on-call, “covering” for another physician requires special attention. The 2003 Michigan court addressed this issue in the case of Blazo v McLaren Regional medical Center. In this case the patient was in the hospital for carpal tunnel symptoms when she went into labor. Her obstetrician was unavailable, but the nurse spoke to the covering partner. The partner gave the nurse a
recommendation which was relayed to the treating physician. Unfortunately, fetal compromise was the outcome after the labor progressed. The award of $22.5 million was the largest verdict award in Michigan. The court held that the covering physician was legally responsible because he gave a treatment recommendation to a patient to whom, as the covering physician, he owed a duty, and therefore it was not a curbside consultation. Formally interpreting films, specimens and studies are also situations that do not meet the “informal” requirement of a curbside consultation. The physician performing these activities affirmatively participates in the diagnosis and treatment of the patient, therefore their formal reports cannot be considered informal opinions or curbside consultations.

If a physician participates in a curbside consultation, it may be helpful for the consultant to document his or her response. The creation of a permanent, separate office file with notes regarding the informal opinion or curbside consultation may prove to be useful should litigation occur and the only other written note regarding the consultation is from the treating physician. When the consultant maintains their own notes, the informal, non-specific and non-directing nature of the conversation can be maintained for future reference. The date of the conversation and the treating physician’s name can be included as well, but a patient name is not recommended.

In summary, whether a physician is the treating physician or the consulted physician, these issues should be reviewed when considering a curbside consultation:

1) Do not ask for or give curbside consultations for patients in active labor, patients who are critically ill, or patients whose conditions are rapidly deteriorating.
2) Be aware of the other situations in which curbside consultations are not appropriate ie. on call physicians, covering physicians, supervising physicians etc.
3) Frame responses in general or hypothetical terms and suggest several potential treatment options and their risks and benefits, and do not request or advocate for a particular course of action.
4) Do not discuss matters outside one’s field of expertise.
5) Do not direct the care of the patient, ie. order laboratory tests, write prescriptions, or order or adjust medications.
6) Discuss the feasibility of a formal consult, particularly if the facts are complex and certainly if more than one consult has been requested for a particular patient.
7) If the request is electronic, include disclaimer language such as “This is just a general answer to your general questions and please don’t construe this as medical advice for any particular patient.”
8) If the request is verbal, remind the treating physician that this is not a formal consultation and the consulted physician’s name should not be included in the patient chart.

In conclusion, curbside consultations are a recognized important component of the practice of medicine. To minimize risks associated with these consultations, follow the suggestions outlined here and consider that participating in a true curbside consultation should be viewed as providing a service to the treating physician rather than to the patient.

Portions of this article reflect information taken from Legal Risks of “Curbside” Consultations by Victor R. Cotton, MD, JD. American Journal of Cardiology 2010, 106: 135-8. The article is recommended reading.