Time to Curb the Curbside Consultation: Medicolegal and Quality Considerations

Rebecca Cady, Esq., BSN
Adam Smith, JD
Bud Wiedermann, MD, MA

June 19, 2019

With special thanks to....

Aneta Nikolic

Associate, Blankingship & Keith

Conflicts of Interest

- None

What's a curbside consultation?

" ... an informal process whereby a physician obtains information or advice from another physician to assist in the management of a particular patient. The consultant neither reviews the patient's record nor examines the patient and does not document his/her recommendations."

JAMA 1998; 280:905-9

A representative email....

Hi Dr Wiedermann,

I have a newborn/DOL 18, who [came] in with mastitis. The blood culture is negative to date, and there was no local drainage to culture. Breast redness and firmness [have] improved but still significant induration. Received 4 days of clindamycin and this is day 6 of Vanc.

Do you have thoughts on the length of treatment? 7 days adequate or treat till tissue normalizes?

Thanks,

The Requester Sees....

Pros

- More efficient than lit search
- No costs to patient or physician
- Minimizes number of formal consultants on a case
- Helps keep current with literature

Cons

- Implicit bias in requester's framing of case
- Reluctant to challenge advice given?

JAMA 1998; 280:929-30

The Consultant Sees....

Pros

- Efficient
- If salaried, no financial loss
- Intellectually stimulating?
- Facilitates future formal consults
- Disseminates knowledge

Cons

- Implicit bias in consultant's framing of case
- Giving wrong advice
- Location, location, location

JAMA 1998; 280:929-30

Neurosurgical Curbsides

- Prospective audit of “referral cards” over 12 months, compared to outside hospital notes
  - 10% sampling of 3672 phone call encounters
- GCS discrepancies 3 – 10 points
- Second contacts for same patient: 37% felt due to poor handoffs
- Quality not associated with grade of referring doctor

Br J Neurosurg 2001; 15:453-5

If you ask the wrong question....

Intervention or Outcome	Questions (N=708)	Unanswered Question (%)	Rec Formal Consult (%)*	Nondefinitive Outcomes (%)**
Neither	**126**	**12 (9.5)**	**28 (22.2)**	**37 (29.4)**
Only 1	**311**	**25 (8.0)**	**40 (12.9)**	**57 (18.3)**
Both	**271**	**11 (4.1)**	**18 (6.6)**	**27 (10.0)**

*p<0.05; **p<0.001

Arch Fam Med 2000; 9:541-7

ID Curbsides Take Time

- 1001 curbsides in adult ID academic practice over 1 year (2004-5)
- 78% complex (CPT level 4-5)
- 2480 wRVUs
  - 17% of total ID clinical work value
- $93,979 revenue if billable

Clin Infect Dis 2010; 51:651-5

The Scale Starts to Tip

Curbside vs. Formal Consult: Bad Advice

	Curbside Consults, N (%)		
	Total	**Accurate and Complete**	**Inaccurate or Incomplete**
	47 (100)	**23 (49)**	**24 (51)**
Formal advice differed from curbside	**26 (55)**	**7 (30)**	**19 (79)***
Formal consult changed management	**28 (60)**	**6 (26)**	**22 (92)****
Minor change	**18 (64)**	**6 (100)**	**12 (55)**
Major change	**10 (36)**	**0**	**10 (45)**
Curbside consult insufficient	**18 (38)**	**2 (9)**	**16 (67)****

J Hosp Med 2013; 31-5

*p<0.001;
**p<0.0001

Can Curbsides Be Lethal?

- Retrospective chart review + 90 day telephone follow up
- 342 *S. aureus* bacteremia episodes
- 2000-2002 and 2006-2007
- Helsinki University Central Hospital
- Primary outcome 28 and 90 day mortality
- Secondary outcomes #deep infection foci, fever duration, hospital days, inadequate Rx, relapse within 90 days

Clin Infect Dis 2013; 56:527-35

Higher 90 d Mortality with Curbside or No Consult

	Curbside N=61		None N=26		Formal N=244
	# (%)	OR (95%CI)	# (%)	OR (95%CI)	# (%)
28d mortality	9 (15)	1.16 (.19-7.09)	3 (12)	0.58 (.04-7.69)	11 (5)
90d mortality	17 (28)	7.09 (2.0-25.0)	7 (27)	5.88 (1.03-33.3)	22 (9)
Deep infection	32 (53)	0.15 (.06-.38)	8 (31)	0.13 (.03-.54)	190 (78)
Afebrile w/in 7d	23 (38)	0.12 (.05-.29)	13 (50)	0.15 (.03-.66)	176 (72)

Clin Infect Dis 2013; 56:527-35

View from Inside Counsel

- Any examples of legal issues at CNMC where curbsides played a role?
- Does it make a difference legally if the curbside request is from CNMC site versus other?
- How does CNMC leadership balance legal risks with practicality of serving our region and beyond?

View from Outside Counsel

- What are broader legal issues of curbsides/advice nationally?
- What are best practices from legal standpoint?
- What should be key principles to include in any curbside guidelines?

Duty of Care

The legal focus in cases involving curbside consults is whether the consulting physician owes the patient a duty of care.

Duty of Care

Whether a physician owes a duty to a patient in a particular set of circumstances is a question of law to be decided by the court, although the answer depends on the totality of the circumstances in each case.

Caselaw Review

No Duty of Care Owed

Case No. 1 – *Newborn v. United States* (D.C.)

- 3 y/o child of military parents was admitted to a German hospital for breathing problems related to his sickle cell disease.
- Dr. D, Pt's attending in Germany, emailed Walter Reed, describing the Pt. and focusing on his abdominal pain and hypoxia despite normal O2 saturations. Dr. D requested recommendations for intermittent home pain.
- A Dr. at the German hosp. called Dr. M at WR about home pain meds for a child with SSD who was being discharged. The caller said that the Pt. had low sats, but had been doing well until recently, and that a transfer to WR was unnecessary.

Case No. 1 – *Newborn v. United States* (D.C.)

- Dr. M answered Dr. D's email, answering his questions about Pt's hypoxia and what type of home meds would be appropriate for his abdominal pain.
- Dr. D emailed Dr. M for recommendations on which U.S. military bases would be best for SS pts. Dr. M also spoke with Dr. D on the phone about eventually sending Pt. back to the U.S.
- While Pt. was hospitalized for abdominal pain, Dr. D spoke to Dr. M by phone about managing his pain. Dr. M recommended a Motrin PCA pump and a transfusion if the pain did not improve. Dr. M asked about the O2 sats, and was told that there was no evidence of lung disease on exam and that the child looked good.

Case No. 1 – *Newborn v. United States* (D.C.)

- Lawsuit brought, alleging that Dr. M negligently recommended pain meds instead of immediate transfusion, and failed to account for Pt's O2 saturations.
- Court: Dr. M did not owe a duty to Pt via this consult.
  - Substantial or frequent consultation that amounts to virtual supervision of a patient's treatment tends to give rise to a duty, whereas informal or occasional consultation does not.
  - Dr. M's involvement falls somewhere close to the informal advice end of the spectrum. Dr. M did not provide the extensive and continuous type of consultation that made her practically the ultimate decisionmaker in Pt's treatment.

Case No. 1 – *Newborn v. United States* (D.C.)

- Docs at German hosp. retained control over Pt's treatment and did not look to Dr. M for supervision. Dr. M did NOT take over the case.

Case No. 2 – *Gilbert v. Miodovnik* (D.C.)

- Parents of child who suffered severe birth-related injuries brought action against Ob for failing to intervene in treatment plan developed by nurse-midwife association.
- Association's midwife oversaw Pt's care. Pt desired VBAC for third child. Midwife advised Pt of associated risks.
- Doctor occasionally conducted chart reviews with midwives. Midwife mentioned Pt to doctor, who expressed same concerns re: VBAC risks. Doctor advised midwife to reiterate risks to Pt, but risks were never re-emphasized.

Case No. 2 – *Gilbert v. Miodovnik* (D.C.)

- On day of delivery, another Dr. took over Pt's hosp. care and restated that risks were high for VBAC. Pt then agreed to C-section.
- Before C-Section, fetus developed distress resulting from uterine rupture. Infant was delivered with brain damage and severe injuries.

Case No. 2 – *Gilbert v. Miodovnik* (D.C.)

- After learning of the Ob's role, Pt alleged that he should have intervened with midwife to immediately alter plan from VBAC.
- Ob had only discussed Pt. with midwife on one occasion. He never met or examined Pt or reviewed chart.
- Pt never knew of Ob's existence, or that Midwife had discussed L&D plan with him.

Case No. 2 – *Gilbert v. Miodovnik* (D.C.)

- Whether a physician owes a duty to a patient in a particular set of circumstances is a question of law to be determined by the court, although the answer depends on the totality of the circumstances in each case.
- Court: No traditional physician-patient relationship existed between doctor and Pt. Doctor owed no duty of care.
  - He never met her, never examined her, reviewed her chart, and was not paid for the one-time “chart review” with midwife.

Case No. 2 – *Gilbert v. Miodovnik* (D.C.)

- Public Policy Note: Imposing liability on a consulting physician under these circumstances would discourage consultation between health care providers.

Case No. 3 – *Sterling v. Johns Hopkins* (MD)

- Pt admitted to medical center at 32.6 weeks' gestation w/ N&V, edema, hypertension, abdominal pain, and proteinuria.
- Pt developed hematuria and oral bleeding, and came under Dr. G's care.
- Dr. G ordered lab tests and an abdominal CT, and presumptively diagnosed severe pre-eclampsia and HELLP syndrome.

Case No. 3 – *Sterling v. Johns Hopkins* (MD)

- Concerned for premature delivery & his center's lack of NICU, Dr. G called UMD's referral service. This led to phone call w/Dr. K at JHH, wherein it was decided best to transfer Pt via ambulance b/c women on mag sulfate could not go by helicopter.
- Pt died during ambulance ride.

Case No. 3 – *Sterling v. Johns Hopkins* (MD)

- Summary Judgment properly granted on ground that Dr. K did not have physician-patient relationship with Pt; therefore, no duty was owed.
- Recovery for malpractice is allowed only where there is a physician-patient relationship as a result of a contract, express or implied, that the doctor will treat the patient with proper professional skill and the patient will pay for such treatment.

Case No. 3 – *Sterling v. Johns Hopkins* (MD)

- Voluntary acceptance of the physician-patient relationship by the parties creates a prima facie presumption of a contractual relationship between them.
- A physician-patient relationship was not established here because:
  - Dr. G, the primary physician, was able to observe the Pt's deteriorating condition, and agreed that he had the final say in making the decision to transfer
  - Dr. K owed no independent consultative duty to the medical center, its staff, or patients with respect to the care and treatment of individual patients

Case No. 3 – *Sterling v. Johns Hopkins* (MD)

- While Dr. K concluded that Dr. G's diagnosis and treatment was appropriate, he did not give any advice that would have caused Dr. G or the medical center staff to rely on his expertise, but in essence, merely conveyed the fact that JHH had the facilities and staff to treat the patient if she was transferred.

Case No. 4 – *Giles v. Anonymous Physician* (IN)

- Executor of patient's estate filed suit against physicians and employers for negligence that led to patient's death within 3 days of outpatient nasal surgery.
- Hospitalist moved for summary judgment on basis that he owed no duty to patient because he did not treat her or have a physician-patient relationship with her.
  - Hospitalist had gone to PACU and checked patient's chart. Her family doctor had not authorized hospitalist group to treat her, so Hospitalist told decedent he could not treat her.
  - Hospitalist never examined or treated patient, and did not bill her.

Case No. 4 – *Giles v. Anonymous Physician* (IN)

- Plaintiff in a medical malpractice action must first prove a duty owed to the plaintiff by the defendant. Whether a duty exists is question of law & appropriate for summary judgment.
- Duty of physician to patient arises from contractual relationship between them. A physician-patient relationship is a legal prerequisite to a medical malpractice action.
- Held: caselaw is clear that a physician who does not treat a patient or perform some affirmative act regarding the patient has no physician-patient relationship, and thus owes no duty to that patient.
- Summary judgment for Hospitalist was appropriate.

Case No. 5 – *Jennings v. Badgett* (OK)

- Plaintiffs filed med mal action against medical providers, including a non-treating physician who had conversation with the treating physician re: pregnant plaintiff's history and complications.
- Plaintiff must show that defendant breached a duty owed to plaintiff which caused the plaintiff's injuries. The existence of duty is a question of law for the court.
- An action for malpractice is based on an employment contract. The agreement of the physician to treat and the patient to receive treatment is the basis of the contract.

Case No. 5 – *Jennings v. Badgett* (OK)

- Because the duty is born out of a physician-patient contract, the relationship is essential to an action for a breach of the duty giving rise to the malpractice action.
- Unquestioned in Oklahoma and other jurisdictions that an attending or treating physician has the requisite connections with the patient to create a physician-patient relationship.
- Here, however, the physician was not an attending or treating physician.

Case No. 5 – *Jennings v. Badgett* (OK)

- Dr. here did not render medical advice to Pt; did not provide services to the treating Dr., did not examine Pt, did not receive referral for treatment, did not review any results or conduct any tests, and did not bill Pt.
- Facts failed to show Dr. agreed to treat Pt or undertook treatment of Pt.
- NO physician-patient relationship existed. Phone conversation, w/o more, is insufficient to establish the relationship.

Caselaw Review

Duty of Care Found

Case No. 6 – *Jacobs v. Harris* (VA)

- Doctor reviewed Pt's pathology slides and rendered his diagnostic opinion to another doctor.
- General test for determining whether a physician-patient relationship exists is whether a physician provided health care to the patient.
  - This relationship must exist for provider to owe duty of care to patient. Look to whether patient entrusted treatment to physician and physician accepted
  - Relationship can exist without face-to-face contact between doctor and patient.

Case No. 6 – *Jacobs v. Harris* (VA)

- A doctor "who assumes to act, even if gratuitously, may thereby become subject to the duty to act carefully, if he acts at all," even if that doctor owed no duty to the patient "prior to this undertaking."

Case No. 6 – *Jacobs v. Harris* (VA)

- Court: A jury could reasonably find that a physician-patient relationship existed.
  - By reviewing the pathology slides and rendering opinion, doctor commenced an undertaking for Pt and provided healthcare.
  - Thus, doctor could reasonably be found to have created such a relationship that gave rise to a duty of care.

Case No. 7 – *Lindeire v. Pediatrix* (MD)

- Father and minor children sued doctors and hospital for negligence in providing medical care to Mother, who died.
- Parties disputed whether there was evidence that Dr. established physician-patient relationship with Mother.
- Dr. did not recall having a conversation with the nurse practitioner who saw the Mother on the date in question.

Case No. 7 – *Lindeire v. Pediatrix* (MD)

- Dr. also stated that he was not the on-call physician on that date.
- NP testified at deposition that she recalled speaking with Dr. about the Mother.
- Dr. argues that NP relied on her own judgment to provide care to Mother because her notes did not indicate that Dr. gave any orders.
- NP stated that she remembered receiving orders from Dr.

Case No. 7 – *Lindeire v. Pediatrix* (MD)

- Court: If Dr. directed NP to provide specific care to Mother, even via telephone, he cannot avoid liability merely because he was not there in person.
- Jury could reasonably find that Dr. directed treatment via phone, according to NP's testimony of her recollection.
- Motion for Summary Judgment denied.

Case No. 8 – *Mead v. Legacy Health Sys*. (OR)

- ER Dr. telephoned defendant on-call neurosurgeon for his advice about Pt, who had come into ER for treatment.
- Pt argued that an implied physician-patient relationship arose when defendant offered an opinion regarding her condition to the ER Dr.
- In Oregon, as in most states, a physician-patient relationship is a necessary predicate to stating a medical malpractice claim. A physician-patient relationship may be either express or implied.
- Neither the ER Dr. or defendant testified that defendant's advice in his capacity as the on-call neurosurgeon was sufficient, without more, to give rise to a physician-patient relationship.

Case No. 8 – *Mead v. Legacy Health Sys*. (OR)

- Standard for determination of whether a physician who has not personally seen a patient has a physician-patient relationship with that patient is whether the physician either knows or reasonably should know that he or she is diagnosing a patient's condition or treating the patient
- Here, a jury issue was presented as to whether a physician-patient relationship arose as a result of defendant's telephone advice to ER Dr.

Steps for avoiding liability

Do not:

- Examine or have contact with the patient
- Review or make entries in the medical record
- Bill for the service
- Ask for identifying patient information

Do:

- Be clear that your answer is hypothetical
- Give general direction as opposed to advice
  - For example, say “You might consider....” instead of “You should do the following....”
- Use disclaimer language
  - For example, say “To be clear, this is not an official consult; it is an informal conversation only”

Do:

- Tell the treating physician if you believe-
  - they are in over their head
  - the patient needs to be evaluated

- Make notes about the conversation that could later be used to prove:
  - you did not have a physician-patient relationship
  - the conversation was general, not specific

Do:

- Develop a consistent practice for informal consults so you can say with conviction that you know you handled a call in a certain way based on your custom, habit, and practice

What About the Newborn with Mastitis?

ID Division Curbside Policy: Be Consistent

1. Ask clarifying questions PRN
2. Be clear answer is hypothetical/general advice
3. Use disclaimer language
4. Do not review medical record or ask/allow requester to divulge patient identifying info
5. Clearly state if needs more evaluation
6. Make clear that ID offers formal consults inpatient or outpatient

Suggestions for Requesters (curbside or formal)

- Know the patient's story
- Identify yourself by name and role (e.g. student, pediatric resident, rotating adult resident, attending, PA, NP)
- Use SBAR format
  - Make clear whether request is for curbside advice or formal consult
  - State your question clearly

Further Suggestions for Curbside Consult Requests

- Question should be straightforward, simple, does not require review of detailed history or diagnostic tests
- Do not provide patient name, MR, or other identifying info unless formal consult
- Do not record consultant name unless formal consult
- Request formal consult if advice unclear


time for questions