Liability Risks Associated with the Physician Consult – Both Formal and Curbside

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Consultation v. Referral v. Transfer of Care

Although these terms are frequently used interchangeably, the American Academy of Family Physicians believes there are essential differences between these terms.

Consultation

A request from one physician to another for an advisory opinion. The consultant performs the requested service and makes written recommendations regarding diagnosis and treatment. The requesting physician utilizes the consultant's opinion combined with his own professional judgment to provide treatment to the patient.

Referral

A request from one physician to another to assume responsibility for management of one or more of a patient's specified problems. This may be for a specified period of time or ongoing. This represents a temporary or partial transfer of care to another physician for a specific condition

Transfer of Care

One physician turns over responsibility for the comprehensive care of a patient to another physician. This could be initiated by the patient or patient's family as well as the patient's original physician. It may be either permanent or for a limited period of time.

Main Types of Consultations

- Pre-Operative
- Specialist
- Emergency

Categories of Consultation Risks

- Patient Related Risks
- Procedure Related Risks
- Provider Related Risks
- Anesthesia Risks

“Many primary care physicians, including hospitalists, feel inadequately trained to function as consultants for preoperative evaluations and feel the need for additional training.”*

***Steven Cohn MD, The Role of the Medical Consultant, Medical Clinics of North America 2003**

Communication

A surgeon's request to a primary care provider to "clear the patient for surgery" is an improper request because it does not specify exactly what the surgeon wants.

Don’t Delay

Both the attending and consultant face the primary risk of a delay in care. The attending must concede the need and benefit of the consult in a timely fashion and the consultant must perform the consultation in a prompt, reasonable time frame.

"***One way to maximize prompt, effective consultation and collegial relationships is to have a formal consultation protocol***."

ACOG Committee on Ethics (May, 2007)

Consultation Policy

There is no one gold standard consultation policy that we are aware of, but best practices should, at a minimum, include:

- Who may provide consultations
- Contingency plans when preferred consultant(s) are unavailable
- Mandated consultations
- Recommended consultations

Consultation Policy (Cont'd)

Duties of physician requesting consult should include:

- Documented order for the consult
- Clearly documented reason for the consult
- Documented communication with patient
- Inform nursing staff
- Emergency consultations shall be personally communicated between physicians

Consultation Policy (Cont'd)

Duties of the consulting physician should include:

- Respond to the request in a timely fashion; within 24 hours if non-emergent.
- Speak with the referring physician before and after the consult.
- Document discussions with patient/patient family
- Timely dictation of consult report for the chart; preferably concise and specific.

Consultation Policy (Cont'd)

The policy should address specifics for:

- Surgical consults
- Psychiatric consults
- Disagreements between physicians
- Refusals to perform the consult
- Acceptable modes for direct and immediate contact of the consult physician

Case Study 1

55 year-old male with complaints of abdominal pain had an upper GI and an endoscopic ultrasound that showed a 2 centimeter nodule consistent with a GIST (gastrointestinal stromal tumor), or less likely, a carcinoid. The patient was referred to a surgeon who recommended a duodenal exploration. A duodenal mass was excised. The patient continued with abdominal pain and a repeat GI endoscopy found a duodenal nodule. A CT revealed a GIST in the duodenum. It appeared stable and the decision was to simply monitor the GIST. A medical malpractice complaint was filed alleging that an improper and/or unnecessary surgical procedure had been performed.

Case Study 1 (Cont'd)

The medical review panel found an issue of fact. The initial endoscopy report was unclear as to the exact location of the GIST. The surgeon said he had a conversation with the referring physician specifically about the location. The referring physician did not recall such a conversation. The panel ruled "there is nothing in the medical records that establishes why Dr. _____ thought the GIST was proximal to the ampulla. To the contrary, Dr. _____ implies that a conversation never occurred. The panel can not make a credibility call. The evidence is simply not definitive."

Case Study 2

A physician contacted a specialist in a critical situation. The physician documented a single phone call. Investigation revealed that there were, in fact, 4 phone calls over approximately 2 hours. The specialist then came to the hospital and reviewed the chart, but did not examine the patient. He spoke with the referring physician, but did not document in the chart. The patient expired and both physicians were sued.

Case Study 2 (Cont'd)

The issue in this case is whether or not a "consultation" was requested. It did not meet the hospital policy definition of a consult, but once the specialist came to the hospital and reviewed the chart will the law hold that he was then required to examine the patient and dictate a report for the chart?

The Curbside Consult

The “curbside” consult is an informal discussion. ACOG refers to “professional dialogue”. Opinions and knowledge are shared, but there is no creation of a physician-patient relationship and should not be documented in the patient’s chart. They are an integral and valuable part of medical culture. Collaboration and brain-storming contribute to better quality health care.

The Curbside Consult

Although the benefits of the “curbside” consult outweigh the risks, the risks must be acknowledged. If the informal discussion comes to light during legal discovery it is certainly possible that the physician giving the informal advice can be dragged into the litigation. A finding of a legal duty or medical standard of care in these situations could have a chilling effect on this valuable tool.

Case Study 3

A physician relaxing at home receives a call from a former student. The former student is now working as a physician's assistant in an emergency room in a neighboring state. She is dealing with a situation in real time and wants reassurance from her former teacher that she has assessed the situation properly. The call only lasts a few minutes and the physician assures the PA that she is handling the matter correctly.

Case Study 3 (Cont'd)

Several months later the physician is named in a medical malpractice lawsuit. He is alleged to be an agent of the hospital and a collaborating/supervising physician of the NP. In this case, the court ruled that no physician-patient relationship was established and the physician was dismissed. What about professional liability coverage is such a situation?

Case Study 4

54 year-old female presents to a clinic with complaints of abdominal pain, fever, chills etc. She is examined by a nurse practitioner. Lab work reveals unusually high white blood cell count. The NP suspects an infection significant enough to require hospitalization. She contacts a nearby hospital and speaks to the on-call hospitalist. They spoke about 10 minutes. The hospitalist felt the abnormal lab results were the result of the patient's diabetes and that should be addressed first with instructions for the patient to follow-up the following Monday. There was disagreement as to whether the NP wanted the patient admitted or inquired as to whether the patient should be admitted. 3 days later the patient was found dead in her home by her son. An autopsy ruled the cause of death as sepsis due to an untreated staph infection.

Case Study 4

This situation occurred in Minnesota and the Minnesota Supreme Court ruled:

"A physician-patient relationship is not a necessary element of a claim for professional negligence. A physician owes a duty of care to a third-party when the physician acts in a professional capacity and it is "reasonably foreseeable" that the third-party will rely on the physician's acts and be harmed by a breach in the standard of care."

Questions

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