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Minimizing the legal risk with 'curbside' consultation

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"Curbside consultations" – in which a physician obtains insights on a medical case from another physician who has not seen the patient or reviewed the record – can yield advantages to the requesting physician. However, shortcomings are inherent in this common type of exchange and pose legal risk to the curbside consultant. This article provides background and practical tips that might help avoid being caught up in a lawsuit by surprise, or if named as a party, avoid being held culpable when the only involvement was a brief conversation with a colleague.

Introduction

Can a physician be held liable for the care of a patient he or she has never seen? Generally, physicians know the distinction between casual advice and a formal consult. However, that line can be blurry not only to the physician but the court system, as well. The informal or "curbside" consultation is common in the medical management of patients and an important part of medical community relationships. This article will offer guidance to reduce the risk and exposure of both the consulting physician and the requestor.

Shortcomings

Although curbside consultations offer advantages to the requesting physician, shortcomings are inherent in this type of exchange and pose legal risk to the "curbside" consultant.(1)
These dangers include:
• The information provided to the consultant could be inaccurate or incomplete.
• Inappropriate advice may be given and followed.
• The consultant's name may be recorded in the record as the source of advice without the consultant's knowledge.
• The treatment provided in accordance with the consultant's advice might be harmful to the patient, when the advice is given without a thorough review of the patient's history.
• Both the consultant and the attending physician are vulnerable to a suit based on inappropriate treatment of the patient.(2)

This article is not intended to discourage participation in informal curbside consultation. Rather, it is intended to provide background and practical tips that might help avoid a surprise lawsuit or, if named as a party, avoid culpability when the only involvement was a brief unmemorable conversation with a colleague about a patient that that was never seen, never examined and never billed.

Physician-patient relationship

The existence of a physician-patient relationship is the predicate for medical malpractice liability in many jurisdictions.(3)
In the absence of this relationship, a physician generally owes no legal duty and cannot be held liable to a non-patient. The physician-patient relationship prerequisite in medical malpractice litigation distinguishes this litigation

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from run-of-the-mill personal injury litigation. The common-law duty to refrain from negligently injuring others generally requires no prior relationship between the parties. By contrast, professionals do not owe a duty to exercise their particular talents, knowledge and skill on behalf of every person they encounter. Thus the duty to treat a patient with proper professional skill flows from a consensual relationship where the patient seeks the assistance of a physician and the physician accepts the person as a patient.(4)

Establishment of a physician-patient relationship is typically created when the physician and the patient voluntarily enter into a contract, either written or implied, wherein the physician agrees to render medical care and treatment to the patient for a fee. Typically, the scope and nature of the relationship is not explicitly agreed upon at the outset. Rather, the relationship evolves and is inferred from the communications and conduct of the physician and the patient.(5)

The relationship may, however, also arise from a gratuitous undertaking to render medical care and treatment to a patient without any form of agreement, promise or expectation on the part of the physician or the patient for a payment of a fee.(6) And, an implied relationship may be found where the physician gives advice through another physician. It has become common in today's highly charged litigation atmosphere for plaintiffs to name numerous defendants in medical malpractice actions, no matter how tenuous the defendant's role was in relation to the plaintiff 's care and treatment. Curbside consulting physicians are often drawn into the mix. The good news is that courts generally view informal curbside consultations as a service to a medical colleague, not as providing care to a patient (7) However, it is up to the court to determine as a matter of law, what characteristics must be present for a relationship to give rise to a duty, but it is essentially a question for the jury to determine whether a relationship has been established.

Identifying the curbside consult

Indications of an informal curbside consultation include the following, although no single feature establishes that there it is an informal consultation or that there is no legal relationship with the patient:

- *The consulting physician was not provided the name of the patient.*
- *The consulting physician has not examined the patient.*
- *The consulting physician has no direct communication with the patient.*
- *The consulting physician does not review the patient's medical records, including films or labs.*
- *The consulting physician has not made an entry in the patient's medical records.*
- *The consulting physician has no obligation for formal consultation, e.g., on-call obligations.*
- *The consulting physician receives no payment for services.*
- *The consulting physician gives opinions and advice solely to the treating physician.*
- *The treating physician remains in control of the patient's care and treatment.(8)*

Conclusion

Published risk prevention and control recommendations suggest that when informally consulted, the physician should:

• *Never give specific treatment advice on a patient never met, seen or examined. It must be clear that any responses are to hypothetical situations, with limited information.*

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• *Keep curbside consultations brief and simple. For more complex cases such as those requiring consideration of two or more confounding variables or detailed discussion of the patient's history and physical examination findings, formal consultation should be considered.*
• *Recommend formal consultation when a curbside consultation regarding a specific patient has to be repeated.*
• *Ask that the physician's name not be recorded in the patient's medical record.(9)*

Putting it in writing

As a general rule, a written record summarizing the discussion should be discouraged. If a discussion with a colleague seems to warrant written memorializing, that may be a signal to recommend a formal consultation so that a note can be made in the patient's record.
Also, curbside consultations by e-mail are discouraged. Special concerns are posed by e-mail, not the least of which is that a record of the communication is created, and distribution cannot be restricted. E-mail may mention the patient's name or attach portions of the patient's chart, including studies, which imply greater connection to the patient than would be warranted if the communication occurred in the hallway or by phone. If communicating to an inquiry by e-mail, physicians should be advised to take time to review what they are saying before they hit the "send" button. They should not suggest a greater degree of involvement with the patient than what is intended. A standard disclaimer paragraph can help make it clear that the writer is not giving advice regarding any particular patient, but rather is responding informally to a general inquiry and would be happy to see the patient formally in consultation.(10)

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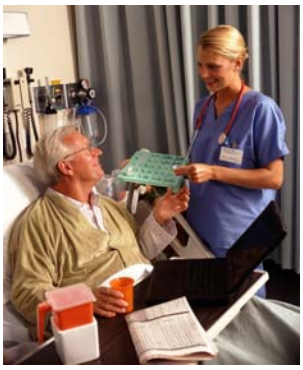

Following the Patient Rights of Medication Administration: Are These Enough to Guarantee Patient Safety?

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According to the Institute of Medicine of the National Academies, the most common medical errors are medication errors and annually account for

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injuries to approximately 1.5 million individuals. Additionally, hospital medical costs related to medication injuries exceed $17 billion a year and in outpatient settings, costs surpass 880 million dollars annually. Because of these astounding numbers, prevention of medication errors is the number one priority of the Joint Commission National Patient Safety Goals.

Why do Medication Errors Occur?

One third of a nurse's time is spent administrating medications to patient in the hospital setting. However, the nurse is not alone in this process: It involves multiple individuals and disciplines including the hospital system, physicians and pharmacists. Because medication administration is complex, there is great potential for error. Medication errors may occur in multiple medication administration processes including: prescribing, documenting, transcribing, dispensing, administering, and monitoring. In a study of adverse drug events, Bates et al. (1995) found that the largest percentage of medication errors (48%) occurred through ordering or prescribing of the wrong drug, dosage, or route. Overall, nurses caught and prevented 58% of all medication errors. (see Table 1)

Table 1. Errors during the medication administration process

Medication Administration Process	% of Total Medication Errors	% of Nurse Interceptions of Possible Errors
Medication orders/ prescription	48%	48%
Transcription of orders	11%	23%
Dispensing of Medications	14%	37%
Administration of Medications	28%	Unable to intercept once medication is administered

Additional causes of medication errors include; communication difficulties such as illegible handwriting, vague instructions, incomplete prescription order; inadequate patient information; patient's compromised health status (co-morbidities); failure to conduct the necessary laboratory follow-up testing to monitor treatment effects; administering intravenous medications too rapidly; inaccurate dosing due to crushing, splitting or discontinuing a medication etc. (Hughes & Ortiz, 2005). Specific to nurses, knowledge and performance deficits may result in medication administration

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errors. Performance deficits related to fatigue due to long hours and understaffing, interruptions by patient call bells and other providers, and complex technology are all potential sources of medication errors (Cohen, 1997). The list of possible root causes of medication errors is endless.

Medication Error Prevention

The most logical step to reducing medication errors is to have hospital system safety nets in place to prevent errors from ever reaching patients. However, nurses play a key role in the first line of defense in this process. According to Pepper (2006), there are 2 important nursing roles to prevent medication errors: 1) check the medication order chain to assure that other healthcare providers have not made errors, 2) prevent their own medication errors. In addition, following the "10 Patient Rights" of Medication Administration listed in Table 2 can prevent errors.

Table 2. 10 Patient Rights of Medication Administration:

Patient Rights
1) Right safety measures
2) Right medication
3) Right time frame
4) Right dose and strength
5) Right route and method
6) Right patient
7) Right to understand
8) Right observation
9) Right intervention and notifications
10) Right documentation

These rights are more comprehensive than the "5 Rights" nurses may have learned in nursing school. This checklist addresses key strategies to intercept and prevent possible errors. Table 3 lists additional specific strategies useful to nurses at the bedside to reduce medication errors.

Table 3. Medication Error Risk Reduction Strategies for the Nurse (Chilton, 2006)

Strategy	Rationale
Follow the "10 Rights"	The "10 Rights" is a comprehensive checklist that allows for multiple points of evaluation as you prepare and administrate you medications!
Double checking 'high-alert' drugs by conducting independent calculations	High-alert drugs are those medications that have an increased risk of causing harm when used incorrectly
Take time out between rechecking calculations	You are more likely to find your errors when there is time between rechecks.
Have one nurse read the medication dose and another nurse check it against the order, then reverse the process	Individuals see what they expect to see and whatever medication or patient name one nurse reads, the second nurse will most likely see it the same.
Cautiously interpret abbreviations. Contact the prescriber and pharmacist for clarification	Specific abbreviations are often misinterpreted: 'qd' vs. 'qid'; 'U' for unit can misinterpret as a zero; trailing zeros – 2.0 vs. 2 and 0.2 vs. .2
Put safety ahead of timeliness	Exercise caution when out of your normal safety zone of practice.
Take time to report errors	An error that occurred in one situation for a patient may occur again in similar circumstances

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Conclusion:

Medication administration is a complex process that involves interactions between diverse health care providers. Transparent health care systems, timely reporting of errors by providers and a shared dialogue will lead to system changes and improved performances and possible solutions to reduce and prevent medication errors.

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Partnering with Patients

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The ten year anniversary of the Institute of Medicine report, *To Err is Human: Building a Safer Health System* is almost upon us. While much has been done to improve patient safety, improve quality and reduce harm, there is still much that needs to be accomplished. The most recent evolution in the patient safety movement is focusing on building partnerships between healthcare providers and their patients and family members in an effort to clearly define their role as an important member of the healthcare team.

Creating effective partnerships can lead to increased patient satisfaction and improve outcomes by improving the patients' understanding of their role in their care. Creating these partnerships depends upon first establishing a pervasive culture of patient safety within the organization that supports open, honest two-way communication between patients and care providers. This communication needs to focus on a variety of subjects including patient education; the risks, benefits and alternatives to procedures requiring informed consent; the members of the healthcare team; the active involvement of the patient in their plan of care; disclosure to the patient, or family, when there are adverse events that can impact future healthcare decisions and how to engage the patient in reporting safety concerns they may identify during the course of their treatment.

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Patient Education

Effective patient education begins with assessing the patients learning needs, level of health literacy, readiness to learn and identifying any potential barriers to learning. It is equally important to identify the most effective learning methods for each individual as they will differ from patient to patient. Each patient's educational needs then need to be incorporated into individualized plans of care to ensure established goals are achieved prior to discharge. Appropriate medication reconciliation at discharge and clear instructions to each patient about the medications they need to take at home following discharge are another essential part of patient education that minimizes the potential for harm by preventing medication errors that could have long lasting adverse effects on the patient.

One of the Joint Commission's 2009 National Patient Safety Goals emphasizes the need to encourage patients' active involvement in their care as a patient safety strategy (Goal #13). In order to actively involve patients in their care, they must first be provided with information about what patient safety initiatives are in place in the facility. Some of these include educating the patient about how they can get involved in their care, how to recognize errors that relate to medications and by encouraging them to speak up if staff or physicians do not follow established practices for hand hygiene, preventing wrong site surgery and methods used for patient identification.

Another 2009 National Patient Safety Goal (Goal #16) focuses on the need to improve recognition and response to changes in a patient's condition. One of the expectations for complying with this goal is for staff to encourage the patient and family to seek assistance if the patient's condition worsens. Many facilities across the nation already have processes in place for staff to activate a rapid response team where designated members of the staff are readily available to respond to the patient's bedside. The role of the rapid response team is to help stabilize a patient's condition before a medical emergency takes place. The newest safety goal is now asking hospitals to develop a process that empowers the patient, or family, to be able to activate this same level of staff response for rapid assessment and stabilizing treatment. As a result of this new expectation, patients need to be educated about the specific process that is in place, what changes in condition are significant and how they can activate the rapid response team.

Informed Consent

All patients need to be provided with the specific details about any operative or invasive procedure, or any treatment that places the patient at significant risk by the practitioner who will be performing that procedure. In most cases, this is a physician-to-patient communication process where the patient is apprised of the risks, benefits, alternatives to the procedure and the consequences if they choose not to have the procedure performed. This process also needs to include an opportunity for the patient to ask questions of the practitio-

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ner who will be performing the procedure and to receive answers that help guide them in making sound health care decisions.

Plans of Care

Involving patients in the development of their plan of care, and daily goals, helps establish their role as an important member of the health care team. This process also enables them to be involved in setting treatment goals and provides them with an opportunity to ask questions of the members of the healthcare team so that they can play a more active role in the ongoing management of their care.

Disclosure

Another area where patients need to be actively involved is when medical errors occur. These errors may relate to medications where incorrect doses or incorrect medications are administered or they may relate to incorrect procedures, retained foreign bodies or wrong site procedures that meet the statutory definition of a significant adverse event. In these situations, a process needs to be in place to facilitate disclosure of the event to the patient by their physician. This process is an important part of a culture of patient safety that provides the patient, or their family, with essential information they can use to make future health care decisions.

Reporting

Developing effective partnerships also involves the need to periodically solicit input from patients about their perceptions of health care quality and safety through patient satisfaction surveys. Whether outside vendors or internally developed survey tools are used, measuring patient satisfaction is one of many ways to identify what's going well from a patient's point of view and where they feel the organization needs to focus improvement efforts in order to meet their expectations.

Patients should also be encouraged to report any concerns about quality or patient safety they might have during the course of their treatment. Internal mechanisms may include leadership rounds, dedicated patient safety hotlines, safety suggestion boxes or by providing all patients with the telephone number of an individual to call about their concerns while they are hospitalized. Patients also need to be informed that if they feel that their concerns are not being adequately addressed, they may contact the Agency for Health Care Administration or the Joint Commission directly.

There are many other ways hospitals can partner with patients to improve outcomes and promote patient safety. While the Florida patient safety statutes require that one member of each hospital patient safety committee represent the lay public, patients can also be invited to participate in process improvement teams to provide insight on ways to improve care delivery from a patients' perspective. Patients are also valuable members of forums, or advisory councils, where ideas about how an organization can improve quality and safety are solicited.

Once you have determined the best approach for developing a partnership with your patients, the next step is to identify measures that can tell you whether or not your efforts to establish this partnership with your patients is succeeding. As with

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all process improvement initiatives, it is important to capture data before changes are made to determine your current, or baseline, performance, then make the changes necessary to begin the patient partnership and finally capture the data after the new process is in place for a period of time. There are many sources of data that can provide you with information on how you're doing. Some of these include patient satisfaction data, outcomes data specific to individual performance improvements such as the implementation of family initiated rapid response and patient complaints.

The resources that are available to help guide you in effectively partnering with patients are endless. The Institute for Healthcare Improvement (IHI), the Agency for Healthcare Research and Quality (AHRQ), the Partnership for Patient Safety (P4PS), the National Patient Safety Foundation (NPSF), the LeapFrog Group for Patient Safety and the Joint Commission are a few excellent resources that can provide more details about how to get started on your journey.

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