

By Dr Asok Kurup

# Curbside Consults



“Death by handphone!” lamented a registrar after being inundated by numerous ‘curbside consults’ (also known as ‘curbsides’) on a particularly dreadful Monday afternoon.

Perhaps the advent of the mobile phone has morphed curbsides to ‘radiowave assaults’! One occasionally wrests with the temptation of crushing one’s mobile! Sigh, if only there was such an easy escape from curbsides! Heard of the ‘ambush curbside’? You may be rushing down the corridor on the way to a clinic session when you get ‘ambushed’. “Sorry, I know you are busy but this wouldn’t take a minute. What antibiotic do you think should be used to treat patient XYZ (whom you have only heard of now) who has bug ABC in the bloodstream?” asks an earnest colleague from a different speciality. Many of us in infectious diseases (ID) will find this scenario all too familiar. ID physicians are amongst the three most frequently curbsided speciality<sup>1</sup> (sharing this dubious honour are cardiology and gastroenterology). Similar experiences have been reported elsewhere<sup>2</sup>.

## CURB-SIDED OR ONE-SIDED?

A curbside consult is perhaps simply defined as an informal consultation in which the consultant (literally the person whose opinion is solicited; not quite the designation of the doctor) does not examine or interact with the patient. The consultant usually answers a simple question from the referring practitioner (maybe from nurses, various designation grades of doctors, general practitioners, and others). There is no fee involved, no documentation in case records, and by right, the referring practitioner should not attribute an opinion to the consultant. This interaction can take many forms, be it face-to-face, or even on the email. But ID physicians are more likely to be curbsided on the phone.

Formal ID consults cost money<sup>3</sup> but have been proven to be cost-effective<sup>4</sup>. So what prompts ID curbsides (advice on diagnosis and management<sup>2,5</sup>: bug-drug choice, how long to treat, tough diagnoses and others)? Perhaps the primary physician is trying to save money by not initiating

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a formal consult; or trying to reduce the number of doctors on the case; or he/she is verifying his/her own conclusion; or the information is not readily available; or the referrer is a good friend who knows that you will take the curbside no matter how exasperated you may be. In short: quick access to current expert opinion, cheap, and hassle-free, that is, no paperwork.

So, why bother with curbsides at all? Well, a lot of us may wish to maintain positive relations with fellow colleagues. It is also a learning experience in some cases. And the opinion given is likely to be respected.

On the flip side, the advice given may be based on incomplete, inaccurate, or a biased history, which may result in erroneous or inaccurate advice. For example, if a house officer confuses *enterococcus sp* with *enterobacter sp* (or vice-versa), the advice given will therefore be equally warped. Dispensing advice based on distorted information is an important pitfall to avoid. Many referrers just do not know how to communicate effectively or convey medical information appropriately. A case in point: a colleague was recently curbsided on an acute onset of fever in a stable hospitalised patient. He cleverly chose to formalise the consult upon which he discovered a sick patient with fever raging for over a week!

### **“EITHER STEP IN WITH BOTH FEET, OR KEEP WALKING”**

The very advantages of the curbside consult – convenience, speed, and lack of paperwork – also pose malpractice risks, especially if boundaries between a curbside and a formal consult are blurred. Some authorities suggest simply declining the curbside request altogether, that is, “either step in with both feet, or keep walking”. So is there any basis for this advice?

Traditionally, in any medical malpractice liability, the law has to first tweak out an established physician-patient relationship. In the eyes of the law, a duty of care is established as the result of a contract, express or implied, that the doctor will treat the patient with proper professional skill. In the past, courts have perceived that such a relationship existed only when patients were seen directly by the physicians. This liability did not extend to specialists consulted informally by the patient’s primary physician.

However the sands of time have shifted (in a bad way, as usual). The blurred definitions of what actually constitutes duty of care in an informal consult have spurred courts to convene

medical malpractice suits against specialists curbsided by patients’ primary doctors. The courts were simply deciding if a physician-patient relationship existed. And if so, was the duty of care breached by the consultant physician?

In my superficial knowledge and reading of the law surrounding this topic, I came across some concepts that might interest you with actual cases and court rulings<sup>6</sup> (all of these occurred in the US).

### **Physician-Patient Relationship Based on Consultant’s Actions:**

This means that a specialist who has no actual contact with a patient is not shielded from liability (horrors!). For example, a physician had consulted a cardiologist about a patient’s test results. The cardiologist determined that the results were not due to any cardiac event. The patient eventually died due to a coronary event. The court ruled “an implied physician-patient relationship may arise when a physician gives advice to a patient, even if that advice is communicated through another healthcare professional.” In another case, a pathologist had diagnosed small cell carcinoma from lung biopsy specimens from a patient. Chemotherapy and radiation therapy were commenced. When there was no response, a second biopsy was done. The same pathologist now diagnosed bronchial carcinoid tumour for which surgery or monitoring was the recommended treatment. The court rejected the argument that “it is not reasonable for a patient to believe that someone he has never met, spoken with, nor personally consulted can be considered his physician.”

### **Physician-Patient Relationship by Pre-existing Contract:**

This basically means that courts have considered whether a physician-patient relationship can be established by a pre-existing contractual obligation between the consultant and the hospital. For example, hospital doctors are expected to go on-call. In yet another case that went all wrong, a patient presented to emergency with severe pain. After a telephone curbside with an on-call physician, the emergency doctor recommended a pain reliever. The patient later died. The court noted “in effect, the patient had paid in advance for the services of the doctor on duty that night ... and the physician-patient relationship existed.” So the court deemed that the on-call doctor had a duty of care to the patient when he presented to the emergency room.

### **Foreseeable Reliance:**

This means that a consultant’s expertise may make

it 'foreseeable' that the treating physician would almost certainly accept the view of the consultant. For example, a cardiologist was curbsided by an emergency room (ER) physician about the ECG of a patient with chest pain. On the basis of the cardiologist's advice, the patient was sent home and promptly died of a cardiopulmonary arrest three hours later. The court felt that the cardiologist was far more qualified than the ER physician in interpreting ECGs and therefore concluded "the absence of a contractual relationship between the patient and the defendant cardiologist did not preclude liability."

So is all doom and gloom? Not all judgements have been unfavourable. For instance, one court ruled "Imposition of liability under these circumstances (the case dealt with a curbside consult) would not be prophylactic but instead counter-productive by stifling efforts at improving medical knowledge. Physicians ... by comparing problem-solving approaches with other members of their disciplines, have the opportunity to learn from one another."

All said and done, what is the best way to deal with a curbside in the practice of ID? While the liability risks of curbsides should not be ignored, this traditional informal professional exchange can continue with several caveats:

- **Curbsides should be kept brief and simple. Once they become complex and prolonged, formal consults should be requested for.**
- **Be cautious in giving a definite diagnosis or opinion in a specific case. Being a specialist, the requesting physician is likely to defer to your opinion. However, you may be setting him or her onto a completely erroneous path.**
- **Consider asking the requestor whether your opinion will be recorded along with your name. This is especially when you are dealing with a specific case. If so, it may be more appropriate to ask for a formal consult instead.**
- **Avoid converting a request for a formal consult into a curbside. This temptation applies to busy hospital practices where one frequently gets overwhelmed by formal consults. ■**

### References:

1. Kuo D, Gifford DR, Stein MD. Curbside consultation practices and attitudes among primary care physicians and medical subspecialists. *JAMA* 1998 Sep 9; 280(10): 905-9.
2. Leblebicioglu h, Akbulut A, Ulusoy S, et al. Informal consultations in infectious diseases and clinical microbiology practice. *Clin Microbiol Infect*. 2003 Jul; 9(7): 724-6.
3. Classen DC, Burke JP, Wenzel RP. Infectious diseases consultation: impact on outcomes for hospitalized patients and results of a preliminary study. *Clin Infect Dis*. 1997 Mar; 24(3): 468-70.
4. Nazeri A, Fakhri M. The effect of infectious diseases (ID) consultation on the use of vancomycin in patients with 2 positive blood cultures for coagulase negative staphylococcus (Co NS). Abstract 409. In *Programs and Abstracts of 43rd Annual Meeting of Infectious Diseases Society of America (IDSA)* Oct 6- 9 2005, San Francisco.
5. Lee T, Pappius EM, Goldman L. Impact of inter-physician communication on the effectiveness of medical consultations. *Am J Med*. 1983 Jan; 74(1): 106-12.
6. Baker K. A Doctor's legal duty – erosion of the curbside consult. *The Federation of Defense and Corporate Counsel (FDCC) Medical Malpractice Section*.

