Attention: FTC Postpones Enforcement of New "Red Flags" Rule

In response to the ever-increasing threat of identity theft, the Federal Trade Commission (FTC) issued regulations requiring any business that provides credit to customers to develop and implement written identity theft prevention programs. The Rule as currently written broadly defines the definition of creditor to include most healthcare providers who extend credit or bill for services.

In recognition of the ongoing debate that the Rule was written too broadly and questions relating to implementation, the FTC has delayed the enforcement date until August 1, 2009. The FTC has also indicated that they will be releasing a template to assist low risk businesses (such as healthcare providers) with compliance. Look for the compliance template to be available at www.ftc.gov/redflagsrule.

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DOCTORS RX

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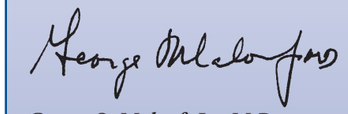
A Letter from the Chair of the Board

Dear Colleague:

This issue of the Doctors RX Newsletter focuses on a facet of medicine that is familiar to all of us – the curbside consult. It also provides insight into the larger issue of when a Patient-Physician relationship is formed. We hope this newsletter gives both the consultant and the treating Physician a better understanding of the many factors behind this much-used communication tool.



George S. Malouf, Jr., M.D.
Chair of the Board
Medical Mutual Liability Insurance Society of Maryland
Professionals Advocate Insurance Company

Curbside or Bedside?

Distinguishing Formal and Informal Consultations

When was the last time you were strolling down the corridors of your local hospital when a colleague approached you with an inquisitive "Do you have a minute to look at this film?" or, "I've got this patient in room 503 with…What would **you** recommend?" Imagine your surprise when a few years after this encounter, you are named as a defendant in a medical malpractice action by a patient whose name you have never even heard of. You discover that, following your brief chat about your colleague's patient, your name was referenced in the chart as a consultant and the patient is suing everyone associated with his/her care.

The goal of this newsletter is to help you understand the precise nature of these types of extemporaneous interactions, and how best to protect yourself so that you are not inadvertently thrust into the chain of liability for the treatment of someone else's patient.

Curbside consults are a useful and efficient way for Physicians to share their expertise, exchange ideas on treatment modalities, establish referral relationships, and improve the quality of patient care. A positive aspect of

Continued on next page

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these consults is the open exchange of information between Physicians. This transfer ideally manifests in a more comprehensive understanding of medicine, and improved outcomes for patients. Unfortunately, the downside to these informal discussions is the potential liability exposure for the Physician being consulted. Because of this possibility, the manner and circumstances under which the information transfer occurs must be carefully evaluated and properly managed. Moreover, there should be a mutual understanding regarding the extent to which the information rendered may be utilized.

Although aspects of informal consultations between Physicians have been addressed by many, but not all states, at the heart of the issue is whether a Patient-Physician relationship has been created. In the absence of this relationship, the Physician owes **no** legal duty of care to the patient. Conversely, if it is determined that the relationship existed, the consultant **may** be liable for injuries sustained by the patient, regardless of the accuracy or quantity of information provided to the consultant by the treating Physician.

How do the courts decide if a Patient-Physician relationship exists?

Maryland and Virginia case law, while non-specific as to curbside consults, offers guidance in determining when a Patient-Physician relationship has been created.

In Maryland, the Patient-Physician relationship is outlined in *Miller v. Shaefer*, wherein the court held that a Patient-Physician relationship may result from an express or implied contract, though there need not be an express contract between the Physician and the patient for the relationship to exist. If the patient and Physician voluntarily accept a relationship, than it is presumed to exist.[1]

In 2002, Maryland's highest court elaborated on this law to expand the Patient-Physician relationship by implication under specific circumstances. In *Sterling v. JHH*, the court implied that a Physician-Patient relationship existed between an ER patient and on-call Physician who was consulted, but who had never met or spoken with the patient.[2] The court indicated that "once an on-call Physician who has the duty to the hospital, its staff, or patients is contacted for the benefit of an emergency room patient, and a discussion takes place between the patient's Physician and the on-call Physician regarding the patient's symptoms, a possible diagnosis and course of treatment, a Physician-Patient relationship exists between the patient and the on-call Physician."[2] This case was limited to on-call Physicians, but may signal a trend toward increased liability for **all** health care consultants.

In Virginia, *Lyons v. Grether* defined a Patient-Physician relationship as "a consensual relationship that exists if a patient entrusts his or her treatment to the Physician and the Physician accepts the case."[3] The issue of whether a Patient-Physician relationship has been established is a question of fact that is decided by a jury. This opens the door to after-the-fact determinations as to whether or not the consultant's actions may be viewed as an implied contract between Physician and patient. If such an implied contract exists, a duty of care arises, which leads to potential liability exposure.

How can one be certain the consult is informal?

In almost all jurisdictions, **formal** consultations create a Patient-Physician relationship sufficient to form the basis of consultant liability. The distinction between formal and informal consultations is not always clear. For public policy reasons, the law generally tends to disfavor the establishment of a Patient-Physician relationship where the consultation is limited and there has been no **direct** contact between the patient and the consulting Physician. Courts understand that the dissemination of information between Physicians is beneficial to the overall practice of medicine. Nevertheless, if an adverse event occurs, it is the judge or jury who ultimately makes the factual determination as to whether a Patient-Physician relationship has been established.

Unfortunately, there is no specific law that defines an informal consult, nor is there one delineating characteristic. As such, there lies no perfect solution or exact course of action that can definitively absolve a consultant from potential legal action. Case history has shown, however, that certain factual elements (particularly when appearing in combination) increase the odds that a consult will be viewed as **informal**. When evaluating a particular situation from a professional accountability standpoint, the fewer of the following actions the consultant engages in, the less likely he/she will be perceived as a treating Physician.[4]

- Performing a physical examination of the patient
- Directly communicating with the patient
- Reviewing the patient's records
- Rendering patient-specific advice
- Billing of consultative services to the patient or Physician
- Directing the treatment of the patient

The characteristics identified above, and most of the reported cases, can be boiled down to two separate but related issues: the expectations of the patient; and the actions and control exercised by the treating Physician. There is a greater chance of liability being imposed when consultants have either done something that leads the patient to believe they have a relationship with them, or when it is foreseeable that the treating Physician will suspend his/her clinical judgment in reliance on the consultant's advice.[5]

CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent twice each year to the Insured Physicians of MEDICAL MUTUAL/Professionals Advocate®. Its mission and educational purpose is to identify current health care related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) Gain information on topics of particular importance to them as Physicians,
2) Assess the newsletter's value to them as practicing Physicians, and
3) Assess how this information may influence their own practices.

CME Objectives for *"Curbside or Bedside?"*

Educational Objectives: Participants should be able to:
1) Understand the inherent legal complications in providing "off-the-cuff" medical advice.
2) Identify circumstances when an unintended Patient-Physician relationship may be formed between the consultant and the patient.
3) Describe techniques that may be utilized to reduce the risk of liability for offering consultative information to another Physician.

	Strongly Agree				Strongly Disagree
Part I. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

_____

_____

_____

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____

_____

_____

_____

CME Test Questions

Instructions for CME Participation

CME Accreditation Statement — MEDICAL MUTUAL Liability Insurance Society of Maryland, which is affiliated with the Professionals Advocate® Insurance Company, is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians. MEDICAL MUTUAL designates this educational activity for a maximum of 1.0 AMA PRA *Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Instructions—to receive credit, please follow these steps:
1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading:

   Med•Lantic Management Services, Inc. Fax: 410-785-2631
   225 International Circle
   P.O. Box 8016
   Hunt Valley, Maryland 21030
   Attention: Risk Management Services Dept.

3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the Doctors RX. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: August 31, 2009
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you.

1. Brief informal discussions between Physicians regarding the diagnosis or treatment of a particular patient may result in a medical malpractice claim only for the treating Physician and not the consultant.

   A. True B. False

2. If you don't actually see the patient in person, perform an exam, or review medical records, a Patient-Physician relationship does not exist.

   A. True B. False

3. The consultant and treating Physician can decide by mutual agreement that the consult will not create a Patient-Physician relationship, and the courts must honor this contractual arrangement.

   A. True B. False

4. It is important to evaluate situations where you are being asked to consult on a medical issue. A consultant should consider factors such as: the complexity of the case, the degree of consultant involvement, the level of expertise involved in answering the inquiry, and the understanding of the purpose of the consult by the treating Physician.

   A. True B. False

5. Medical literature suggests keeping consults brief and simple, and informing the treating Physician that the advice is not the basis for diagnosis or treatment.

   A. True B. False

6. When a consultant acts in a manner that may reasonably lead a patient to believe they are taking an active role in their treatment, the risk that a Patient-Physician relationship may be inferred by a jury increases.

   A. True B. False

7. Patients do not always know who is responsible for their care. When a consultant's name is indicated in their chart, they often make assumptions that the consultant had a level of control over their treatment.

   A. True B. False

8. It is desirable to obtain permission from a colleague prior to entering their name into the record, when they have merely provided general information or significantly less than a formal consultation.

   A. True B. False

9. A concern for consultants is that the treating Physician will overvalue the consultant's expertise or advice and disregard their own clinical judgment.

   A. True B. False

10. Certain cases are better suited for formal consultations, especially if the patient's condition is rapidly declining or if experimental treatment has been suggested.

    A. True B. False

Patients don't always have a clear understanding of who's responsible for their treatment. Their expectations are not always predetermined and if a patient learns that other providers were consulted about their care, they may make assumptions that the consultants had a certain level of control over that care. Patients expect that a consultant has the same information available as the treating Physician. Neither the patient nor a plaintiff's attorney will care if you were given limited information.

The issue of whether a consultant should reasonably foresee when a treating Physician will substitute his/her own recomendations in favor of the consultant's is a bit more challenging. As a general rule, if a specific patient's care may be altered or influenced by the exchange of ideas, there is **potential** for the consultant to expect reliance on this advice. The greater the likelihood that the advice will be relied on by the treating Physician, the closer the consultant becomes to being thrust into the chain of liability for the patient's care. The bottom line? Consultants need to know what they are getting into from the beginning. Non-specific questions relating to unidentified patients are different than invitations to offer treatment-specific advice about a particular patient, and there are numerous gradations in-between.

A primary concern for consultants involves the treating Physician's misuse or over-reliance on the consultant's advice. This may occur when a generalist requests the advice of a specialist or sub-specialist based on the specialist's advanced knowledge and expertise. Treating Physicians may place greater weight on the consultant's clinical judgment than their own, precisely because of the specialist's expertise, despite the fact that the consultant may have had limited information on which to base his/her advice. For this reason, communication between treating and consultant Physicians concerning the purpose, use and limitations of the consult is crucial.

The following is an example of how a breakdown in communication between Physicians can result in the improper and unintended reliance on an informal consultation:

> A 50-year old female patient underwent an exploratory laparotomy and abdominal hysterectomy with bilateral salpingo-oophorectomy for a possible ovarian cancer. The gynecologist performing the surgery was uncertain if there was a primary tumor or metastatic disease stemming from the GI tract. A general surgeon passing through the operating suite to attend to his own patient was asked by the gynecologist to judge the involvement of the bowel. The consulting surgeon quickly looked over the involvement of the bowel and omentum. He felt that, based on what he saw, there was no primary GI tumor. He had no further involvement with the patient. He did not make any notations concerning this consult, never scrubbed in, made only a brief visual inspection, and did not bill for his time. The patient was diagnosed with stage III ovarian cancer, and the gynecologist performed a partial omentectomy, based in part on the consulting surgeon's evaluation. Following the surgery and a course of chemotherapy, the patient's CA-125 levels steadily declined. However, approximately one year later the patient's CA-125 levels began to increase and additional surgeries and course of chemotherapy was required. Suit was brought against the gynecologist for not properly staging the cancer and failing to perform the more extensive surgery necessary to prevent a recurrence. The consulting surgeon was implicated by the gynecologist as having rendered a surgical opinion which he followed. The surgeon indicated it was common practice to be available for these types of general surgical questions that were presented to him. He believed the consult to be a "professional courtesy" and stated that it was the primary responsibility of the treating surgeon to evaluate the clinical findings and determine how to best perform the surgery. The consulting surgeon was ultimately dismissed from the case. Notwithstanding this victory, he had expended an extensive amount of time, effort, expense, and emotional well-being in defending his actions.

What makes a case like this difficult is that there are often two versions of what transpired in a consult. Generally, the consulting Physician has **no** record of the events. This failure to document on the part of the consultant opens the door for the event to be interpreted based on the recorded recollections of the treating Physician, who may have memorialized the account from his/her own perspective. Often the consultant will have no proof of his intentions or actions other than a faded memory of the account. It is appropriate to request to know if your name has been entered into a patient's record. Likewise, it is a good practice to obtain permission from a consulting colleague prior to entering his/her name in the record when the consultant merely provided you with general information or significantly less than a formal consultation.

Under certain circumstances, it may be a better course of action to insist that the patient be seen as a formal consult, especially if an exam is clinically indicated or requested. There are a number of situations that should always be considered as red flags for informal discussions. These typically involve complex medical/surgical cases; those involving a critically ill patient or a patient whose illness is rapidly progressing, or where experimental treatment has been suggested.[6]

Despite the innate legal hazards associated with giving off-the-cuff medical opinions, the desire for and convenience of these exchanges is ever increasing. With advances in technology such as telemedicine, and the ability to transmit patient records, radiographs, and lab

results digitally, it is likely that the frequency of informal consultations will increase as well as the risk of exposure to consultants. Care should always be exercised and thought given to the best interests of the patient as well as the risk associated with one's involvement.

When you are solicited for an Informal Consultation, consider the following:

It is important to evaluate the situation for which you are being requested to consult. Know what you are getting into. Are you being asked for information for the purpose of enhancing the treating Physician's general understanding of a particular procedure; for general guidance; or to vicariously treat a specific patient? The more detailed the question and advice sought, the more specific level of expertise may be required to answer the inquiry. Likewise, the more complex the case, the greater the chance you may be unwittingly pulled into the chain of patient care.

Evaluate peripheral aspects surrounding the question. Is the requesting Physician a colleague with whom you have an established referral relationship? Has this Physician requested more than one consult on the same patient or situation? What is your expected level of involvement? Are you answering a general question about an unidentified patient, reviewing a film or diagnostic test, dropping by an unconscious patient in a surgical suite, or a scenario somewhere in the middle? Your clinical judgment and individual risk tolerance will play a role in your response.

Some experts have even recommended documenting (for your own records) those encounters that represent more involved or specific curbsides (e.g. where patients have been identified, or when other aspects of the advice are more involved, even if only general information is rendered). The rationale for documentation? Situations may arise where there is doubt as to the consultant's level of involvement or the quantity or quality of information that was available to him/her. Should it become necessary, having documentation of the exact circumstances for which the opinion was based may be helpful in one's defense.

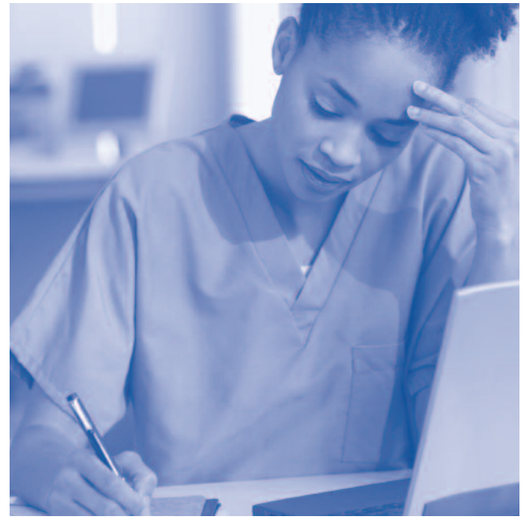
Some general recommendations on medical consultation that have been identified in the medical literature are:[5, 6]

- Keep informal consults brief and simple
- Explain to the treating Physician that the advice is not the basis for a diagnosis or treatment
- Request to be informed when your name is to be referenced in the patient's record as a consult
- Do not bill the patient or the treating Physician for informal consults
- Consider factors like the severity, complexity, and urgency of the case when deciding whether to insist on a formal consult
- When in doubt, ask to see the patient as a formal consult

Summary:

It is not unusual for professionals in any field to confer with one another and discuss hypothetical situations, problem-solving approaches, or innovative techniques. Physicians, in particular, are in a unique environment to learn from one another – for the benefit of patient care and the enhancement of the profession. As a general rule, the court system is not interested in stifling professional development; however, a balance must be maintained and care exercised when considering whether a Patient-Physician relationship has been created, regardless of the intention of the consultant. It may not always be clear to the parties involved how the advice a consultant gives is intended to be used. As a result of the changing climate in health care, many Physicians are questioning the practicality of offering informal advice to colleagues. While the value of the "information exchange" between Physicians should not be discounted, it is important for both the consultant and the treating Physician to evaluate and understand the context of the exchange. A suitable degree of caution should be exercised, so as not to confuse informal knowledge with serious formal involvement in patient treatment.

With advances in technology allowing for instantaneous exchange of patient records and diagnostic tools, it is likely that the use of informal consultations will dramatically increase, as well as the risk of liability. More than ever, Physicians need to evaluate their potential for exposure. This is not an easy process. It involves a plan of action, thoughtful consideration of patient and legal factors, and an understanding that a successful outcome is only possible if there is accurate communication and appropriate documentation.



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Doctors RX

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