Special Article

Malpractice Liability for Informal Consultations

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Background: *Informal ("curbside") consults are widely used by primary care physicians. These interactions occur in person, by telephone, or even by e-mail. Exposure to malpractice liability is a frequent concern of subspecialty physicians and influences their willingness to engage in this activity. To assess this risk, we reviewed reported judicial opinions involving informal consultation by physicians.* Methods: *A search of the existing medical literature, and of the Westlaw® national database was undertaken to identify reported judicial opinions involving informal physician consults that address whether informal consultations create a legal relationship between consulting specialist physicians and patients that gives rise to a legal duty of care owed by the consulting specialist to the patient.* Conclusions: *Courts have consistently ruled that no physician-patient relationship exists between a consultant and the patient who is the focus of the informal consultation. In the absence of such a relationship, the courts have found no grounds for a claim of malpractice. Malpractice risks associated with informal consultation appear to be minimal, regardless of the method of communication. While "informal consultation" is not a term used by the courts, the courts have applied a consistent set of criteria that help define the legal parameters of this activity.*

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> I have a 24-year-old healthy patient who, over the last 8 years, develops diarrhea when she gets very nervous. At her best friend's wedding, in which she was maid of honor, she had to leave the picture-taking session because of stool urgency and diarrhea. Her own wedding is coming up in 6 weeks, and she wants to know what she can do to prevent getting diarrhea. Do you think a prophylactic dose of Immodium would work?

> A fairly healthy, well-functioning, 75-year-old lady recently asked me for a tetanus shot because she has never had one before. She does not know if she had immunizations as a child but knows she has not had any vaccinations or boosters as an adult. If this is primary immunization, she needs three doses, but I don't know if it is primary. Would you give three doses or check tetanus antibody levels after one dose?

> I have a 64 year old whose prostate-specific antigen (PSA) was 2.28 last year and 12 months later it is 3.60 (same lab). His prostate was moderately enlarged without nodularity. My concern is the velocity of his PSA increase. Is it time for him to see the urologist, or should I just follow it up in 6 months with another PSA?

Family physicians and residents asked subspecialty physicians the above questions after encountering clinical situations they were not sure how to handle.[1] Clinical questions such as these regularly arise during patient care, and physicians frequently seek answers to these questions by querying a colleague.[2,3] Indeed, about one third of the information needs of family physicians are fulfilled by these informal ("curbside") consultations,[4-7] sometimes undertaken to satisfy intellectual curiosity but more often used to support the medical care of patients. For this reason, the informal, or curbside, consultation is widely viewed as central to good clinical medicine[8] and has been characterized as "among the survival skills of the busy clinician."[9]

These informal consultations occur in hospital hallways, doctors' lounges, and by telephone.[10,11] Today, e-mail offers another medium for these consultations.[12] One such e-mail system was the source of the clinical

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questions at the start of this paper. This system, at the University of Iowa, has handled more than 2,000 consultations between primary and specialty care physicians. The vast majority of these e-mail curbside consultations have been about specific patients.[13]

Physicians who provide informal consults frequently worry about the quality of the information supplied by the asking physician and whether the asking physician accurately and appropriately documents, recalls, interprets, and uses the specialist's advice.[12] The most common concern with this activity, however, is increased exposure to malpractice liability,[11,14] a concern expressed in our recruitment of more than 40 consultants for the University of Iowa e-mail-based curbside consultation system. A survey of these consultants during the third year of their involvement found that while most enjoyed answering e-mail questions from primary care physicians and residents, nearly half (44%) were uncertain whether their involvement with the e-mail service increased their exposure to malpractice claims. Another persistent, and related, concern has been the creation of a retrievable record that could give third parties access to these exchanges. No consultants have terminated their involvement due to these concerns, but several routinely place legal disclaimers at the end of each e-mail consultation.

To answer the liability concerns of subspecialty physicians, we undertook an in-depth analysis of whether informal consultation occurring by personal encounter, telephone, or e-mail exposes the informal consultant to a risk of malpractice liability. Our findings also inform primary care physicians and residents about their legal risk associated with use of informal consultations in patient care.

Methods

Search of the Legal Literature

The analysis presented here rests largely on a national review of reported judicial opinions involving informal telephone or in-person consultations. Computerized searches of the Westlaw® database for all 50 states and the District of Columbia (West Group, Eagan, Minn) were conducted using literal keyword searches for combinations of the terms "liability," "doctor or physician," "patient," "relationship," and variations on the term "consultant." Similar searches were conducted under the topical heading "health and medicine," also in the multistate database. Using the term "formal" or "informal" was not helpful because courts rarely characterize consultations expressly in these terms. All cases were "key cited" ("shepherdized") to determine their current status as law of the state. We also reviewed precedents cited on relevant points of law in key cases. Our research discovered no reported cases specifically addressing liability for consultations using e-mail, although e-mail communications have on occasion been involved in other medical cases when they have been introduced as evidence.[15,16]

Legal Assumption

It is well established that the existence of a physician-patient relationship is a prerequisite to any malpractice claim. Existence of such a relationship creates legal (not just ethical) responsibilities to exercise sound professional skill and judgment on the patient's behalf and to act with due care as a reasonable physician with like expertise would under the circumstances. Failure to do so would constitute negligence. But, if there is no physician-patient relationship, no duty is owed to the patient, and hence no legal duty can be breached. Absent a legal duty, physicians cannot be said to have caused the alleged injury, nor can they be found liable for damages.[17] In sum, if there is no legal relationship with the patient, there is no basis for an informal consultant's liability. The further implication is that primary care physicians and residents remain legally responsible for the advice and care they provide to patients, even when they seek out and rely on recommendations from specialists.

Results

Does Informal Consultation Create a Consulting Physician-Patient Relationship?

The physician-patient relationship is consensual in nature and is based on the idea of contract, whether express or implied. Typically, the scope and nature of the relationship are not explicitly agreed on at the outset. Rather, the relationship evolves and is inferred from the communications and conduct of physician and patient. Most often, the essential issue for informal consultations is whether a physician-patient relationship has been implicitly created, based on assessment of the facts and circumstances of the consultant's role. To make this assessment, courts have consistently inquired whether the physician exercised "independent medical judgment" on the patient's behalf.[18-20] A small number of courts have framed the inquiry in slightly different terms, asking whether it was "reasonable and foreseeable" that the patient would rely on the physician's advice or whether the physician's actions created a "reasonable expectation" of care.[21,22]

Application of these general principles requires a factual inquiry into the nature and content of physician-patient communications and interactions. Review of pertinent court cases involving alleged malpractice by a specialist consulted by a treating physician, either by telephone or in person, suggests a number of indicators of a physician-patient relationship or, conversely, its absence.

The Michigan case of Hill versus Kokosky[23] illustrates how judges typically frame the issues. An obstetric patient, at 23 weeks gestation, was hospitalized

with an incompetent cervix. During the hospitalization, her obstetrician sought the advice of two physicians at a nearby hospital. The child was born with severe disabilities, and the parents subsequently sued two physicians for rendering "substandard" advice during telephone conversations with the treating obstetrician. Rejecting the parents' claims, the court ruled that no physician-patient relationship existed between the mother and the physicians consulted by telephone because it found several factors persuasive: (1) The telephone consultants never contacted the patient, examined her, or spoke with her, (2) They never reviewed her chart, (3) There was no referral for treatment or in-person consultation, (4) The patient never sought advice or treatment directly from the consulting physicians nor otherwise tried to hire them, (5) The telephone consultants' opinions were directed solely to the treating physician, and (6) The treating physician retained authority to accept or reject the recommendations. In summary, the telephone conversations between the treating and consulting physicians did not, by themselves, create an agreement between the consultants and the patient.

Using similar reasoning, numerous state courts have held that informal consultations between physicians do not create a legal relationship between the consultant and the patient.[18-31] In several of these cases, treating physicians used the telephone to obtain a consultant's opinion about whether a diagnosis or treatment was correct and received an answer based solely on the content of the conversation(s).[18,26,27] Other instances in which malpractice liability has been rejected include a conversation in the newborn nursery while the informally consulted physician attended his own newborn patient,[28] a mere request for in-person consultation,[29] discussing patients at weekly staff meetings in a private practice,[30] and a professor's response to a case presentation during a medical education meeting.[31]

Collectively, these legal decisions support a general rule: a physician contacted by a treating physician to discuss medical concerns or options related to a patient does not form a legal relationship with the patient whose care is being discussed. The general understanding is that informal consultations are services to medical colleagues, not to patients.[22] Moreover, courts have specifically affirmed the importance of informal consultation. One case notes that holding informal consultants directly accountable to patients "would be detrimental in the long run to those seeking competent medical attention" and would be contrary to public policy.[26] Other decisions assert that exposure to legal liability "would unacceptably inhibit the exchange of information and expertise among physicians"[24] and would have a "chilling effect" on the practice of medicine.[32]

Still, it is not always easy to mark off the line between formal and informal consultation. Several factors have been repeatedly identified as important features of informal consultation, but the law does not provide one simple checklist of necessary or sufficient conditions for a physician-patient relationship. Few factors taken alone clearly differentiate formal from informal consultation. Personally examining the patient or expecting payment for services—features typical of formal consults—would almost certainly establish a legal relationship with the patient. This is the case even if diagnostic information and recommendations for care are communicated to the treating physician rather than the patient, and the treating physician retains control of the patient's care and treatment.[16] On the other hand, the absence of these two features does not necessarily make the consult informal. Providing care without compensation does not negate a legal relationship; charity care does not give license to be negligent. Nor is the absence of direct contact with the patient necessarily conclusive, as shown by the cases discussed later involving pathologists and radiologists (see "Invisible Specialists").

Other "Consultative" Relationships and the Duty of Care

Physicians regularly encounter various "consultative" relationships that share some features of informal consultation but are distinguishable in important ways. Our research came across a number of cases involving teaching physicians and residents, pathologists, radiologists, and "on-call" contracts with hospitals or health plans in which the existence of a physician-patient relationship was a central issue. These cases illustrate important points that can help physicians understand when they might be transitioning from an informal to a formal consultative role and a relationship with the patient that has legal importance.

Supervisory Relationships

Several cases suggest that a supervisory (ie, teaching attending) role that may feel consultative actually creates a physician-patient relationship, at least where the supervising physician's authority extends to directing patient care. Courts have consistently ruled that a staff teaching physician has a legal duty to the patient managed by a resident when the staff physician renders medical advice to a resident under the staff physician's supervision.[33,34] This duty may arise even if the staff physician does not actively participate in the patient's care. In one such case, a court found that a doctor-patient relationship existed between a patient and a group of staff neurosurgeons, despite the staff physicians' claim that they did not interact with the residents managing the patient during a 3-week hospital stay and did not recommend the care that was delivered to the patient. Central to this ruling was the physicians' contractual obligation to provide "guidance and direction"

to a group of residents on the neurosurgical service at the medical center. Because of the contract, the court held that even if the staff physicians did not have ongoing interaction with the patient, they were "nonetheless obligated to do so under the terms of their contract . . . and accepted medical practice."[35]

Absent this defined contractual supervisory responsibility, we found no cases suggesting that other exchanges of information between residents and staff physicians established formal responsibility for patient outcomes. Indeed, if the mere existence of a mentor-student relationship established a physician-mentor's duty to all patients under the care of a resident, this would be detrimental to both patient care (the courts' concern) and medical education. A cardiologist would be reluctant to respond to a resident's hallway inquiry about patient management, concerned that if his/her response were used in the care of the patient, he/she could be involved in a lawsuit, despite having had no direct supervision of the involved resident.

"Invisible" Specialists

Another group of cases suggests that "invisible" specialists who routinely provide patient care services but (almost) never see or speak with patients may be liable for the services they render. The leading examples are pathologists and radiologists. Notwithstanding their distance from the bedside, these specialists are expected to act consonant with the standard of care in their area of expertise and typically can be held liable for negligence if they fail to do so.[36-38] What distinguishes these situations from informal consultations involving these same specialists is the shared understanding among patient, treating physician, and specialist that professional services are knowingly rendered for a specific patient's benefit (not as an educational service for a colleague) and will be directly relevant to the patient's care. Most often, the patient consents to delivery of a tissue sample or the taking of an X ray and to the sharing of pertinent medical information with the specialist. In turn, the specialist's assessment generates a fee for these services.

On-call Physicians

Another set of cases involves on-call arrangements, typically involving emergency room care. The key factors here are control over patient care and the nature of the on-call agreement. On-call physicians expressly responsible for admission and patient care decisions under a contract with a hospital or health plan have been held responsible for refusing to accept a patient's care[39] and for denying inpatient care in favor of outpatient treatment.[40] An on-call specialist had a duty to the patient when he authorized discharge and transfer of a woman in labor[41] and when the specialist, on call for his group, actively participated in the diagnosis and treatment of a patient's cardiac condition.[42] In each of these cases, decisions were made by telephone, without the physician having ever seen or spoken with the patient.

By contrast, merely being on call does not create a legal duty to all patients admitted to the emergency room during the call period.[43-45] On-call physicians may, in appropriate circumstances, decline to accept the care of a patient, notwithstanding the emergency room physician's request for their expertise.[43,46] In sum, the nature of the on-call physician's role and responsibilities, as shaped by both the on-call agreement and the way in which the consultation is handled, are essential determinants of a legal duty to the patient.

Discussion

Courts generally view informal consultation as a service to a colleague, not as providing care to a patient. The typical informal consultation creates no legal relationship between consultant and patient. Consequently, this frequent and important practice appears to involve minimal risk of malpractice liability for consultants, while providing opportunity to help a colleague deliver good medical care. Other commentators have reached similar conclusions.[15,16,47-49]

Our analysis is based on case law in nearly 20 states and allows us to articulate guidelines for how to categorize the legal implications of physician-to-physician consultations (Table 1). It is important to note that relevant cases were not found in every state, but, equally important, we did not find any cases contrary to our conclusions. This uniform body of law should be highly persuasive in states where courts are yet to address the question.

Curbside consults between medical colleagues should be understood as legally distinct from formal consultations, from advice given by staff physicians to residents they supervise, and from consults undertaken because of on-call obligations, though these latter distinctions are less developed in extant law. Physicians should be attentive to the nature of the services they provide and the point at which informal consultation becomes formal. Contractual agreement to provide emergency on-call services is a condition of staff privileges at many hospitals. Attorney review of proposed contracts to clarify on-call obligations may be advisable.

Fox and colleagues have previously studied the malpractice risk for informal consults rendered by infectious disease specialists.[49] Our analysis, based on a much larger body of case law, reaches similar conclusions to their 1996 paper. Expansion of the case law over the past 7 years allows for more strongly grounded conclusions about the state of the law. The more extensive, contemporary body of cases also affords greater insight into the legal rules applicable to some of the various

Table 1

Indicators of Informal Consultation

Each of the following features suggests that a consult may be informal. The typical informal consult shares a number of these characteristics. No single feature establishes that the consult is informal or that there is no legal relationship between consultant and patient.

1. The consulting physician has not examined the patient.
2. The consulting physician has no direct communication with the patient.
3. The consulting physician does not review the patient's records.
4. The consulting physician has no obligation for formal consultation.
5. The consulting physician receives no payment for services.
6. The consulting physician gives opinion and advice solely to the treating physician.
7. The treating physician remains in control of the patient's care and treatment.

relationships between physicians that sometimes seem merely informally consultative in everyday practice but may be viewed differently by the law.

The increasingly busy nature of medical practice, together with constantly evolving specialization in medicine, make the informal consultation as much an essential resource of primary care practice as it has ever been. E-mail is a valuable tool for the busy clinician. Among its advantages are that it allows asynchronous communication, alleviates the need to be in the same place (or on the telephone) at the same time, avoids the frustration of "telephone tag," facilitates opportunities to reflect on and clarify questions and replies, enables preservation and later retrieval of information provided by a colleague, and reduces on-the-spot time pressure, which has been identified as a source of "incomplete or erroneous" advice with curbside consults.[14] Although our analysis discovered no cases involving the use of e-mail for physician-to-physician communication, the same rules governing informal consultation by traditional means should be equally applicable to informal consultations using e-mail. It is the nature of the communication, not the method used, that truly matters.

Our conclusions are not intended to suggest that e-mail consultations raise no new issues when compared to traditional in-person or telephone consults. New rules implementing the Health Insurance Portability and Accountability Act (HIPAA) strengthen protections for the privacy and security of personal health information, in particular information that is electronically transmitted or maintained. Compliance with HIPAA may foster greater vigilance in deleting or masking identifying information, a hallmark of informal consultations—for example, the common use of "hypothetical" cases. As noted earlier, a distinguishing feature of e-mail is ready creation of a permanent electronic (and perhaps paper) record of communications that ordinarily should be considered part of the medical record and, thus, potential evidence in a malpractice suit.[15,16,50] Responding to concerns about accuracy and liability, a group of neurosurgeons recently decided to fax their recommendations to physicians at other hospitals following informal telephone consults after discovering that their recommendations were often inaccurately recorded in patients' charts.[51] E-mail offers a convenient alternative approach to this problem. In addition to confidentiality concerns, e-mail, like telemedicine more generally, also presents some new challenges for interpreting rules against practicing medicine across state lines without a license.[52-54] These are important questions but lie beyond our more narrow inquiry about the malpractice risks associated with informal consultations.

Finally, that the typical curbside consult does not increase the malpractice exposure of subspecialists does not mean that consulting physicians have no obligations of professionalism and due care in the conduct of informal consults. To the contrary, consultants have professional and ethical obligations to act with the skill, knowledge, and diligence commonly expected in their field of specialty. In addition, both parties need to be in agreement about when these "educational exchanges" should be used in lieu of formal involvement of the subspecialist in the patient's care.

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