MedicoLegal In Dermatology

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Disclosures

- No Conflicts of Interest Relevant to this Lecture

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MOST IMPORTANT ADVICE

- Think Like an Attorney & CYA
- Cover Your Assets
- This lecture is intended for the sole educational benefit of our audience and should not serve as a substitute for advice from your attorney.

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Tort Law and Negligence

- Tort is **an act or omission that gives rise to injury or harm to another and amounts to a civil wrong for which courts impose liability**.
- In the context of torts, **"injury" describes the invasion of any legal right,** whereas **"harm" describes a loss or detriment** in fact that an individual suffers.
- There are 3 main types: **intentional torts, negligence, and strict liability**.

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Negligence

- Negligence has 3 key characteristics: – The action is not intentional. – The action is also not planned. – Some type of injury is created. demonstrate the defendant owed him or her a duty of care—a specific legal obligation to not harm others or their property.
- **Ordinary gross negligence,**
- **comparative negligence,**
- **contributory negligence, and**
- **vicarious negligence or vicarious liability**

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Ordinary vs Professional Negligence

- **Professional negligence is similar to ordinary negligence but is specific to the context of business**.
- It occurs when a business owner or, by extension, an employee fails to meet the reasonable duty of care standards required to ensure the safety of clients and customers, which then results in harm or injury.

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Professional v Medical Negligence

- **Medical malpractice is sometimes called professional negligence**.
- When a medical provider's actions or inactions fail to meet the medical standard of care, their behavior constitutes medical negligence. **If their medical negligence causes their patient to suffer an injury, it becomes medical malpractice.**

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What is medical malpractice?

- Derives from the Tort law of Negligence
- Negligence requires 4 elements:
  - Duty
  - Breach of duty
  - Causation
  - Damages

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Malpractice Litigation Impact (According to RMF)

- 20% of MD's = most stressful experience in life
- Most MD's = disruptive to lives
- 40% = Full blown depressive disorder
- 20% = adjustment disorder
- 2/3 = significant symptoms
- 1/4 = feelings of worthlessness, low self esteem

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IMPACT = 5 Stage Process (RMF)

- Initial Impact - Hrs - Denial
- Disorganization - Days to wks - Shame + Doom
- Reattachment - 2-4 m - anger to sad - career chg
- Reorganization - 1-2 yr - coping, distancing
- Reconstitution - some - see pt perspective, not personal competence but some = stuck and distant

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Medical Malpractice Stress Syndrome (MMSS)

- Shame, bitterness, low self esteem,
- Depression, anxiety, insomnia,GI, Angina, MI
- Sporadic Outburst against others
- Seek help from spouse, clergy, psychologist and attorney
- Avoid self medication

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Why the Fuss?

- It's Personal, Dude!
- It's our Identity not just Business.
- Physicians tend to be OBSESSIVE-COMPULSIVE CONTROL FREAKS.
- So maintaining Control is important

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JAMA Dermatology | Original Investigation

Characteristics of Medical Liability Claims Against Dermatologists From 1991 Through 2015

Heather Kornmehl, BS; Sanminder Singh, BS, BA; Brandon L. Adler, MD; Alexander E. Wolf, JD; Dean A. Bochner, JD; April W. Armstrong, MD, MPH

IMPORTANCE Recognizing malpractice trends in the field of dermatology is important for establishing safeguards for patient care and minimizing liability. However, there is a lack of published data on malpractice claims against dermatologists.

OBJECTIVE To determine characteristics of medical professional liability claims in the field of dermatology and to compare these claims with those against all physicians.

DESIGN, SETTING, AND PARTICIPANTS We examined malpractice liability data collected on dermatologists and other physicians insured by companies that report data to the Physician Insurers Association of America Data Sharing Project (PIAA-DSP), a nationally representative liability claims registry. Data analyzed spanned the years 1991 through 2015.

MAIN OUTCOMES AND MEASURES Demographic characteristics of dermatologists subject to claims, characteristics of closed claims, medical errors associated with closed claims, and patient outcomes leading to closed claims.

RESULTS Data on a total of 90 743 closed claims were analyzed, 1084 (1.2%) against dermatologists and 89 659 (98.8%) against nondermatologists. More lawsuits were brought against male (n = 753, 69.5%) than female dermatologists (n = 270, 24.9%); 5.6% of claims (n = 61) did not identify the physician's sex. Full-time practitioners (n = 1035, 95.5%) and those in solo practice (n = 600, 55.4%) were more likely to be sued than those in group practices (n = 429, 39.6%) and institutions (n = 31, 2.9%). Most claims against dermatologists were abandoned, withdrawn, or dismissed (n = 735, 67.8%). Between 2006 and 2015, trial verdicts favoring defendants exceeded trial verdicts favoring plaintiffs by a factor of 7. Errors that occurred during a procedure spawned the most claims (n = 305), of which 102 were paid. Misdiagnoses comprised the second-highest number of claims (n = 192), of which 62 were paid. The average recovery per claim was $238 145. The most common procedure leading to claims was skin operations (420 claims, of which 130 were paid). The most common adverse patient outcome associated with claims was dyschromia, resulting in 171 claims, of which 40 were paid.

CONCLUSIONS AND RELEVANCE Male dermatologists were sued more often than female dermatologists. Overall, alleged errors in procedures and misdiagnosis gave rise to the most lawsuits. Dyschromia was the most common adverse outcome alleged in lawsuits.

- Most malpractice cases against dermatologists are "abandoned, withdrawn or dismissed". [1]
- Downward trend in claims for dermatology and all specialties.
- Net reduction of 29.2% in paid claims for dermatologists.

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- Female physicians across all medical specialties, including dermatology, are less likely to be sued.
- Dermatologists practicing at institutions had fewer closed claims.
- Errors during an operative or diagnostic skin procedure and misdiagnoses were the first and second leading reasons for highest number of claims, respectively.
- Dyschromia was the most common adverse outcome resulting in claims.

[1]Kornmehl H, Singh S, Adler B, Wolf A, Bochner DA, Armstrong AW: Medical liability in dermatology: Trends in liability claims against dermatologists from 1991-2015. JAMA Dermatol. 2018;154(2):160-166.

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Downward Trend in Claims for Dermatology & All Specialties

- Dermatologists = 1.4% of all physicians yet = 1.2% of total closed claims ranking them 21 out of 28 specialties. [1]
- Ratio of % total closed claims/% of all physicians for dermatologists, the result is 1.2/1.4 = 0.86.
- Ratio approaches 1 implying being sued in proportion to our numbers.
- Should calculate similar ratios for other specialties and they may actually be getting sued less.

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Medical Malpractice = A **downward trend in claims for dermatology and all specialties.**

- **A net reduction of 29.2% in paid claims for dermatologists**
- The last 20 years, **only a 2.5% net reduction for dermatologists compared to a 17.9%** for all specialties.
- Dermatologists = 1.4% of all physicians yet = 1.2% of total closed claims ranking them 21 out of 28 specialties
- Ratio of *% total closed claims / % of all physicians* for dermatologists, the result is 1.2/1.4 = 0.86
- **Ratio approaches 1 and implies that sued in proportion** to our numbers.

Kornmehl, H., Singh, S., Adler, B., Wolf, A., Bochner, D. A., Armstrong, A. W. Medical Liability in Dermatology: Trends in Liability Claims Against Dermatologists from 1991-2015. JAMA Dermatology.

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Downward Trend in Claims for Dermatology & All Specialties

- Mean recovery per claim was $238,145, which is a two-fold increase when compared to $117,832 (1991-2005). [1,2]
- Could dermatologists be slipping behind while other specialties are improving?
- The risk of being sued during career = **75% - 99%.** [2]
- Mega awards have increased to >2 million for Melanoma, exceeding avg insurance coverage.[3]

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Female Physicians Across All Medical Specialties (including Dermatology), are Less Likely to be Sued

- ***Unwin et al.*** - "male physicians are 2.5 times more likely to be sued in medical malpractice actions." [4]
- Meta-analysis = female physicians are more likely to actively engage in 'patient centered' communication.
- Yet, dermatology workforce has shifted from 30% female in 2002 to 45% female in 2014, = nominal change in claims. ? trend

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Handling Expectations

- Most lawsuits stem from:
  - **Poor communication**
  - **Unrealistic expectations**
- That dyschromia is the common outcome resulting in claims highlights communication since dyschromia is often unavoidable or a natural consequence of the process.
- Returning to basics of physician-patient relationship can help resolve medicolegal issues even when outcomes not always as expected.

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Why Informed Consent?

- **Ethically** → Principle of Autonomy
- **Legally** → A cause in action in negligence
- Consider it less Legal Duty and more of an opportunity to **develop relationship**

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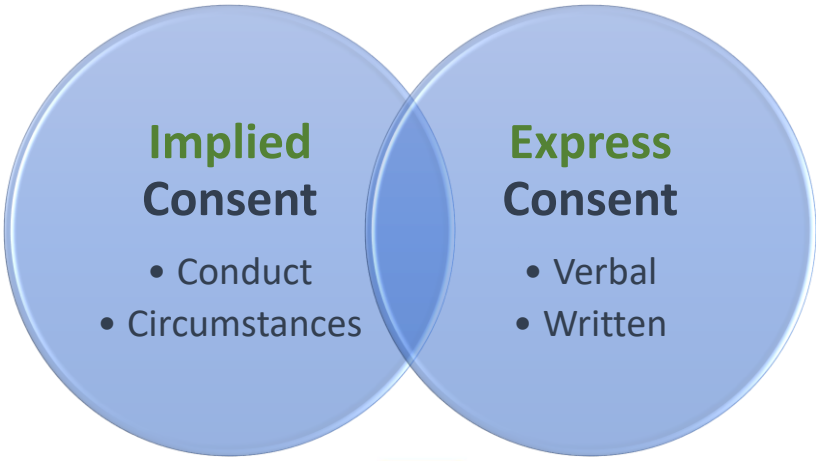
Types of Consent



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Assault and Battery

- **Assault** is an act intended to cause a fear of a harmful or offensive touching/contact. When that contact actually occurs, a **battery** has occurred. Examples:
  - The surgeon performs a procedure **without** a patient's **consent.**
  - The surgeon performs a significantly **different procedure** than that to which the patient consented.
  - The surgeon **surpasses** the scope of the **consent**.

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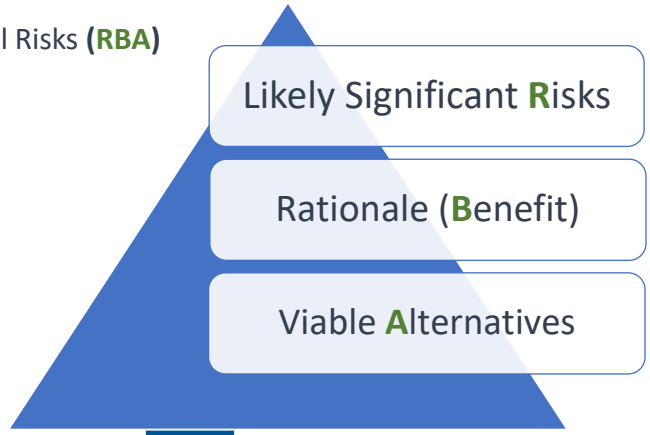
Informed Consent

- A process in which the physician explores the patient's needs, values, and beliefs.
- Discuss Material Risks **(RBA)**



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Informed Consent

- Discuss nature of the intervention at length
  - Increased invasion = increased discussion
- No Miranda Warning
- Advice = OK
- Track record not necessary but must be honest/can't deceive

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Informed Consent

- Circumstances that involve a greater degree of risk to the patient
  - Isotretinoin for females of childbearing age
  - Surgical excision vs. topical therapy for skin cancer
  - The option of sentinel node biopsy for stage II melanoma
- Patients take part in their own medical decision making

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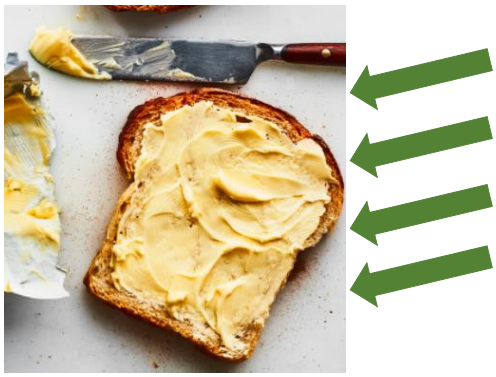
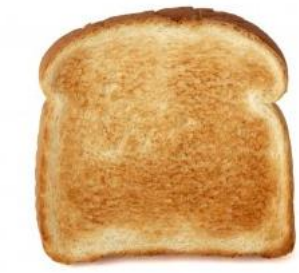
Let's talk "**bread and butter**"





Which piece of bread are you more nervous to drop on your nice carpet?

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Let's talk "**bread and butter**"

Which carpet are you more nervous to drop it on?

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Written vs Oral Consent

- Forms = inference of opportunity to read.
- **Forms do not = proof of consent**
- Physician documenting discussion = key
- Document Process with RBA note (RBA discussed with pt with emphasis on risk of dyschromia because of her Fitzpatrick skin type.)
- Oral Consent may be hard to prove if witness moves on.

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Informed Consent in Dermatologic Surgery

- 85 pts undergoing Mohs given verbal & written info including 10 complications.
- Asked to recall at 20 min & 1 wk s/p informed consent.
- Mean retention:
  - **20 min = 26.5%**
  - **1 wk = 24.4%**
- Only 12.9% recalled 5 or more at 20 min.
- No difference with gender, age, education, refer.
- Consider Pt to ask questions for comprehension.

[8]Fleischman M, Garcia C: Informed consent in dermatologic surgery. *Dermatol Surg*. 2003;29(9):952-955.

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Informed Consent & the Elderly

- Aging = impairs decision making/comprehension capacity.
- Aggravated by:
  - Lower vocabulary and educational level
  - Chronic and acute medical illness
- Consider asking questions and/or multiple-choice test immediately after discussion.

[9]Christensen K, Haroun A, Schneiderman LJ, Jeste DV: Decision-making capacity for informed consent in the older population. *Bull Am Acad Psychiatry Law*. 1995;23(3):353-365.

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What Have We Learned?

- Oral consent = Written consent
  - But harder to prove
- Documentation (**RBA**) unique to every patient is wise
- Patient retention decreases with time
- Advisable to help patients remember
- How can we do that?
  - **Ask questions or use questionnaire**

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PENNSYLVANIA SUPREME COURT (Shinal v Toms 162 A.3d 429 (Pa. 2017)

- A patients consent for a procedure cannot be delegated to a nurse practitioner or physician assistant.
- Judicial desire to hold physicians responsible regardless of larger trend towards team approach with more authority for extenders, etc.

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REMEMBER:

All informed consent is expressed
But **not all** expressed consent is informed

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Variations on Informed Consent

- IC and the use of interpreters
- IC and positive reviews HIPPA violations
- IC and texting
- IC and Cut and Paste (AMA article what is SOC)
- IC and getting Doxed (Dangers of info on devices)
- IC and Stipulated agreements with Medical Board

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Hearing Impaired & Interpreters

- no mandate for American Sign Language (ASL) interpreter.
- ADA requires “reasonable accommodations” to bring about “effective communication.” such as writing, lip-reading, or using family or friends as interpreters

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Hearing Impaired

- office policy that the first pt visit is to determine if can accept the patient to prevent reasonably believing that a doctor-patient relationship has formed

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Hearing Impaired

- Section 44 of the IRS Code, tax available for “small businesses” (30 or fewer full-time employees or < $1,000,000 in annual revenues)
- to help cover cost of making reasonable “access improvements

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Hearing Impaired

- After the first $250, 50% of the eligible access expenditures to a maximum expenditure of $10,250. What this comes out to is a maximum credit for the tax year of $5,000.
- expensive interpreter = cheaper than the cheapest lawsuit

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IC and Language

- Critical issue to consider when you have a patient who is not proficient in English: informed consent.
- Title VI of the Civil Rights Act of 1964 prohibits exclusion from services and/or discrimination on the grounds of limited English proficiency.
- Other than in an emergency situation where it is not possible to wait for a translator or a video relay to be set up, you would be expected to use the most optimal translation available.

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Interpreter Services Summary

- *Translation must be adequate to reasonably allow communication.*
- *The ADA does not require an ASL translator if other reasonable accommodations can be made*
- *Translation services can be offset with a tax credit.*
- *Language translation is best performed by a certified medical translator*
- *Documenting translation should be undertaken in IC*

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Summary Interpreter Services

- all contacts that are made through a translator should be documented.
- If the patient elects not to use the translation services in favor of a personal translator, this should be documented

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Consent and Liability

- C and texting
- C and Cut and Paste (AMA article what is SOC)
- C and getting Doxed (Dangers of info on devices)
- C and Stipulated agreements with Medical Board

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Texting - TCPA

- Changes to in-network status with different insurance carriers. Or whether you'll even take third-party insurance at all Happen
- changes require doctors to notify their existing patients

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Texting & TCPA

- TCPA stands for the Telephone Consumer Protection Act.
- A cash cow for plaintiff's attorneys.
- The second most frequent federal lawsuit after employment law claims

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Texting

- TCPA litigation is mostly triggered by SMS text message marketing
- Damages are $500 per text or actual damages, whichever is greater. The statutory damages are up to $1,500 per text for willful or knowing violations.

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Texting

- You must consider the content and purpose of your messages before scheduling a blast.
- Obtain written authorization from your patients before sending such materials – no matter what.

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Texting and TCPA

- "Under the health care message ecept§ 64.1200(a)(2), a covered entity or its business associate may lawfully place a telemarketing call that delivers a message about health care, as long as the called party provides prior express consent.

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Responding to Positive Reviews

- Acknowledging the patient is actually your patient.
- The patient has "outed" themselves publicly, but HIPAA does not allow disclosure of PHI without advanced signed authorization or a statutory exception.

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Responding to Negative Reviews

- A good idea, if done without acknowledging the poster is your patient and if you do not disclose protected health information.

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Responding to Negative Reviews

- Must be sure the response complies with HIPAA.
- Not to get into a debate with the patient,but to educate how your practice solves problems. Not to demonstrate how you are right and the patient is wrong.

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Copy and Paste

- Most healthcare providers copy and paste. Sprinkling in some new stuff.
- JAMA analyzing 100 million clinic notes - >1/2 was duplicated, >16.52 billion words. As of 2/2022, the Wikipedia = 3.9 billion words

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Copy and Paste

- Duplicate content was prevalent in notes written by physicians at all levels of training, nurses, and therapists, and was evenly divided between intra-author and inter-author duplication.

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Copy and Paste

- the mean patient record has 56% of the word count of William Shakespeare's longest-written work, *Hamlet*)
- a physician seeing 10 pt/day would be reviewing at least 85 pages of single-spaced text across 691 notes

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Copy and Paste

- Recently, the Deputy Attorney General (DAG) in one state advanced an accusation against a licensed physician. The charge: He was using templates to document his notes. And the notes did not vary much from visit to visit.

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Copy and Paste

- Dr. X's notes =minimal variation. Occasional copied note without a complete update might be forgivable, but consistent similarity between notes across many visits = a negligence of extreme departure proper documentatio

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Consent Agreements

- A Stipulated Agreement or Consent Agreement is one way physicians can negotiate a certain type of disciplinary outcome with Board of Medicine.
- It trades uncertainty for certainty.

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Consent Agreements

- Is is still unpleasant? but terms often better than may be delivered if one goes to a hearing or court?
- If you defend, you may be exonerated. Or you may lose big.

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Consent Agreements

- That's why being open to a Stipulated Agreement or Consent Agreement is not unreasonable. Particularly, if you CAN go back to work the next day, just as you did the day before If license revoked butorder stayed b/o probation

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What is medical malpractice?

- Derives from the Tort law of Negligence
- Medical negligence requires **expert testimony**
  - Specialist vs. generalist, ordinary negligence exception, group practice pitfalls
- **4 elements** are required:

1. **Duty to Care**: Doctor-Patient relationship (reasonable expectation of care)
2. **Breach of Standard of Care**: Determined by expert
3. **Proximate Causation**: Foreseeable, direct effect of particular injury in question
4. **Damages**: Actual injury but can be emotional

[6]Torres A, Konda S, Nino T, de Golian E: Medicolegal Issues. Clin Dermatol. 2016;34(1):106-110.
[7]McGahan JP: Advice on avoiding a malpractice lawsuit. Appl Radiol. 2018;47(6)4-6.

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Malpractice and Complications/Adverse Events

- Complication may not be a Breach of Duty, fail to meet SOC, or cause of Damage
- Not every adverse even may result in causation of of damages
- However, it can lead to malpractice claim

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How is duty established?

- Giving medical advice
  - Clinical setting
  - Social setting
- Performing a procedure
- Dermatopathologist who reads slides
  - May never even see the patient
- Having a set appointment with a patient
  - May imply a relationship
  - Prudent to follow up on missed appointments

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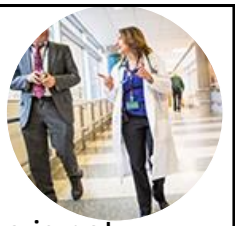
How Doctors Risk Becoming Casualties of Casual Care...and Solutions (medicaljustice.com



Casual care is when you consult informally with someone who is not your patient such as a a family member, a co-worker, neighbor, etc.

In environments where your guard is down such as a neighbor asking about the adequacy of an Rx or a family member asking for advice

A bad outcome, patient reasonably relying & the severity of the patient's inquiry plays a role. If your neighbor asked you to interpret data your willingness to do so may signal that you acted as their Dr.

by Medical Justice | Oct 26, 2020 | Legal

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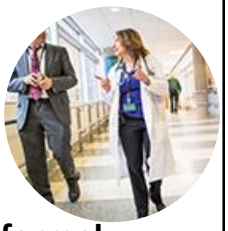
How Doctors Risk Becoming Casualties of Casual Care...and Solutions (medicaljustice.com

Beware of change in environment and effect on judgment (Church v Family Gathering v School v Office)



Know your **state regulations**

Stay in your **lane of expertise**

Prescription almost guarantees a patient-doctor relationship

Invoke the Doctor Patient relationship -**Treat the matter as a formal encounter and follow protocols even if you tell person not to rely**.

Act as a **physician not their friend**

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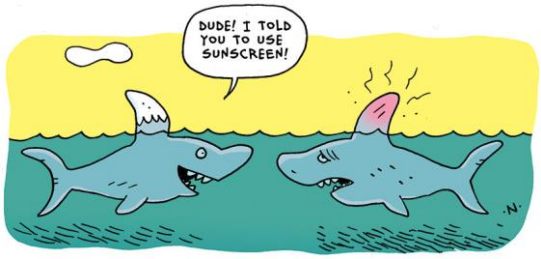
How Doctors Risk Becoming Casualties of Casual Care...and Solutions (medicaljustice.com

REMEMBER

"No Good Deed Goes Unpunished"

"Blood is Thicker than Water but Sharks/Lawyers are ATTRACTED TO BLOOD"



https://jokes.scoutlife.org/topics/shark-jokes/

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Curbside Consultation Risk Mitigation Strategies for Doctors (medicaljustice.com)

- Curbside consultations = informal collaboration with another doctor
- Criteria for informal = two physicians must have equal standing, (not attending/resident), can't have pre-existing relationship with pt or fill in for another doctor, can't be on call with question specific to pt.,must be free, can't require a written report or contact between pt and consultant
- Remember "You aid your colleague not the patient"

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Curbside Consultations

- Commonplace in both hospital and ambulatory settings
- 1998 survey reported subspecialists requested 3.6 /wk and primary care requested 3.2/wk
- One study in 2004 & 2005 found that at one 500 bed hosp infect dz IC =1000/yr=17% of clinical work value, $93,979 in 2005
- A 2019 survery = academic radiologists frequently render verbal undocumented consults
- Data on frequency across specialties is lacking as is frequency, scope and quality data from lawsuits

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Curbside Consultations Potential Benefits

- Bolstering Access to specialty care especially in rural areas
- Increase multidisciplinary collegiality exploring knowledge gaps, sharingknowledge, educating
- Cost savings vs uncompensated doctor time
- Are they preferred to formal consults
- ½ -3/4 are complex in nature

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Curbside Consultations Knowledge Gaps

Burden M, Sarcone E, Keniston A et al. Prospective Comparison of curbside v formal consultations, J Hosp Med 2013:8(1):31-35

- Of 47 curbside consultations reviewed that became formal , recommendations changed in 55% and changed management in 60%

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Zacharias, Rachel L., Feldman, Eric A., Joffe, Steven, Fernandez, Holly Lynch, "Curbside Consults in Clinical Medicine: Empirical and Liability Challenges", Journal of Law, Medicine & Ethics, 49 (2021) : 599-610 (University of Pennsylvania Carey Law School – RLZ- JD.M.B.E,EAF-J.D.PhD, SJ-Md,MPH University of Pennsylvania Perelman School of Medicine (PSM) and HFL-J.D.M.B.E PSM and Carey law School)

- Duty requires express Physician Patient Relationship -AL,CA,GA,KY,MA,MI,PA
- Duty Duty established by express, special or implied physician patient relationship - AK,AR,CT,FL,IA,IL,IN,KS,LA,MD,MO,NE,NJ,NY,OH,OR,RI,TN,TX,VA,WA,WV
- Minority – No Physician Patient Relationship required – AZ,CO,MN,MS
- Insufficient Case Law to determine– DE,HI,ID,ME,MT,NV,NH,NM,NC,ND,OK,SD,UT,VT,WI,WY

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Curbside Consultations Knowledge Gaps

- How does lack of $ and legal repercussions affect adequate time and care – Ethics rule
- When to prefer informal over formal now that we have telederm, new technology, licensure across jurisdictions
- To what extent does brevity, second hand info and gaps in detail compromise quality
- Information exchanged inaccurate or incomplete ½ of time
- Not identified if experience level of Rx'ing or consulting MD hinder or facilitate
- Not clear when threshold to convert to formal is reached

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Curbside Consults – Warren v Dinter, No.A17-0555 (Minn Apr. 17, 2019)

- 54 yo plaintiff Susan Warren
- NP contacted hospitalist Dr. Dinter in different health care system regarding- admit the patient
- Dinter –was on call and the gatekeeper for the hospital system involved.
- Another physician who agreed with Dr. Dinter.
- The patient wasn't admitted and subsequently died from sepsis
- There was a suit for medical malpractice

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Curbside Consults – Warren v Dinter, No.A17-0555 (Minn Apr. 17, 2019)

- When sued Dr. Dinter claimed that it was a curbside consultation with no duty created
- The district court and appeals court agreed with Dinter.
- The Minn Supreme Court overturned based on the fact that the hospitalist had a responsibility to take the call and served as the gatekeeper and thus had a duty. BUT
- They also went a step further and said that the hospitalist had a DUTY OF CARE because it was forseeable the NP would rely/act on that advicepotentially leading to patient harm

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Curbside Consults (Skillings v Allen 173 N.W. 663 (Minn 1919) Minnesota Precedent

- Doctor advised parents of a girl that her scarlet fever had resolved & she was not infectious
- Relying on advice, parents took girl home and contracted scarlet fever
- Court held doctor liable even though no physician patient relationship existed
- Logic = a duty can arise from foreseeability of harm absent a doctor patient relationship.
- Minn SC claimed this precedent for foreseeability preceeded Dinter.

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Zacharias, Rachel L., Feldman, Eric A., Joffe, Steven, Fernandez, Holly Lynch, "Curbside Consults in Clinical Medicine: Empirical and Liability Challenges", Journal of Law, Medicine & Ethics, 49 (2021) : 599-610 (University of Pennsylvania Carey Law School – RLZ- JD.M.B.E,EAF-J.D.PhD, SJ-Md,MPH University of Pennsylvania Perelman School of Medicine (PSM) and HFL-J.D.M.B.E PSM and Carey law School)

- Without Duty worry that a)clinicians unreasonably agreeing to provide IC because of lack of experience or formal obviously needed, b) providing unreasonable advice
- Treating physician held accountable for reasonably relying
- Dinter standard of foreseeability encourages physicians to be more prudent or forgo unreasonable consults.
- Imposing liability fair to patients = unblock, fair to treating physicians = apportion liability, fair to consultants = act reasonably and no liability.

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Zacharias, Rachel L., Feldman, Eric A., Joffe, Steven, Fernandez, Holly Lynch, "Curbside Consults in Clinical Medicine: Empirical and Liability Challenges", Journal of Law, Medicine & Ethics, 49 (2021) : 599-610 (University of Pennsylvania Carey Law School – RLZ- JD.M.B.E,EAF-J.D.PhD, SJ-Md,MPH University of Pennsylvania Perelman School of Medicine (PSM) and HFL-J.D.M.B.E PSM and Carey law School)

- Solution by legislature – allows all parties to contribute perspectives and more predictable for clinicians
- Solution by courts –patient already harmed, may cause clinician defensiveness resulting in refusal of IC and
- Reasonableness will depend on circumstances and information needed and precedent will help define the boundaries.
- Burden should be on Majority to show it is better option and If reasonableness diminishes quality of care the standard can be adjusted.

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M.M.Mello, M.D. Frakes and E Blumenkranz et al.,"Malpractice Liability and Health Care Quality", JAMA 323,no4(2020)352-366

- Systematic Review of studies examining the relationship between malpractice liability risk and health indicators of health care quality or outcomes.
- Although gaps in the data exist, greater tort liability was not associated with improved quality of care.
- Suggests that neither majority or Minority approach will change quality but doesn't address patient recourse.
- However treating physician is still liable so there is recourse for pts

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Dangers of Curbside Consults

- Incomplete or inaccurate Information
- Inappropriate advice followed
- Consultant name in record without their knowledge
- Advice harmful with out all the facts
- Makes treating and consulting physician vulnerable
- Patient can't recover from negligent party

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Curbside Consultation Risk Mitigation Strategies for Doctors (medicaljustice.com)

- Illinois Case = child fell with head trauma, pediatrician **discussed with neurosurgeon but consult not requested even though he volunteered**. Child died but neurosurgeon held blameless

- NY Cardiologist called by ER and said cardiac enzymes not significant and pt had MI= liable because Card **gave recommendation for pts care that would be followed**

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Curbside Consultation Risk Mitigation Strategies for Doctors (medicaljustice.com)

- If colleague names you on chart you are held accountable
- If you are supervisor or captain of the ship you are liable
- If on call assume you are at risk.
- If an answer requires reading a chart or studies formalize
- If approached more than once with questions about same pt consider formalizing
- Documenting preserves your record but may imply formalized

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Limiting Curbside Consult Liability

- General advice given to treating physician with no named patient discussed
- No exam, communication with, or review of patient records
- No medical record entry by Treating or consulting doc
- No obligation to patient such as on call, prior relationship, gatekeeper, etc
- Gratuitous
- No control of care by consultant

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Curbside Consult Caveats

- Avoid emails or texts
- Consider disclaimer of general educational advice provided and offer to see patient in consultation
- Ask that clinician name not be recorded since you are being to asked to help the clinician not the patient.
- KISS, the greater the complexity or need for information the greater the risk
- Avoid confirming or making Dx
- Limit consults to general educational opportunities

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Fla Tort Reform Bill HB 837 Revelations

- Letters of Protection (How is this ethical?) – agreement between pt and doc to be paid if she prevails. Circumvent lower insurance payments. Under HB 837 must disclose LOP, bills must be itemized, include codes and what insurance would have paid.
- Multipliers not allowed except when competent counsel can't be obtained. Can use Lodestar Fee

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