Curbside Consultations in Pediatric Infectious Diseases

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The Pediatric ID Consultant section provides brief reviews of topics relevant to the day-to-day practice of pediatric infectious diseases. The reviews are placed in context by a short vignette, followed by one or more questions which are addressed.

Pediatric infectious diseases physicians are often asked by medical colleagues to provide recommendations for management of a patient without the benefit of a formal consultation. This article relates a story exemplifying such a request and discusses the possible quality of care, medical liability, and financial implications of informal consultations.

Story
It is 3 p.m., and we’ve nearly finished afternoon rounds. The pediatric infectious diseases fellow’s pager sounds. She looks at the screen, then reads the message out loud.

“I was hoping to get a curbside consult on C. S. reg # 0000-0000 regarding outpatient antibiotics. We were thinking TMP-SMX/Vanco.”

“Hmm,” I say. “Wonder what ‘we’re’ treating? Wonder who ‘we’re’ treating?” Today is my first day on service. “Was pediatric infectious diseases consulted on this patient in the past week or two?”

“No,” says the fellow who has been on service for the past month.

We head up to the ward, home to the team that requested the curbside consult.

“Oh, hi,” says the pediatric resident. “We’d like a quick curbside. This patient has an abscess.”

“This is 7W,” I say, “so should I assume this patient has cancer?”

“Yeah, he has a spinal cord glioblastoma and an abscess on his head.”

“Wait a minute. This can’t be a simple clinical situation,” I say. “It would be irresponsible for me to tell you how to treat your patient when I know nothing about the patient. I’ll be happy to answer a generic question but I can’t tell you the best management for this particular patient without all the information.”

The resident looks at me as if I have 3 heads. “Okay. Our question is: Is it all right to send him home on Bactrim and vancomycin?”

“We’d be happy to do a consultation,” I say. “When we have all the pertinent information, then we can give you suggestions for managing your patient.”

“Well, he’s ready to go home. We really don’t have time.”

“It’s your choice: ask for a consult, which we’ll be happy to do today, or not.”

Denouement
We didn’t get the consult. Out of curiosity, I checked a few things. This patient had a spinal cord glioblastoma, had a cranial abscess, was neutropenic, had a positive wound culture for methicillin-susceptible Staphylococcus aureus and Enterobacter, had a positive blood culture for Enterobacter, and so on. That was enough. Clearly I had made the correct decision.

Message
Informal (ie, curbside) consults are often the bane of a consulting service’s existence. Yet, they may be
Regarding a professional courtesy to a medical colleague. They could also be considered a threat to the consultant’s revenue or terrible medical practice. Which is correct?

Free exchange of information and opinion between physicians for educational purposes and to assist in the care of patients is fundamental to our medical ethos and an integral component of our medical culture. In fact, it is implicit in the Hippocratic Oath, which states, in the modern version, “I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow” [1, 2]. This exchange may take several forms, including medical consultation. A number of studies have described many aspects of medical consultation in infectious diseases [3–11]; few focused specifically on pediatrics [5, 6], however, and some were conducted in Canada or Europe where medical systems differ from those in the United States [7–11]. Yet, these studies provide a valuable framework to consider the complicated issue of informal consultations.

Infectious diseases consultations have been demonstrated to have clinical value because they have a positive impact on infection control [3, 8, 12], on the appropriate use of antibiotics [9, 13], on shortening the median length of hospital stay [8], and on patient outcomes [8, 12, 14, 15]. These consultations come in 2 forms: formal, in which a complete patient evaluation is conducted and a written report of the evaluation and recommendations is generated, and informal, which may come from outside physicians (ie, via phone calls, e-mails, or online services established by healthcare systems to promote patient referrals) caring for patients in their practices or in another hospital or from colleagues caring for patients at the same institution as the doctor seeking the consultation. Consult questions have been categorized as those seeking a diagnosis, a management plan, a prognosis, or general direction [7, 16].

Informal consultations—often called curbside consultations although they are virtually never conducted near a curb nor are they true consultations—provide advice, suggestions, or opinions regarding management of a patient without the consultant conducting a history and physical examination, reviewing all pertinent laboratory work, or documenting the encounter in the medical record; they are extremely common. In a study from France [7], almost half the consults sought from the infectious diseases service were informal, whereas in a study from Vermont [17], approximately 1 in 8 (7% inpatient, 30% outpatient) consults were informal. In a study by Kuo et al [18], rates of informal consults in infectious diseases were above other specialties except for cardiology and endocrinology, and informal consults to the endocrine and infectious diseases services exceeded formal consults. In a Canadian teaching hospital [19], 14.6% of all inpatient consultations were informal, a rate second only to gastroenterology.

The clinical questions asked in informal consultations tend to be similar to those in formal consultations [11, 18], and the reasons for seeking an informal over a formal consultation include having direct contact with the consultant, saving time in obtaining information necessary to make a decision, saving money for the patient or third-party payer, and exercising the opportunity to remain up-to-date with current medical information [10]. Formal consultations often involve more complex patients than informal consultations [10, 17], yet a study from France documented no difference in the outcomes of formal versus informal consultations in terms of compliance with a recommendation for antibiotics and for diagnostic or monitoring testing, rates of early clinical improvement of the patients, in-hospital mortality, or median length of stay [10].

Potential drawbacks to informal consultations [10, 18] include risk of legal liability, lack of compensation for the infectious disease expertise of the consultant, and, most important, inaccuracy and incompleteness of the clinical information on which recommendations are based.

The legal risks of providing an informal consultation are often overstated [20] because the only situations for which a physician may be liable when giving a recommendation include an interaction that results in a formal, written consultation report; establishment of a true physician–patient relationship by reason of professional contact with a patient; provision of official coverage for a partner/professional colleague; service as an on-call, paid consultant to an emergency room; formal service as a supervisory physician to a trainee; or provision of services for which a bill is rendered. The appearance of a physician’s name in a patient’s medical record does not impose liability of that consulting physician for verbal recommendations made to the patient’s physician. This situation, however, does not remove the possibility that the consulting physician would be named in a malpractice suit in which, initially, every medical practitioner involved in any way with the patient’s care would be listed in an allegation.
Infectious diseases consultations have monetary value [17]. In a study from an academic practice, informal consultations, had they been billed, would have accounted for 17% of the practice’s work relative value units and, over a year, would have generated $34,115 for inpatient and $59,864 for outpatient consultations, based on a 2005 Centers for Medicare and Medicaid Services conversion factor. In a consortium of pediatric subspecialists offered $40 per phone consultation, 306 informal consultations led to avoidance of 98 specialty clinic visits, 35 hospital transfers, and 14 hospital admissions over 8 months [6]. Whether physicians should be compensated for informal consultations is a complicated issue involving possible liability and quality of the medical opinion [17].

Increasingly, infectious diseases physicians assist hospitals in managing antibiotic use [21]. These programs, as well as the roles of the infectious diseases physicians, differ greatly from hospital to hospital. Although approving use of a restricted antibiotic and recommending an antibiotic for management of a specific infection in a specific patient are different clinical activities, little literature explores this important area of infectious diseases physician practice.

In summary, a troubling informal consultation is one that requests a recommendation for management of a specific patient. Examples include:

- “We have a bone marrow transplant kid who has 3 bugs growing from his line and want to know what antibiotics to use.”
- “I have a 3-year-old patient with acute lymphoblastic leukemia on maintenance chemotherapy who developed a Broviac line infection last week with a Gram-negative rod. The inpatient service sent him home on intravenous Levo for 7 days after he received 3 days of pipericillin-tazobactam and gentamicin. The speciation came back as Acinetobacter species. I’m not so familiar with the bacterium so I wanted to check with you guys to see if this is appropriate coverage.”
- “Quick curbside: We have a 6-year-old patient with fever and neck pain. Do we need to tap the child and admit him?”

A good informal consultation would be one that requests a factual answer to a question not directly related to specific management of a specific patient, such as the following:

- “Do you always use vanco for empiric treatment of staph infections?”
- “Do you know of an association between strep and catatonia?”
- “I have a kid in my office who was adopted from China and has Entamoeba coli in his stool. Is this ever a pathogen?”

Rigid refusal to participate in informal consultations and, thus, to share medical information with a colleague may result in harm to a patient. Keeping informal consultations brief and vague may endanger collegial goodwill and, ultimately, patient care. The best response to a query about managing a specific patient may be, “I’ll be happy to formally evaluate the patient. That way, you and the patient will get the best recommendation for his care.”

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