

Claims



clinical & risk management perspectives

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The Risks Associated with “Curbside” Consults

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Introduction

A "curbside" consultation can be described as an event in which one physician informally asks another for information or advice to aid in the management of a particular patient. In general, the "curbside consultant" neither reviews the patient's medical record, nor examines the patient, but instead bases advice on information provided by the requesting physician – information that may be incomplete and/or inaccurate. When a requesting physician bases treatment decisions on faulty recommendations, medical liability exposure and patient safety risk increases. NORCAL Group claims data and nationwide appellate court opinions clearly indicate that curbside consultants are routinely drawn into medical liability lawsuits when their advice plays a role in patient injury.

Without a physician's realizing it, a curbside consultation can quickly turn into an actual consultation in the eyes of the law. While the "consultant" may assume he or she is engaging in an academic conversation over a cup of coffee, the conversation may get specific enough to create a patient-physician relationship between the consultant and the requesting physician's patient. Because a curbside consultant rarely documents the event, when he or she is named as a defendant in a lawsuit, the defense of the claim becomes complicated because of the lack of documentary evidence to support the consultant. The defense becomes further complicated when the requesting physician documents the consultant's recommendations and his or her documentation differs from the consultant's memories of the event (assuming the consultant even has a memory of the event.) Different versions of the curbside consultation can lead to confusing or conflicting testimony among defendants and even finger-pointing during litigation, which rarely plays out well for any of the defendants involved.

Using a NORCAL Group closed claim, this publication describes the inherent risks associated with curbside consultations. Practical strategies are provided for

recognizing when a curbside consultation can result in the establishment of a physician-patient relationship and for avoiding curbside consultations when circumstances call for formal consultation.

Allegation: The vascular surgeon failed to emergently treat the patient's splenic aneurysm, resulting in the patient's death.

The Event

On February 23, 2009, the patient, a 54-year-old male, presented to the Emergency Department (ED) complaining of upper left back and shoulder pain that moved downward around to the abdomen and groin. Upon examination, ED physician #1 found mild tenderness over the posterior thorax and over the anterior costal margins and under the diaphragm. He ordered a contrast CT to evaluate the pain. The patient requested admission for pain control and was admitted by his family physician (FP) for observation and rest overnight.

The patient had the contrast CT the next morning. The radiologist's impression was a 2.7 cm vascular structure in the left splenic hilum that probably represented a splenic artery aneurysm. The radiologist made a report and discussed his findings with the FP; he described the findings as incidental. The FP took this to mean that the patient's condition was not emergent. The FP later visited the patient in the hospital, told the patient that the splenic artery aneurysm was not an emergency and informed him that he would need further tests to determine whether they should watch and wait, or repair it. He prescribed Vicodin and Motrin for pain relief and asked the patient to return to his office within the next week for follow-up. The FP then discharged the patient.

On March 1, the patient returned to the ED complaining of pain to his mid-back radiating up to his left shoulder and down to the left upper quadrant. On a pain scale, he rated his pain as 8 out of 10. His pain was "throbbing, crushing, stabbing, cramping and sharp." He was examined by ED physician #2, who discussed the case

with the FP. They decided that because the patient had recently been worked up for the same problem and had improved after taking Motrin, he could be discharged and seen in the FP's office the next day. ED physician #2's impression was acute epigastric pain with back pain. He prescribed antacids.

On the morning of March 2, the patient was seen in the FP's office by the physician's assistant (PA). The patient complained of continued back pain, explaining that when he coughed and raised his arms over his head, he felt a sharp pain in his upper back, left shoulder and chest, followed by continued pain in those areas. The PA referred the patient to a cardiologist for evaluation. The February 24 contrast CT report was faxed to the cardiologist that day. Later that afternoon, the cardiologist told the FP that the patient needed to be referred to a vascular surgeon.

The FP then walked down the hall to the vascular surgeon's office. The FP showed the vascular surgeon the contrast CT report and asked if the suspected aneurysm was significant. He said that it was, but he wanted to get a better idea of what he was dealing with before he formed any opinions about how the patient should be treated. The vascular surgeon then called radiologist #2 to discuss the best way to further study the patient's condition. Following the discussion, the vascular surgeon told the FP that the patient should have an Endoscopic Ultrasound (EUS) evaluation. He wrote "EUS" on the report and handed it back to the FP. The FP then scheduled an appointment for an EUS with a gastroenterologist for the afternoon of March 5. The vascular surgeon called the FP on March 5 to find out the results of the EUS, but the patient had died that morning.

The coroner found a 4 x 3 x 3.5 cm splenic artery aneurysm at the hilum with a 1 cm area of rupture. There were 2.6 liters of blood and a blood clot found in the peritoneal cavity. The cause of death was determined to be a hemoperitoneum due to rupture of a splenic artery aneurysm.

The patient's wife filed a lawsuit against all of the providers who had cared for her husband, alleging that if they had met their duty to treat the aneurysm in a timely manner, the patient would not have died. Specifically, the plaintiff claimed that the vascular surgeon should have asked the patient to meet him in the ED to be admitted and should have ordered the EUS as soon as possible.

During the course of litigation the radiologists and ED physician #1 were dismissed. The FP settled for a significant amount. On the eve of trial, the vascular surgeon and ED physician #2 settled.

Discussion

Much of the litigation in this case was focused on whether the vascular surgeon's discussion with the FP established a physician-patient relationship between the vascular surgeon and the patient. The establishment of a physician-patient relationship is a primary hurdle that any plaintiff must clear in a medical liability lawsuit. In this case, the vascular surgeon believed he had engaged in a curbside consultation, and therefore no physician-patient relationship existed. The plaintiff, however, argued that the vascular surgeon did more than a curbside consultation due to the following facts:

- The vascular surgeon contacted the radiology department to determine which study was most appropriate, and the FP recommended the EUS.
- The vascular surgeon determined which part of the body the EUS would examine.
- The vascular surgeon made notes on the FP's copy of the ultrasound report.
- The FP relied on the vascular surgeon's choice of an imaging study
- The vascular surgeon called the FP to inquire about the results of the EUS.
- The FP kept the vascular surgeon informed of the patient's condition, in that he informed the vascular surgeon of the patient's death.

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In an effort to have the case against him dismissed during the early stages of the litigation, the vascular surgeon filed a motion for summary judgment. He countered the plaintiff's contention of a physician-patient relationship with the following facts:

- The vascular surgeon never met the patient.
- The vascular surgeon did not bill the patient's insurance company.
- The vascular surgeon did not make a medical record reference to the patient, other than the notation on the ultrasound, which was meant to help the FP remember which study the radiologist had recommended.
- The vascular surgeon was not offered the opportunity to examine the patient, nor did he request or perform a formal consultation.
- The vascular surgeon was not an on-call consultant at the hospital.

Unfortunately, even though the facts of this case were significantly similar to the facts in other cases where courts have found no physician-patient relationship, this court refused to dismiss the vascular surgeon from the lawsuit. The court felt that the plaintiffs had presented evidence that raised a reasonable inference that the vascular surgeon had taken affirmative steps in the treatment of the patient, steps that went beyond the scope of a curbside consultation and created a physician-patient relationship.

Risk Management Recommendations

To minimize liability risks and provide quality care while engaging in curbside consultations, consider the following risk management recommendations:^{3,4}

Strategies for Managing Curbside Consultant Risk

- **Keep the conversation general and brief.**

Clarify the nature of the consultation. Make it clear that you are not providing treatment recommen-

dations. Remember that the requesting physician may not be sharing all the facts necessary for you to provide an accurate opinion. Advise the requesting physician of the assumptions underlying your advice and when possible include medical literature evidence to support your opinions. If the discussion becomes complex; turns to a discussion of a particular patient; or requires that you make treatment decisions, diagnosis, admission or discharge recommendations; suggest a formal consultation. Additionally, a formal consultation should be recommended if the same physician asks you to do more than one curbside consultation on the same patient.

- **Avoid direct and indirect contact with the patient.**

Do not step into the role of a treating physician. For example, a physician-patient relationship can be formed by ordering tests, scheduling studies or writing prescriptions. The vascular surgeon in the foregoing case was targeted because he became involved in the patient's testing.

- **Consider the skill level of the person who is asking for the consult.**

If you do not have complete faith in the other physician's ability to treat the conditions being discussed, ask for a formal consultation. In the foregoing case, the FP informed the vascular surgeon that he had never treated a patient with a splenic artery aneurism.

- **Document when appropriate.**

An appropriate curbside consultation—providing *general* academic advice for the benefit of the physician seeking the consult—should not need to be documented. Ironically, the very act of documenting a curbside consult can indicate that the conversation was more than just informal. Realize when you have crossed the line and have established a physician-patient relationship. When this is the case, documentation can protect you against possible inaccuracies in other physicians'

memories of what occurred during the consultation. It is very likely that later you will not remember what you said during a "curbside-like" consultation, so if you are going to document, detail the advice that you gave to the extent necessary to accurately reflect your involvement with the patient's situation. Consider asking for a formal consultation.

Although it is unrealistic to assume you can control the actions of a requesting physician, if you engage in an appropriate curbside consultation, request that your name and opinions not be recorded in the patient's medical record. On the flipside, if you are a requesting physician, you should not document the transaction without the permission of the consultant. In the foregoing case, the FP had extensively documented his encounter with the vascular surgeon. Unfortunately, the documentation was not entirely consistent with the vascular surgeon's memories of the encounter. The inconsistencies further complicated both providers' ability to defend themselves against the plaintiff's claims.

- **Avoid curbside consultations by email**

Finally, avoid providing curbside consultations via email. By sending email you create a permanent record of your recommendations; and you have no control over the other physician's distribution of your email.

Strategies for Managing the Requesting Physician's Risk

- **Consider whether the situation is appropriate for a curbside consultation.**

Before requesting a curbside consultation, think carefully about whether it is appropriate in the situation. In a curbside consultation, the consultant

may be forced into providing a prompt solution to a problem that the requesting physician has been struggling with for many days. In a sense, it is unfair to put the consulting physician in this situation. It is generally recommended that a case that requires consideration of two or more problems, or a detailed discussion of the patient's history and physical examination be addressed in a formal consultation.

- **When depending on a curbside consultation, weigh the risk of taking wrong advice against the potential gain of taking good advice.**

If, for example, you take the wrong advice regarding a scalp rash, the patient may suffer the effects of the rash for a longer time. However, the consequences may be much more severe if you rely on the wrong advice about chest pain. Basing admission and discharge decisions on curbside consultations is similarly risky. As this case shows, splenic artery aneurysms can be deadly.

- **Recognize the limitations of a curbside consultation.**

Advice gained from a curbside consultation is imperfect. In reaching conclusions about patient care, a curbside consultation should be given no more weight than a medical text book, medical journal or a diagnostic test. In this case, the FP based his treatment plan on the vascular surgeon's recommendations without ever considering other sources of information.

- **Be precise.**

Avoid ambiguous terms or a biased presentation. Raise all relevant complicating details.

The Virtual "Curbside"

Curbside consultations have gone virtual. The number of social networking Web sites devoted to physicians, and the number of physicians participating in them continues to grow. Sites like Sermo (which reportedly adds new members (average age 49 years) at a rate of more than 1,000 every week), Ozmosis and IMedExchange give physicians an opportunity to engage in virtual curbside consultations with other providers across the globe.^{1,2}

Although a social networking site may seem far removed from the water cooler or doctor's lounge, the liability issues are fairly similar. As far as the establishment of a physician-patient relationship is concerned, until the courts clarify the status of social networking in this regard, it may not matter if the curbside consultation happens electronically or face-to-face. In fact, a virtual curbside consultation can raise even more liability issues than a traditional one. For example, if recommendations are being sent between distant states, privileging, credentialing and licensure issues can arise.

Additionally, unlike a traditional curbside consultation, the entire "conversation" is recorded electronically when it happens online. This information can be used as evidence of a physician-patient relationship; and overly casual responses to a colleague's request can be used to present a defendant physician in an unflattering light. In addition to all of this, patient confidentiality can be compromised. In a physician-limited social networking site like Sermo, physicians may wrongly assume that the information is confidential. Although the issue has not been challenged in court so far, HIPAA and state privacy laws most likely apply to information posted on physician social networking sites.^{1,2}

Risk Management Recommendations^{1,2}

If you are engaging in physician-only social networking sites (e.g., Sermo), posting information in open networks like Facebook or Twitter, or blogging, consider the following risk management strategies:

- Do not assume that what you or others post online is anonymous, cannot be accessed by attorneys or is in compliance with HIPAA or state privacy rules.

Generally, anything posted on the Internet can be traced back to the person who posted it. Even if the information you are sending seems to be protected from the outside world, it is not. As a result of the filing of a malpractice lawsuit, a plaintiff's attorney will most likely be able to gain access to a physician's posts on physician social networking sites like Sermo, or on any other electronic media source.

- View the advice gathered from a social networking site as a resource, not a consultation.

Even when a site is touted as "physician-only" you have to consider the credentials of the person with whom you are exchanging information. Take advantage of the Web site's tools to receive information only from trusted colleagues. Any time you make treatment decisions using information gained through social networking, the weight given to the information should be comparable to information you could have obtained from other sources, such as journal articles.

- Make sure that using social media is not a violation of employer/hospital policies.

Resources

¹ Glenn B. *Behind doctors' social networking Web sites*. Feb 20, 2009. Available on the Modern Medicine Web site at: www.modernmedicine.com/modernmedicine/article/articleDetail.jsp?articleId=1285703023753&location=http%3A%2F%2Fwww.modernmedicine.com%2Fmodernmedicine%2FModern%2BMedicine%2BNow%2FBehind%252Ddoctors%252Dsocial%252Dnetworking%252Dwebsites%2FArticleStandard%2FArticle%2Fdetail%2F581594&cid=581594 (accessed 10/5/2010).

² Davies B. *Social Media and Physicians*. March 2010. Available on the NEMJ Career center website: www.massmed.org/Content/NavigationMenu2/ContinuingEducationEvents/KeyCourses/SocialNetworking10forPhysicians/ManagingTheRisksOfFacebookTwitterAndOtherSocialMedia/ManagingTheRisks-0.htm (accessed 10/5/2010).