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CLINICAL & RISK MANAGEMENT PERSPECTIVES

AUGUST 2020

Curbside Consultation Strategies for Risk Reduction

Case One | Patient Safety Risks Associated with Curbside Consultations

Special Feature | The Virtual "Curbside"

Case Two | Starting in a Curbside Consultation, Ending in a Physician-Patient Relationship

Special Feature | Radiology Curbside Consultations

Case Three | Electronic and Telephone "Curbside" Consultation Agreements

Case Four | "Curbside Consultation" in the News

Curbside Consultation Strategies for Risk Reduction

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INTRODUCTION

A "curbside" consultation can be described as an event where one physician informally, without specifying the patient, asks another for information or advice to aid in the management of that patient. The "consultant," in turn, provides general educational advice for the benefit of the requesting physician, not the patient (although the patient may benefit indirectly).

> It is important for physicians to understand the elements and limitations of "classic" curbside consultations.

Liability risk is lower in a classic curbside consultation, because there is no physician-patient relationship, which is a requirement of an actionable medical malpractice claim (except under very limited circumstances; for example, see the recent Minnesota Supreme Court case summarized later in this article). NORCAL Group closed claims, policyholder calls to the Risk Management Department, and appellate opinions indicate that among physicians there is a gap in the understanding of what is (and is not) a curbside consultation. Better understanding can result in appropriate use of the consultant and appropriate consideration of the reliability of the advice given, which can decrease patient injuries and malpractice risk exposure.

Confusion sometimes arises because the "curbside" label is attached to consultations where an underlying physician-patient relationship already exists (including those created by law, agreement, or assumption) between the consultant and patient. For example, encounters between the following physicians are NOT curbside consultations but rather true consultations because of the pre-existing physician-patient relationship:

- An on-call panel specialist contacted by an emergency department (ED) physician
- A covering physician contacted by a physician with questions about the covered physician's patient
- A supervising physician contacted by the individual being supervised

In general, these would-be curbside consultants already owe a duty of care to the patient. Using the term "curbside" to describe these consultations can suggest that all of the attendant obligations and accompanying liability risks of a physician-patient relationship need not be realized and attended to, when the opposite is true.

Where there is no underlying physician-patient relationship, a curbside consultation is generally defined by lack of involvement between the consulting physician and patient. The less involved, less formal, more theoretical, and more "academic" the questions and responses, the less likely a physician-patient relationship will be found, and the interaction deemed to be a curbside consultation. Consequently, a classic curbside consultant generally does not review the patient's medical record, examine the patient, order laboratory tests, write prescriptions, adjust medications, bill for the consult, or provide a report. Patient information is communicated by the requesting physician verbally, without noting the name of the patient or any other identifier. As the detail of the patient information exchanged increases, so does the risk of establishing a physician-patient relationship. It is important for curbside consultant physicians to request conversion to formal consultations when physician-patient relationships are imminent or arguable, both for ensuring patient safety and managing liability risk.

The key to managing liability risk is preventing patient injuries. Curbside consultations, though beneficial as they allow exchange of up-to-date educational information and management using nuanced experiences, are associated with an increased risk of error.[1] The injury risk intensifies when the clinical picture presented to the consultant is incomplete or inaccurate, which can be common in curbside consultations because of the casual nature of the information exchange.[2] If the requesting physician bases treatment decisions on ill-informed

recommendations, patient injury risk increases.[3] NORCAL Group claims data and appellate court opinions clearly indicate that curbside consultants are routinely drawn into medical liability lawsuits when their advice plays a role in patient injury.

Lack of, or conflicting documentation and memories of, an encounter that results in litigation will most likely complicate the defense of a curbside consultant. Curbside consultants frequently do not document their discussion and advice. The requesting physician's documentation may be inaccurate, incomplete, or biased due to misunderstanding/mishearing the curbside consultant. Different versions of the curbside consultation can result in finger-pointing, which can complicate the defense of claims against either or both defendant physicians. When a curbside consultant has neither memories nor documentation of an encounter, and the requesting physician has them, juries have a tendency to give more weight to the party who provides more and/or better-quality evidence.

Telephone and electronic consultations can further complicate a curbside consultation analysis. The lack of an in-person examination, abbreviated communication, and/or limited medical record evaluation and documentation can convince consultants that no physician-patient relationship has been formed. However, telephone, email, text message, and online chat communications can easily form the basis of a physician-patient relationship. Furthermore, when communication is electronic, there is a record and usually metadata that can support patient allegations. Electronic records of physician exchanges can also damage the credibility of a defendant physician who fails to accurately testify about long-past electronic exchanges or electronic medical record review due to faded memories.[4]

Using NORCAL Group closed claims, a recent appellate court opinion, and risk management department inquiries from policyholders, this publication defines curbside consultation and describes the inherent risks associated with the practice. Practical strategies are provided for recognizing when a curbside consultation establishes a physician-patient relationship and for pursuing formal consultations when warranted.

Please note, recommendations for physicians will also be appropriate for advanced practice professionals.

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Patient Safety Risks Associated with Curbside Consultations

The following case highlights the patient safety risks associated with medical decision-making based on curbside consultations.

CASE ONE

Allegation: Delayed diagnosis and treatment of spinal cord impingement resulted in quadriplegia.

A patient was admitted by an internist from the ED. The patient had injured his back two weeks earlier, and was now reporting weakness in his arms and legs. He was extremely anxious. During hand-off, the ED physician told the internist that he did not know what was causing the patient's physical symptoms, but he suspected the weakness was psychosomatic. Shortly after she examined the patient, the internist encountered a neurologist who was rounding on patients. The internist requested a curbside consultation to help her generate a differential diagnosis.

The internist told the neurologist that the patient failed to follow commands for most movements during the internist's neurological exam and claimed he was unable to move his extremities. However, he was able to protect his face when his hand was dropped over it; he had deep tendon reflexes in all extremities; and he withdrew from painful stimuli. The internist also shared the ED physician's impression that the patient's inability to move his extremities was due to his extreme anxiety.

According to the neurologist, the internist presented the case in a way that indicated she thought the patient's symptomology was associated with a psychological problem that was unrelated to any triggering injury event, and, in fact, described examination findings that indicated the patient's neurologic function was intact. Based on the internist's description, the neurologist formed the impression that the patient's reported sensory deficits were not due to a pathologic cause. He concluded an MRI of the cervical spine was not necessary.

Thereafter, the internist focused on managing the patient's anxiety and looking for other non-neurologic reasons for the patient's paralysis. An MRI was ordered two days after the patient's admission. It showed spinal cord impingement. Surgery was unsuccessful. The patient filed a lawsuit against the hospital and everyone who treated him there. He specifically alleged that the neurologist's failure to diagnose his spinal cord impingement was negligent.

It is worth noting, the neurologist did not make an entry in the patient's medical record. During the internist's deposition, she was asked (under oath) whether she had discussed this case with anyone else. In response, she testified about her curbside consultation with the neurologist. The neurologist was then added as a defendant in the case.

DISCUSSION

According to experts, both the internist and the neurologist had sufficient information to order an MRI within the window of time that could have resulted in diagnosis and treatment of the patient's spinal cord compression. Physician-patient relationship analysis aside, the neurologist's incorrect conclusions (based on incomplete information) about a non-pathologic cause of the patient's paralysis contributed to the delayed treatment. The risk of patient injury would have been lower if the neurologist had obtained better information. Whether the neurologist could have obtained sufficient information during a curbside consultation is unknown. The safer option would have been a formal consultation.

The risk management recommendations for this case follow case two.

Starting in a Curbside Consultation, Ending in a Physician-Patient Relationship

When a curbside consultation leads to a lawsuit, it can be difficult to predict how a judge will decide the issue of whether a physician-patient relationship exists. In the following case, the defense team attempted to get the curbside consultant dismissed from the case. Unfortunately, even though the facts of the case were significantly similar to the facts in other cases where no physician-patient relationship was found, the court refused to dismiss the consultant from the lawsuit. The court found that the plaintiffs had presented evidence that raised a reasonable inference that the consultant had taken affirmative steps in the treatment of the patient that went beyond the scope of a curbside consultation and created a physician-patient relationship.

CASE TWO

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

A patient presented to the ED complaining of upper left back and shoulder pain that moved downward around to his abdomen and groin. The ED physician ordered a contrast CT and admitted the patient for observation. Radiologist 1 found a vascular structure in the patient's left splenic hilum that he believed represented a splenic artery aneurysm. He told the patient's family practice physician (FP) that the aneurysm finding was incidental. The FP took this to mean that the patient's condition was not emergent. The FP discharged the patient with plans for further testing to determine how the aneurysm should be managed.

A week later, the patient was complaining of the same pain at his follow-up appointment. The FP referred him to a cardiologist, to whom he faxed the hospital CT report. In response, the cardiologist informed the FP that the patient needed to be referred to a vascular surgeon. The FP then walked down the hall to a vascular surgeon's office. The FP showed the vascular surgeon the CT report and asked his opinion about how it should be managed. The vascular surgeon called Radiologist 2, who told him that an endoscopic ultrasound (EUS) evaluation would be the best type of study to evaluate the patient's condition. The vascular surgeon relayed this information to the FP, and wrote "EUS" on the CT report before he handed it back. The FP then scheduled an appointment for an EUS a week later. The vascular surgeon called the radiology department to find out the results of the EUS, but was told the patient had missed his appointment. He then called the FP and discovered the patient had died before the study could be performed. The coroner listed the cause of death as 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. She alleged their failure to treat the aneurysm in a timely manner caused her husband's death. In addition to claims against the other defendants, the wife 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 emergently.

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 vascular surgeon believed he had engaged in a curbside consultation with the FP and, therefore, no physician-patient relationship existed. The plaintiff, however, argued that the vascular surgeon was more than a curbside consultant due to the following facts:

- The vascular surgeon reviewed the CT report.
- The vascular surgeon contacted the radiology department to determine which study should be scheduled for the patient.
- The vascular surgeon made notes on the FP's copy of the report.
- The FP relied on the vascular surgeon's choice of an imaging study.
- The vascular surgeon followed up with the radiology department, and then the FP.

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 an entry in the patient's medical record, other than noting EUS on the report, 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.

Various issues further complicated the vascular surgeon's defense, for example the FP had extensively documented the encounter, while the vascular surgeon had not recorded anything. The FP's documentation indicated the vascular surgeon had assumed more responsibility for the patient than the vascular surgeon recalled.

RISK MANAGEMENT **RECOMMENDATIONS**

Keeping curbside consultations from causing or contributing to patient injury is a team endeavor. It is important for everyone involved to engage in curbside consultation appropriately, and to transition to formal consultation when the circumstances demand it. Consider the following recommendations:[3,5,6]

Consultant (Curbside)

- Advise the requesting physician that you are not providing treatment advice, and your answer is hypothetical, for example, "This is an informal consultation. I'm providing it for general informational purposes only. Please do not rely on it for any patient-specific diagnosis or medical treatment."
- Remember that the requesting physician may not be sharing all the facts necessary for you to provide an accurate opinion.
  - Tell the requesting physician about the assumptions underlying your advice.
- Have a low threshold for requesting a formal consultation. Suggest a formal consultation if any of the following occur:
  - The discussion becomes complex, e.g., involves more than one issue, or requires image or medical record review
  - A particular patient is identified
  - You believe your response will be relied upon to make treatment decisions, diagnosis, admission, or discharge recommendations
  - The same physician asks you for more than one curbside consultation on the same patient
  - You do not trust the requesting physician's ability to manage the condition being discussed
- Avoid direct and indirect contact with the patient.
  - Tell the requester not to divulge patient identifying information.
  - Do not order tests, schedule studies, or write prescriptions.
  - Do not log into or otherwise review the patient's medical record. (Your review will become part of the electronic health record (EHR) metadata, which can be used to support an argument that a physician-patient relationship was established.)
  - Ask the requesting physician not to add your name to the patient's record. (Be aware that not being identified in the patient's record is not a guarantee that you will not be named in a lawsuit. Curbside consultants may be otherwise identified during litigation.)
- Give general direction instead of advice. For example, say, "You might consider xyz," instead of, "You should do xyz."
- Develop a consistent practice for curbside consultations. If you are ever named in a lawsuit and there is no documentation, you can confidently testify that you handled the curbside consultation at issue in a manner consistent with your custom and practice.
- Document when appropriate (i.e., when a physician-patient relationship is possible, or when the requesting physician indicates he or she will record your opinions), even if that means dictating brief notes into a "generic consult file."

Requesting Physician

- Do not provide information that identifies the patient.
- Limit curbside consultation requests to single issues, about low acuity conditions, that provide general education about the standard of care.
- Do not present an issue that requires a detailed patient history and exam description.
- Do not request a curbside consultation for a patient who is at high risk of death or significant injury if the curbside consultant is wrong.
- Be precise and unbiased when presenting a case.
- Raise all relevant complicating details.
- Learn as much as possible about the patient before presenting the case to a curbside consultant.
- Request the consultant's permission before identifying him or her in the patient's record.
- Give curbside consultation information no more weight than what you would give to medical textbook, medical journal, or diagnostic test information.

Operational

- Develop formal policies regarding curbside consultation requests.
  - Define formal and curbside consultation.
  - Explain how a physician-patient relationship could develop during a curbside consultation and provide directions for transitioning to a formal consultation.
- Develop a system for a curbside consultant to record the date and time of the discussion, the name of the person requesting the consultation and a confirmation that a notice was given regarding the informal nature of the encounter.
- Educate physicians about the risks associated with requesting, providing, and documenting informal consultations.

Curbside Consultation Documentation

There is no easy answer to whether a curbside consultation should be documented. A classic curbside consultation should not require documentation. Ironically, the very act of documenting a curbside consultation can support an allegation that a physician-patient relationship was established. Feeling prompted to document a curbside consultation can indicate potential development of a physician-patient relationship (in which case, formal consultation should occur, and the encounter should be documented). Additionally, if a curbside consultation is not documented, the consultant can be at a disadvantage in future litigation. Consultant documentation can reduce the risk that a requesting physician's documentation inaccuracies will drive the narrative if the matter results in litigation. Furthermore, forgetting informal curbside consultation details is common. Documenting the details of the advice given to the extent necessary to accurately reflect your involvement can be advisable.

Curbside consultations via email, text messaging, or any other electronic content interchange create a permanent record that can later be used in litigation. When engaging in electronic curbside consultations, it is appropriate to remind the requesting physician that you have provided no more than a curbside consultation by adding a notice to the communication, such as: "We have engaged in an informal consultation, which has been provided for general informational purposes only and is not to be relied upon for any patient-specific diagnosis or medical treatment." Although this type of statement may not be an effective liability risk mitigation strategy (the notice is not likely to prevent a physician-patient relationship from occurring), it can improve patient safety.

Electronic and Telephone "Curbside" Consultation Agreements

Specialty group policyholders have called the NORCAL Group Risk Management Department to ask about liability risks associated with providing informal electronic or telephone consultations to primary care physicians (PCP). These arrangements are usually referred to as curbside consultations by the callers; however, the reality is these encounters fall somewhere between a curbside consultation and a formal consultation. Physicians who call the Risk Management Department about these arrangements sometimes wonder whether their liability risks are lower because there is no examination of the patient, and their role is limited, for example, to approving/disapproving PCP-proposed treatment plans.

CASE THREE

Problem: Informal electronic and telephone consultations potentially create physician-patient relationships between specialists and patients.

Two different specialty groups entered into agreements with healthcare systems to provide informal and formal consultations when requested by system PCPs. In the e-consultation scenario, a PCP would send a consultation request to a specialist through the EHR. The specialist would then review the patient's EHR and give the PCP feedback via a brief note in the patient's record, such as: "I agree with your treatment plan." "I think you should do *XYZ*." "I should see the patient as a formal consultation." In the telephone consultation scenario, the consultations, which were also patient-specific, were documented in the EHR by the requesting physician. The notes were brief, for example: "Spoke with Dr. *specialist*, who recommended *XYZ*" or "Spoke with Dr. *specialist* who agrees with my treatment plan." The telephone consultants were often unaware of the documentation and did not record the encounter.

DISCUSSION

Electronic and telephone consultation models can improve quality of care for the patients of PCPs who do not otherwise have the ability to informally consult with specialists.[7] For example, they can reduce wait times for specialist advice, provide advice to patients who are too frail to travel or cannot leave work, and improve access to specialists in areas with specialist shortages.[8] In the specialty groups scenarios described, adding a "curbside" label to the consultations could mislead consultants, giving them a false sense of security about liability risk based on an incorrect assumption that no physician-patient relationship exists. In fact, these consultations likely form physician-patient relationships because the consultations are patient-specific, involve treatment recommendations and diagnosis, and result in medical record documentation (by either party). Patient injury risk can increase when medical decision-making occurs without complete patient evaluation and discussion, which increases liability risks.

RISK MANAGEMENT **RECOMMENDATIONS**

In patient-specific situations, where a requesting physician is seeking treatment recommendations or diagnoses, special consideration should be given to whether scheduling a formal consultation is preferable to electronic or telephone consultation. The standard of care does not change when consultations do not include an in-person examination of the patient. Electronic and telephone consultants should be prepared to meet standard of care requirements, including obtaining sufficient patient information, creating appropriate consultation notes, and following up. The risk management recommendations following Case Two are also applicable to electronic and telephone curbside consultations. Consider these additional recommendations:[9]

- Ensure telephone and electronic consultations are as beneficial to patients as traditional consultations (face-to-face).
- When entering into telephone or electronic consultation agreements, retain the right to withhold evaluation and demand traditional consultations and/or teleconsultations with patients, or recommend an urgent office or emergency department visit.
- Put a good process in place for managing requests for telephone or electronic consultations that includes:
    - Patient selection criteria
    - Documentation requirements
    - Patient urgent care or ED referral criteria
    - Guidelines for obtaining pertinent patient information for review prior to the consultation (e.g., medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc.)
    - Guidelines for communication and follow-up with the patient
    - Guidelines for hand-off between the referring physician and consultant when appropriate
    - Guidelines for coordination of care
- When an electronic encounter is a true curbside consultation, add a statement that makes it clear that you are not giving advice regarding any particular patient, but rather responding informally to a general inquiry, for example, "This is an informal consultation. I'm providing it for general informational purposes only. Please do not rely on it for any patient-specific diagnosis or medical treatment."

The Virtual "Curbside"

Physician-only social networking sites like Sermo, Doximity, Ozmosis, QuantiaMD and Doc2Doc give physicians an opportunity to engage in virtual curbside consultation. Providing responses to scenarios and questions posted on these sites may seem far removed from a traditional curbside consultation; however, the platform does not necessarily change the analysis of whether a physician-patient relationship has been created or whether malpractice has occurred. Depending on the circumstances, liability risks can be more complicated for virtual consultants. For example, if the virtual consultant is in a different state (or country) than the patient, licensing issues can arise. If patient health information (PHI) is shared, it may be a HIPAA or state privacy law violation. Unlike a traditional curbside consultation, posts on a social networking site are retained electronically and, generally, anything posted on the internet can be traced back to the person who posted it. Although social networking sites often promise some level of confidentiality to physician members, the promises do not shield against privacy violations or discoverability in malpractice liability cases.[10]

RISK MANAGEMENT **RECOMMENDATIONS**

Information quality, patient safety, patient privacy, ethics, and standard of care are all issues to consider before providing and accepting advice on a social networking site. The risk management recommendations following Case Two are also applicable to curbside consultations on physician social networks. Consider the following additional recommendations:[11,12]

- Do not assume online posts are anonymous, cannot be accessed by attorneys, or comply with HIPAA or state privacy rules.
- Consider the credentials of the person with whom you are exchanging information.
  - Take advantage of the site's tools to limit receipt of information only from trusted colleagues.
- Do not treat social network exchanges like curbside consultations with trusted colleagues. Responses from unknown users should be given no more weight in decision-making than a non-peer-reviewed journal article.
- Ensure that using social media is not a violation of employer/hospital policies.

Radiology Curbside Consultations

Radiologists are frequently asked to take a "quick look" at an image, provide an opinion about which imaging to order for a patient, or overread a study acquired at an outside hospital. However, aspects of a radiology curbside consultation can increase the risk of misdiagnosis, for example:[13,14]

- Targeted questions may disrupt routine search patterns, increasing the risk of diagnostic error.
- The study may not be appropriate for the question asked (e.g., a CT with contrast is required, instead of the CT angiogram that was performed).
- Findings peripheral to the curbside question may not be reported.
- Interpretation may be rushed.
- Interpretation may be done in an environment in which viewing conditions are suboptimal.
- The mere reason that curbside consultations and overreads are requested is that the patients have complex conditions.

Patient safety and liability risk can increase when discrepancies occur between initial and secondary reviews. Initial radiologists may have had access to better history, additional images, and prior studies for comparison; and secondary reviewers may be accustomed to different protocols and machines, and often do not have access to radiology reports. For whatever reason, the requesting physicians may rely on the overreading radiologist's impressions. This scenario can be problematic in malpractice litigation because the radiologist who provided the initial correct interpretation becomes an inadvertent expert for the plaintiff, which can facilitate litigation.

According to The American College of Radiology (ACR) Practice Parameter for Communication of Diagnostic Imaging Findings:[15]

> An interpreting physician may be asked to provide an interpretation that does not result in a "formal" report but is used to make treatment decisions. Such communications may take the form of a "curbside consult," a "wet reading," or an "informal opinion" that may occur during clinical conferences, interpretations while involved in other activities, or review of an outside study. These circumstances may preclude immediate documentation and may occur in suboptimal viewing conditions without comparison studies and their accompanying reports or adequate patient history. Informal communications carry inherent risk, and frequently the ordering physician's/health care provider's documentation of the informal consultation may be the only written record of the communication. Interpreting physicians who provide consultations of this nature in the spirit of improving patient care are encouraged to document those interpretations.

Radiologists are encouraged to use the ACR Practice Parameter when asked to provide an informal opinion or overread of outside images.

RISK MANAGEMENT **RECOMMENDATIONS**

Before agreeing to an informal consultation, analyze the situation for patient safety and liability risk. Even when professional courtesy demands a curbside consultation, it is best to consider whether a curbside consultation (versus formal consultation) is in the patient's best interest, and prioritize patient well-being. Labeling something a "curbside" or "wet read" does not affect the radiologist's duty toward the patient at issue. If discussion or interpretation impacts treatment decisions, diagnosis, or admission or discharge recommendations, it is safer to assume a physician-patient relationship has been formed and request follow-up with a consultation following normal procedures. Due to the likelihood of a physician-patient relationship, a system for documenting to the extent necessary to accurately reflect your involvement with the patient is an important risk management strategy.

The risk management recommendations following Case Two are also applicable to radiology curbside consultations. Additionally, consider the following risk management recommendations when an informal images review is requested:[13,14]

Clinical

- Review images in a formal medium.
- Tell the requesting physician that your interpretations are subject to change if additional imaging or information becomes available.
- Treat overreads as "formal consults." Transfer the images to your PACs system, register the patient, and dictate a report of the exam, even if it is only to say, "Agree with interpretation done by Dr. *radiologist* at *XYZ facility* on *date*, *time*."
- Document impressions, findings, etc., unless extenuating circumstances make doing so unreasonable.
- Note any issue that limits your ability to interpret a study presented to you (e.g., images were not obtained according to your protocols, images are poor quality or incomplete, outside reports are unavailable, contact with the ordering physician did not occur, etc.).
- If a full report is not warranted, dictate an addendum to the original report.

Operational

- Develop formal policies for doing overreads of outside studies.
  - Require access to prior reports.
  - Require images be uploaded onto your PACS so they can be optimally manipulated by the radiologists doing the overreads. Do not accept outside disks or software.
  - Establish an overread documentation process.

“Curbside Consultation” in the News

The following case summary is based on a 2019 Minnesota Supreme Court opinion. In this case, the defendant hospitalist claimed he was not liable for the patient’s injuries because his conversation with the patient’s treating nurse practitioner (NP) was a curbside consultation.[16] The court rejected this claim. The case illustrates how a court can dissect a curbside consultation defense and unexpectedly find duty of care exists for the consultant.

CASE FOUR[16]

An NP believed her patient needed to be hospitalized due to leukocytosis caused by an infection. She called a local hospital to seek the patient’s admission. Her call was randomly assigned to one of the three hospitalists in charge of making admission decisions. It was her expectation that the hospitalist would either agree to admit the patient, or suggest a different plan after hearing her summary of the patient’s symptoms. The hospitalist refused to admit the patient. He believed the leukocytosis was caused by the patient’s diabetes. The NP, who disagreed with the hospitalist, then called her collaborating physician for direction. The collaborating physician disagreed with the NP and concurred with the hospitalist. The NP advised the patient that the other physicians believed his symptoms were caused by diabetes, not infection. She prescribed diabetes medication and scheduled a follow-up appointment. The patient died three days later of sepsis caused by an untreated staph infection.

The patient’s son sued the NP, collaborating physician, hospitalist, and hospital for wrongful death based on their failure to diagnose and treat the patient’s sepsis. The NP and collaborating physician settled. The hospitalist and hospital filed a summary judgment motion, arguing the hospitalist had no duty of care towards the patient because the NP and hospitalist had engaged in a curbside consultation and, therefore, there was no physician-patient relationship. The case was ultimately accepted by the Minnesota Supreme Court, which primarily focused on whether the hospitalist had a duty of care to the patient because of foreseeable harm due to his negligent admission decision.

The court recognized that most medical malpractice cases involve an express physician-patient relationship, but pointed out that a physician-patient relationship is not a necessary element of medical malpractice claims in Minnesota. In Minnesota (and a minority of other states), a duty arises between a physician and an identified third party when the physician provides medical advice and it is foreseeable that the third party will rely on that advice. In this case, the court determined it was foreseeable that the hospitalist’s decision whether to admit the patient, if made negligently, would be relied on by the patient, through the NP, and could cause the patient harm. Due to the foreseeability of harm, the court determined the hospitalist could owe a duty of care to the patient, even if there was no physician-patient relationship.

The court determined that the NP and hospitalist’s interaction could not be characterized as a curbside consultation due to the following reasons:

- The NP was randomly assigned to the hospitalist, they were not acquainted, and she was not calling a colleague to get informal advice about a patient.
- The NP had already settled on a diagnosis; she was seeking admission, not advice.
- The NP was following hospital admissions protocols by contacting a hospitalist.
- The hospitalist did not give the NP advice; he denied admission.

CONCLUSION

Curbside consultations are a recognized component of medical practice; however, they raise liability concerns for both the consulting and requesting physicians and safety risks for patients. Courts vary in how they determine whether a physician-patient relationship has been initiated during a presumed curbside consultation. Even if no physician-patient relationship is found, the process of extricating a curbside consultant from a lawsuit can be complicated and lengthy due to faded memories and a lack of documentation in the medical records. A dismissed defendant still endures the inconvenience, expense, and emotional strain of being involved in litigation.

It is wise to approach curbside consultation requests with caution and have a low threshold for requesting a formal consultation and/or documenting a curbside encounter. Ultimately, patient safety should be the main concern of physicians engaging in curbside consultations. Limited information and rushed encounters can increase the risk of medical error, which, in turn, increases liability risk. Implementing the risk management recommendations in this publication should decrease the liability exposure associated with these common, casual conversations among colleagues.

ENDNOTES

The NORCAL documents referenced in this article, along with many other Risk Management Resource documents and past editions of the *Claims Rx*, are available in the Risk Solutions area of MyACCOUNT, or by policyholder request at 855.882.3412.

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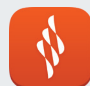

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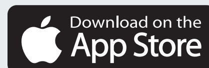

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