

Curbside Consults: Liability Perspective

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The informal consultation, or “curbside” consult, is a long-standing medical practice. Extending beyond the traditional “curb” – a hospital hallway or physician lounge – such consults are increasingly being conducted via cell phone and e-mail. Quick, paperless, and cost-free information exchange benefits both physician and patient alike. While the advantages of curbside consults are many, the inherent liability should be considered and a modicum of risk management savvy initiated.

A curbside consult may be defined as the solicitation of medical advice regarding a specific patient’s medical condition, care or treatment without the consultant actually seeing the patient. Most curbside consults entail recommendations from a subspecialist. However, medical advice sought by a person other than a physician during a social function or in the hardware aisle at Home Depot also constitutes a curbside consult.

Primary care physicians frequently rely on curbside consults. In a study published in the *Journal of the American Medical Association*, 70 percent of primary care

physicians and 68 percent of subspecialists participated in at least one informal consult in a week, usually a brief hallway chat or telephone conversation.⁽¹⁾ Consults most often entailed which diagnostic testing should be obtained or treatment initiated for a patient. The subspecialists most often consulted were cardiologists, gastroenterologists and infectious disease specialists.⁽²⁾⁽³⁾

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Physician-Patient Relationship

Advice or discussions that are not patient-specific are generally not considered a curbside consult. Most courts have ruled consistently that a curbside consult does not create a physician-patient relationship – the primary factor determining liability exposure.⁽²⁾ Absent a physician-patient relationship there is no “duty” on the part of the consultant and thus no basis in tort for legal action against the consultant.

However, the courts have applied certain criteria that define the legal parameters of a physician-patient relationship in the context of an informal or curbside consult, such as:

- the extent of the conversations;
- whether or not the consultant had a prior physician-patient relationship or participated in the subject’s health care;
- whether the consultant did a physical examination;
- whether the consultant had access to the medical chart;
- the relative experience of the physician seeking the consult;

- whether the consultant was paid;
- the relationship between the physician and consultant;
- whether the patient was aware of, or requested the consult; and
- the extent to which the clinical situation was in any way emergent.

Things get a little blurry when a curbside consult is sought by someone other than another physician. Such solicitations for medical advice typically take place outside of a clinical setting. These are risky types of information exchanges and are best avoided. Courts are more likely to find that a professional service was rendered for which the physician will be held liable even if the person seeking the advice is not an established patient.

Ultimate Responsibility

What remains crystal clear is the fact that a physician who seeks informal consultation remains legally responsible for the care and treatment provided to the patient. This includes following the advice sought as well as rejecting any advice offered.

Consider the case of a pediatrician who discussed her patient’s case with an infectious disease specialist in the hospital’s medical staff lounge. The pediatrician recorded the advice given by the specialist and the specialist’s name in the medical chart. Because no formal consultation had been sought, the specialist was unaware of all of the medical facts. A lawsuit subsequently brought against the pediatrician also named the specialist whose medical advice, retrospectively, would have been entirely different had all the medical facts been known at the time of his discussion with the pediatrician.

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News Alerts

New law affecting dermatologic or skin care services, including aesthetic skin care services other than plastic surgery

First Professionals Insurance Company publishes Preventive Action on a quarterly basis as a service to its policyholders. Information in this publication does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained in this newsletter are generalized and may not apply to all practice situations. First Professionals Insurance Company recommends you obtain legal advice from a qualified attorney for a specific application to your practice. The information should be used as a reference guide only.

For comments, questions, or to obtain additional copies contact the First Professionals Insurance Company Risk Management Department at 800-741-3742, ext. 3100, or rm@fpic.com.

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Effective July 1, 2006, Florida law limits the number of satellite offices, in addition to the primary practice location, where a physician can supervise Advanced Registered Nurse Practitioners (ARNP) and Physician Assistants (PA). The limits are based on the type of care provided and as follows:

- Four satellite offices for primary care;
- Two satellite offices for specialty care; and
- One satellite office that offers primarily dermatologic care including aesthetic skin care services other than plastic surgery. (The physician may supervise up to two such offices other than the physician's primary place of practice until July 1, 2011, if the addresses of the satellite offices were submitted to the board before July 1, 2006.)

A supervising physician for a PA or ARNP, who delivers primarily dermatologic care, which includes aesthetic skin care services other than plastic surgery, at more than one satellite office, which is not under your on-site supervision, must provide notice to the Board of Medicine or Osteopathic Medicine of the addresses of the satellite offices if you wish to continue to offer such services at a second satellite office until July 1, 2011.

For a complete copy of the new law visit: www.fmaonline.org or www.leg.state.fl.us.

ACOG research finds 40 percent of pregnancy-related deaths potentially preventable

According to a review of pregnancy-related deaths published in the December issue of *Obstetrics & Gynecology*, 40 percent of all pregnancy-related deaths in North Carolina from 1995-1999 were potentially preventable. The North Carolina Pregnancy-Related Mortality Review Committee examined 108 cases in which death occurred within one year of the end of the pregnancy and was caused by the pregnancy or its treatment. The study found that 41 of these deaths may have been averted by one or more changes in the health care or counseling provided or by changes in patient actions. Results suggest that lack of preconception care, patient actions, failures in the health care system, and a substandard quality of care were the four main contributors in the preventable deaths.

In cases involving lack of preconception care, there was no evidence that women with serious medical conditions were counseled about the risks of pregnancy before becoming pregnant. Patient actions contributed to mortality when women did not follow medical advice, failed to follow up with care or recommended therapies, or failed to seek care in a timely fashion. In some instances, failures in the health care system led to inadequate planning for patient follow-up or transfer. Quality of care contributed to mortality when the care provided was below expectations for the level of facility in question.

Preventable causes included hemorrhage, pregnancy-induced hypertension, and complications of chronic disease (e.g., cardiovascular disease). Deaths from conditions such as amniotic fluid embolism were not considered preventable. Researchers suggest more comprehensive study of maternal mortality cases and an open dialogue among clinicians to develop strategies that will continue to make pregnancy even safer for U.S. women.

ACOG News Release. ACOG Office of Communications



The inherent risk factors of curbside consults include: reliance on incomplete, inadequate or inaccurate information; the logistical disadvantages when the consult is sought external to a clinical environment; being named as a consultant in the medical record or in deposition testimony such that a physician-patient relationship is inferred; the obvious legal implications of giving off-the-cuff medical advice; and exposure to inappropriate care and treatment rendered by others for which you are held accountable.

Minimize the exposure

Although few medical malpractice claims are attributed to curbside consults, clever legal theories abound. While it may be flattering to be consulted, consider the potential liability exposure and follow these tips:

- Decline curbside consults involving complex medical situations, controversial care and treatment, or when examination of the patient is warranted.
- Keep the informal consult simple – discussion should be brief and recommendations specific to the information exchanged.
- Offer to see the patient in a formal consultation if the case is complex.
- Request a formal consultation if curbside consults for the same patient are repeatedly requested.
- Do not bill for curbside consults.
- Do not provide curbside consults for patients in active labor, patients who are critically ill, or patients whose conditions are rapidly deteriorating.
- When seeking the consult, do not record the name of the consulting physician in the medical record unless the consultant is aware and in agreement. ●

(1) Washington School of Medicine. Risk Prevention and Control: Informal: Curbside Consultations. <http://aladdin.wustl.edu/riskmgmt.nsf>

(2) Family Medicine 2003; 35(7):476-81.

(3) JAMA, Vol. 275, No. 6, 145-147. F.A. Manian M.D. and D.A. Jansen, M.D. Curbside Consultations: A Closer Look at a Common Practice.

Case Study: Wrong-site surgery due to mistaken identity

Editor's Note: This case study analysis reflects an actual First Professionals' case.

Case Analysis

Two female patients were scheduled for breast surgery on the same day, by the same surgeon. The surgeon, who arrived after the first patient had been prepped and draped for the procedure, carried out a right total mastectomy due to breast cancer. At the close of the procedure, the holding area nurse informed the surgeon that his mastectomy patient was “ready” and in the holding area. The surgeon and O.R. staff then realized that the first patient was supposed to have undergone a right breast biopsy only. Suit was filed against the hospital and the surgeon for the unnecessary surgery. A defense was not possible given the lack of any preoperative measures or safeguards to prevent the mistaken identity of the two patients – including the “Time Out” measures required by Florida law. Consequently a seven-figure settlement resulted. Disciplinary action by the Board of Medicine was also taken against the physician, resulting in a finding of probable cause.

Risk Management Discussion

- Communication breakdown is a prevalent root cause of wrong-site surgery.
- Be mindful of incorrect site preparation by staff.

- Errors in Consent Form and medical records can facilitate wrong-site surgery.
- The potential for wrong-site surgery increases with emergent situations, unusual time pressure, equipment or set-up, morbid obesity, and when multiple procedures and multiple surgeons are involved.
- Florida law requires the surgical team to engage in a “Time Out” prior to initiation of the surgery/procedure to confirm the side, site, patient identity, and surgery/ procedure.
- Florida law requires that the notes of the procedure specifically reflect when the “Time Out” confirmation procedure was completed and which personnel on the surgical team confirmed each item.
- Adhere to Universal Protocols.
- Clearly delineate site in discussions with patient, consent form, medical record, and x-rays.
- Check the chart preoperatively.
- Verify surgical site with x-rays.
- “Sign Your Site” – mark the surgical site. ●

Risk Management Products & Services

Available at no charge to policyholders

First Professionals offers a number of highly effective risk management products and services to its policyholders – **at no additional cost**. These comprehensive products are designed to avoid claims and disciplinary actions, and encourage physician participation.

Educational Programs

We offer numerous CME/CE educational courses for physicians, surgeons, and dentists. Presentations are also available to other health care professionals, administrators, and non-physician clerical and clinical support staff. Our risk management experts can present to organized medicine groups and society functions, and programs can be designed for a specific legal topic, medical specialty, or specific regulatory compliance.

Reference Sources

Comprehensive risk management manuals

- *A Reference Tool For Risk Management*

Risk Management Group Programs

- Written risk management plan
- Training of designated risk manager
- Incident reporting form
- Reporting of claims
- Analysis of administrative and clinical office systems

Risk Management Newsletter

Preventive Action, published quarterly and targeted to physicians, surgeons, anesthesiologists, dentists, office administrators, and health care professionals, provides timely tips and information to help minimize risk and maximize patient safety.

On-site Risk Management Assessments

- Office layout and appearance
- Storage and handling of pharmaceuticals and supplies
- Equipment services and checks
- Laboratory level, scope of services
- Waste disposal
- Office surgery scope

- Patient contact: telephone, fax, e-mail, appointments, medical advice, answering service, prescription refills, waiting time, billing & collection, emergency procedures
- Managed care process review
- Electronic communications
- Medical record documentation
- OSHA, ADA, AHCA compliance plans
- Written report citing strengths and weaknesses with recommended action plan
- Follow-up determination of action plan implementation
- Risk management consultations
- Individualized guidance and consultations of risk management and legal issues

Risk Management Reference Guides

- Medical Records Do's and Don'ts
- The Lawsuit
- License Investigation Defense Coverage
- Terminating the Physician/Patient Relationship
- The Deposition
- Office Guide for Dental Risk Management (CD-ROM)
- Early Diagnosis Steering Committee Education Booklet entailing:
 - Unstable Angina
 - Breast Abnormalities
 - Colorectal Conditions
- Office Managers and Administrators Guide: Risk Management Principles for the Medical Office Staff

An order form is posted on our Web site, at www.firstprofessionals.com under Risk Management, Products and Services. Or you can contact the Risk Management Department at:

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Florida doctors need to report NOIs to First Professionals Insurance Company

When you receive a Notice of Intent to Initiate Litigation (NOI), a patient's notification of their intent to sue you, ***time is of the essence***. There are specific steps you need to follow so that First Professionals Insurance Company (First Professionals) can provide you with the best claims management and defense. The more you share with us as soon as you receive the NOI, the better prepared we are to meet the time deadlines imposed by state statute.

Your first action must be to call First Professionals, to let us know that you have received a NOI. The Claims Representative who takes your first report will advise you about the next steps and what to expect.

It is imperative that you forward ***everything*** you received to First Professionals. The Claims Representative will advise you of where to send the information (see sidebar for reference).

Please follow this checklist and send:

- The envelope in which you received the NOI and supporting documentation. The postmark on that envelope could prove to be an important piece of information.
- The NOI and any accompanying correspondence. This enables our staff to determine whether or not the NOI is defective.
- The expert's affidavit that accompanied the NOI.
- Any copies of the patient's medical record that accompanied the NOI. As a result of the September 2003 tort reform legislation, the patient's attorney is required by FL Statute 766 to include the medical records with the NOI that is sent to you.
- Any other documents or materials originally included.

You will be contacted by the Claims Director assigned to your case, who will schedule a time to meet with you to discuss the claim. The Claims Director will respond in writing to the patient's attorney. There are established timelines by which we must abide to comply with the statute, so it is imperative that you contact our Claims Department immediately.

First Professionals' policyholders outside of Florida need to contact a Claims Representative any time they receive any legal notification of a pending claim or lawsuit. In other states it may not be a NOI, but we still need to be notified in order to provide you with the best claims management and defense. The sooner you notify us, the better prepared we are to meet the time deadlines imposed by the particular states' statutes.

Notify a First Professionals' Claims Rep if you receive Legal Notice of a Claim or Pending Litigation

By Florida statute, Florida policyholders will receive a Notice of Intent to Initiate Litigation (NOI), a patient's notification of their intent to sue you. If you receive a NOI (Florida policyholders) or other legal notice of a claim (policyholders outside of Florida) please contact a First Professionals' claims representative ***immediately***.

Policyholders in South Florida (Martin, St. Lucie, Okeechobee, Palm Beach, Broward, Dade, Monroe or Collier counties) should contact our Plantation office.

600 N. Pine Island Rd., Suite 250
Plantation, FL 33324
Phone: (866) 760-2121
Fax: (954) 577-2721

Policyholders elsewhere in Florida or in any other state should contact First Professionals' headquarters in Jacksonville.

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Legal FAQs



What is the HIPAA Security Rule?

Security standards that were developed to protect electronic health care information. The Security Rule adopts a set of national standards for safeguards to protect the confidentiality, integrity, and availability of protected health information.

What is the HIPAA Security Rule compliance deadline?

With the exception of small health plans, all covered entities had to comply by April 20, 2005. Small health plans had until April 20, 2006.

Are all covered entities required to comply with the HIPAA Security Rule?

Yes. All covered entities that must comply with the HIPAA Privacy Rule must comply with the HIPAA Security Rule.

In what ways do the HIPAA Security Rule and Privacy Rule differ?

Although the Security Rule is closely linked with the Privacy Rule, the Security Rule entails the privacy of electronic protected health information.

Does the HIPAA Security Rule require specific technology?

No. Security Rule standards are technology-neutral and thus do not require the use of specific technology. A covered entity is free to choose technologies appropriate for its particular practice.

Does HIPAA Privacy Rule compliance establish HIPAA Security Rule compliance?

No. However, many of the requirements set forth by the Privacy Rule satisfy those required by the Security Rule in terms of a covered entity having in place appropriate administrative, physical, and technical safeguards for the protection of protected

health information. However, the Security Rule contains 18 security standards that must be implemented. Moreover, there are 42 implementation specifications that are either required or addressable. If implementing a specification is not reasonable and appropriate, the covered entity must document why, and must implement an equivalent alternative measure that is reasonable and appropriate.

Is there a reference site for information, guidelines, and instructions pertaining to HIPAA Security Rule compliance?

Yes. <http://www.cms.hhs.gov/hipaa/hipaa2/default.asp>. ●