

# Preventive Action

Quarterly Risk Management Newsletter for Policyholders of APAC

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## Liability Perspective: Curbside Consults

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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 email. 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.<sup>(1)</sup> Consults most often entailed which diagnostic testing should be obtained or treatment initiated for a patient. The subspecialties most often consulted were cardiologists, gastroenterologists and infectious disease specialists.<sup>(2)(3)</sup>

### 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.<sup>(2)</sup> 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.

**“While the advantages of curbside consults are many, the inherent liability should be considered ...”**

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Anesthesiologists Professional Assurance Company



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For comments, questions or to obtain additional copies contact the Anesthesiologists Professional Assurance Company Risk Management department at 866-294-6014, ext. 3016.

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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.

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

# NEWS ALERT: CMS DELAYS REPORTING REQUIREMENT

In a surprise move, the Centers for Medicare & Medicaid Services (CMS) revealed in an unannounced website posting that the Mandatory Medicare Reporting Requirement implementation date has been delayed from April 1, 2010 to January 1, 2011. The release noted that all insurers should currently be registered as “responsible reporting entities” and that testing of the reporting system should continue throughout 2010. Insurers that feel they have satisfactorily completed testing may begin submitting reports earlier if desired. It is not clear at this time if all claims paid to Medicare beneficiaries in 2010 will have to be reported, or if only those claims paid in the immediately preceding quarter will have to be reported. CMS promises to provide additional information next week. The PIAA will keep members apprised of any breaking developments. (*PIAA*, 2/18/10)

APAC will continue to provide updates regarding this requirement as necessary. For more information, please contact our Risk Management Department at (800) 741-3742, ext. 3016 or send an e-mail to [rm@fpic.com](mailto:rm@fpic.com). •

## APAC RISK MANAGEMENT BULLETIN

### SUBJECT

Patient Awareness During Inadequate General Anesthesia

### OBJECTIVE

Implementation of loss prevention measures designed to reduce claim frequency and severity attributed to inadequate sedation.

### CONCLUSION

A patient’s awareness of pain and paralysis attributed to inadequate anesthesia can lead to significant consequences including psychological trauma for the patient and financial exposure to the anesthesiologist. The implementation of several fundamental procedures can significantly reduce the incidence and impact of this risk.

### DISCUSSION

A review of 69 suits (1996 ASA Closed Claim Project) for awareness during general anesthesia was conducted and indicated that 54 patients had recall of events or surroundings. An additional 15 were paralyzed awake prior to receiving an induction agent. Claim payments arising out of these suits ranged from \$1,500 to \$600,000. Some of the factors contributing to these claims include widespread usage of neuromuscular blocking drugs, use of ultra-short IV agents without close control of their serum concentrations, the demand for rapid turnover of operating rooms, media coverage of awareness during anesthesia, and successful litigation in malpractice suits for awareness.

When confronted with a patient who indicates that he/she recalls events during anesthesia, make time available to see him. Elicit the details of their recollection, in detail, asking what the last thing they remember before going to sleep and what their first memory is upon awakening. Document the discussion thoroughly, and try to give a candid explanation of what happened. You should notify the surgeon and your insurance carrier of the incident as well.

Recommendations to avoid awareness claims include:

- Review the anesthesia techniques utilized – are the drugs and dosages adequate?
- Begin each day with an anesthesia machine checklist
- Check the drug labels on syringes
- Limit the anesthesia materials on your cart to the ones necessary for induction and maintenance
- Avoid large doses of muscle relaxants – don’t use muscle relaxants to cover up inadequate anesthesia
- Consider including the possibility of awareness in your informed consent documentation •



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## Legal FAQs For information specific to your state of practice, contact APAC's Risk Management department



### **What is meant by the term 'negligence'?**

Generally, the failure to use such care as a reasonably prudent and careful person would use under similar circumstances, or the doing of some act which a person of ordinary prudence would not have done under similar circumstances.

### **What is a deposition?**

A deposition is testimony given under oath before a court reporter. Depositions are important in the preparation of a case for trial. Depositions also freeze testimony

and can be used to impeach your credibility if you deviate from them later. They are used to discover facts of the case and to uncover additional witnesses. Depositions are also used to narrow the issues of the case. Failing to appear for a deposition subjects you to the potential to be held in contempt of court.

### **What is an 'active failure'?**

An error which is precipitated by the commission of errors and violations. These are difficult to anticipate and have an immediate adverse impact on safety by breaching, bypassing, or disabling existing defenses.

### **What is the definition of 'malpractice'?**

Improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officers to denote negligent or unskillful performance of duties when professional skills are obligatory. Malpractice is a cause of action for which damages are allowed.

### **What is a 'sentinel event'?**

An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

### **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. •