“Curbside” consults, in which physicians informally solicit one another’s opinions, are an integral part of our medical culture. Although curbside consults are usually limited in scope and do not provide the breadth of information as formal consults, formal consultation is often unavailable or impractical because of time constraints, insurance coverage, geographic location, or patient preference. And in these situations, the delivery of optimal patient care often depends on access to the expertise of a colleague via curbside consultation. Despite their value, there is a growing concern in the risk management community that curbside consults should be “curbed,” and some medical malpractice insurers have gone as far as recommending that curbside consults not be rendered under any circumstances. These recommendations place curbside consultants in an awkward situation, seemingly forced to choose among their ethical obligation to patients, their sense of duty to colleagues, and their own legal well-being. The author evaluates the legal aspects of curbside consults, distinguishes them from clinical interactions with which they must not be confused, and then provides guidance for conducting curbside consults. In conclusion, curbside consults should occur as often as needed and to whatever degree is necessary for proper patient care. © 2010 Elsevier Inc. All rights reserved. (Am J Cardiol 2010;106:135–138)

Methods

PubMed was searched on November 11, 2009, for reports and studies that reported original data, recommendations, or commentary related to informal or curbside consultation. WestLaw was searched on November 11, 2009, for court opinions related to informal or curbside consultation. The reference lists of all identified documents were also searched. The studies, commentaries, and court opinions were then subjected to scholarly analysis.

Results

Curbside consults occur frequently and consume considerable amounts of physician time. Kuo et al found that primary care physicians obtained, on average, 3.2 curbside consults, and specialists received an average of 3.6 requests for curbside consults per week. The specialties most frequently consulted were cardiology, gastroenterology, and infectious diseases. Endocrinology, infectious diseases, and rheumatology were requested to provide more curbside consults than formal consults. Pearson et al found that gastroenterologists spent an average of >1 hour per week rendering curbside consultation.

Curbside consults are generally conducted in person or by phone, although e-mail is an increasingly popular method. Most curbside consults directly relate to the current care of an actual, rather than a hypothetical, patient. The most common reasons for curbside consults are to aid in selecting appropriate diagnostic tests and treatment plans and to determine the need for formal consultation. Sixty percent of curbside consults involve the acute management of patients with new symptoms or test results. And 81% of the involved patients are previously unknown to the consultants.

Despite the critical role that curbside consults play in patient care, the quality of the interactions is often limited. Eighty percent of specialists and 50% of primary care physicians believe that the information communicated during curbside consults is inadequate, with 78% of specialists and 44% of primary care physicians stating that important clinical detail is not described. These gaps create a legitimate possibility that the care that is subsequently rendered will decrease below acceptable standards and thereby raise medical-legal concerns, especially for the physicians who are consulted.

Discussion

A curbside consultant faces 2 types of medical-legal risk: actual liability (which is rooted in established legal principles) and alleged liability (which refers to the filing of a lawsuit against a defendant who has no legal responsibility). From a purely academic perspective, actual liability is the only concern. However, for the practicing physician, alleged liability is equally important. For merely being named as a defendant in a lawsuit, even if the allegations are without merit, often results in a long and arduous process. In this discussion, I therefore weigh both of these risks.
Although a plaintiff may make any number of allegations, actual liability for medical malpractice hinges on the existence of a doctor-patient relationship. To successfully sue for medical malpractice, a plaintiff must first prove that he or she was in a doctor-patient relationship with the accused physician. The existence of a doctor-patient relationship is often said to be an issue of contract. However, the analysis of whether a doctor-patient relationship exists is only vaguely related to principles of contract law.

Instead, the issue is better addressed with a simple rule: a doctor-patient relationship arises when a physician has professional contact with a patient and thereby undertakes to diagnose and/or to treat the patient. This critical interaction between doctor and patient usually takes place in person, but it can occur by phone, fax, e-mail, or any other form of communication. It can also occur indirectly, such as when someone calls on behalf of an ill family member, or when a physician relays a treatment recommendation through a member of his or her office staff. However, regardless of how the interaction occurs, a doctor-patient relationship does not arise until a doctor assumes some degree of responsibility for the diagnosis, care, and/or treatment of a patient. Before that critical point, a physician has no (actual) liability for medical malpractice.

Under this rule, a curbside consult, which is simply an informal discussion between 2 physicians, does not result in the formation of a doctor-patient relationship. And it therefore cannot create any (actual) malpractice liability for the consulted physician. This legal conclusion has been repeatedly recognized by our courts and was eloquently articulated by the Kansas Supreme Court in 2001: “A physician who gives an informal opinion at the request of a treating physician does not owe a duty to the patient because no doctor-patient relationship was created. A physician cannot be liable for medical malpractice where he or she merely consulted with a treating physician and nothing more. A physician who assumes the role of treating the patient, however, can be liable for medical malpractice.”

Consistent with this reasoning, a Michigan court refused to extend liability to a specialist who was consulted curbside about the same patient on multiple occasions, made specific recommendations, and even reviewed the patient’s chart. The court based its decision on the facts that the specialist was not formally consulted, never wrote a note or an order in the chart, and never contacted or examined the patient. It held that he was therefore not in a doctor-patient relationship and not legally responsible to the patient.

In a display of great insight, an Illinois court articulated the importance of protecting the curbside consult. The court noted that extending liability to include curbside consults “would have a chilling effect upon practice of medicine. It would stifle communication, education and professional association, all to the detriment of the patient.” The court’s proclamation of a link between extending liability to curbside consultations and patient detriment is particularly noteworthy. From a judicial perspective, it sends a message that the legal protections enjoyed by the curbside consult are unlikely to disappear.

Although our courts have been unanimous in protecting and even encouraging curbside consults, it is often recommended that the curbside consult be curbed. This paradox is a result of misunderstanding on the part of many medical-legal commentators, who have frequently misapplied the term “curbside consult” to a broad range of physician-physician interactions, most of which are not actually curbside consults. Because many of these misclassified interactions are associated with liability, a belief has arisen that curbside consults are associated with liability. However, this is not correct. To avoid this confusion, the following situations must not be mistaken as curbside consults.

On call for an emergency room: The act of being on call for an emergency room brings the Emergency Medical Treatment and Active Labor Act (EMTALA) into the analysis and adds a legal obligation that does not exist in any other situation. Under EMTALA, an emergency room and its on-call physicians owe a duty of care to any person who presents with an “emergency medical condition.”

As an Ohio court correctly noted, “Once an on-call physician . . . is contacted for the benefit of an emergency room patient, and a discussion takes place between the patient’s physician and the on call physician regarding the patient’s symptoms, a possible diagnosis and course of treatment, a physician-patient relationship exists between the patient and the on-call physician.”

This means that because of EMTALA, an interaction between an emergency room physician and an on-call physician regarding a patient who is in the emergency room is not a curbside consult.

“Covering” for a colleague: A physician who “covers” for a colleague assumes full responsibility for all the covered physician’s doctor-patient relationships. As a result, the covered patients now belong to the covering physician and are legally indistinguishable from his or her other patients. Although the covering physician may have never seen, examined, or treated any of the patients he or she is covering, the physician is nonetheless in a doctor-patient relationship with every one of them.

A Michigan court addressed a case in which a covering physician mistook his role for that of a curbside consultant. A pregnant patient developed contractions while she was at the hospital for carpal tunnel surgery. A hospital nurse called the patient’s obstetrician, but the obstetrician was unavailable. The nurse spoke with the obstetrician’s partner, who was “covering.” After a discussion, the physician gave the nurse a recommendation, which was relayed to the treating physician. Unfortunately, the patient’s labor progressed and resulted in fetal compromise.

The covering physician was sued for malpractice but argued that he had never seen the patient, was not in doctor-patient relationship, and had merely participated in a curbside consult. The court reasoned, “[This] case does not involve a treating physician’s solicitation of an informal opinion from another physician. Rather . . . a nurse called the patient’s treating physician seeking directions for care, and was directed to the doctor who had assumed the responsibility of covering for the treating physician.”

Because the interaction was not a curbside consult but rather a treatment recommendation for a patient to whom
the covering physician owed a duty, the court held that he was legally responsible for the recommendation.

**Supervising residents and other health care providers:** A curbside consult involves an exchange between 2 independent physicians, both acting on their own authority and free to exercise their own clinical judgment. However, residents, nurse practitioners, and physician assistants do not have such clinical freedom. Instead, they act under the authority of their supervising physicians, who are thus vicariously liable for their actions, regardless of when or if the supervising physicians actually see the patients.

In a Missouri case, a resident called her attending physician about a new patient, whom the attending physician had never seen. The attending physician instructed the resident to give the patient several medications, but the resident did not do so. The patient deteriorated and subsequently sued the attending physician. Although the attending physician had never seen the patient and had given appropriate instructions to the resident, the court determined that “a physician is responsible for the negligence of those he or she supervises” and permitted the lawsuit to go forward. This means that the interaction between a resident or midlevel practitioner and a supervising physician must not be viewed as a curbside consult.

**Formally interpreting films, specimens and studies:** The formal involvement of radiologists, cardiologists, pathologists, and others in interpreting films, specimens, and studies creates limited doctor-patient relationships in which the physicians are legally responsible for issuing proper interpretations. Although these physicians may never see, examine, or treat the involved patients, they issue official reports that are used to guide diagnosis and treatment. Because these situations involve “formal” participation in the care of patients, they do not satisfy the “informal” requirement of a curbside consult. This distinction, which forms the basis of liability, was well phrased by the Tennessee Supreme Court: “In light of the increasing complexity of the health care system, in which patients routinely are diagnosed by pathologists or radiologists or other consulting physicians who might not ever see the patient face-to-face, it is simply unrealistic to apply a narrow definition of the physician-patient relationship in determining whether such a relationship exists for purposes of a medical malpractice case. . . . We hold that a physician-patient relationship may be implied when a physician affirmatively undertakes to diagnose and/or treat a person, or affirmatively participates in such diagnosis and/or treatment.”

A curbside consult is an interaction (1) that is informal, (2) that occurs between 2 physicians (neither of whom is subordinate to the other), (3) that involves a consultant who does not have a preexisting doctor-patient relationship with the affected patient and who is not covering for someone who does, (4) that does not involve an on-call consultant and the care of a patient who is in the emergency room, (5) that does not involve any contact between the consultant and the patient, (6) that does not result in the generation of a written report, and (7) for which no payment is received.

As long as all of these criteria are met, the interaction is a curbside consult that does create any actual liability for the consultant. Of course, even in the absence of actual liability, there is always a possibility that the consulted physician will be sued for medical malpractice. Although such a physician should ultimately prevail as a matter of law, the entire process is best avoided. It is therefore appropriate to examine the means by which a curbside consultant can minimize his or her risk for being sued (albeit that the lawsuit would be without merit).

The most obvious option is to simply refuse to participate in curbside consults. Although occasionally recommended, this strategy has several shortcomings. First, refusing to answer a colleague’s question potentially damages our professional relationships, and, as a result, will eventually compromise the care of our own patients. In addition, the refusal betrays our ethical obligation to the many patients who place their trust in our profession.

Finally, and most important, a refusal to provide any information will, to some degree, compromise the affected patient’s care. Eventually, one of these compromises will result in a “bad outcome.” And every bad outcome is accompanied by the possibility of a lawsuit. In the end, because it compromises patient care, a blanket refusal to participate in curbside consults may actually increase the risk for a lawsuit. Although physicians who refuse to participate in curbside consults may take comfort in the fact that such lawsuits are “not theirs problem,” the reality is that they could still be named as defendants (as this is always a possibility). In short, because a complete refusal to participate in curbside consults will invariably compromise patient care, it cannot be recommended.

The second option for reducing the risk for being sued is to conduct curbside consults in a manner that is brief and devoid of specifics. This strategy is commonly recommended, which may account for the fact that 80% of consultants believe that they do not receive sufficient information during curbside consults. Unfortunately, this approach is based on the flawed premise that a specific response creates more legal risk than does a vague response. However, a curbside consultant has no actual liability for any response, be it vague, specific, right, or wrong. And just as with the strategy of refusing to participate in curbside consults, the practice of offering vague responses will invariably compromise patient care and thereby increase the risk for being sued. As a result, the practice of keeping curbside consults brief and nonspecific cannot be recommended.

The most viable lawsuit avoidance strategy is to conduct curbside consults in whatever manner is needed for proper patient care. This approach reduces the risk for a lawsuit by giving patients the best opportunity for good results and creates no actual liability for consultants. In more complex situations, it may be appropriate for one of the physicians to suggest the need for formal consultation. However, because of patient preference, geographic limitations, or financial considerations, this option may not be feasible and is not required.

Some authors recommend that consulted physicians keep written records of curbside consults. However, because the absence of liability depends on the informal nature of a consultant’s role, he or she should generally avoid creating a written record. It is commonly recommended that a consulted physician’s name not be written in the patient’s
medical record. However, this advice discounts the substantial medical-legal benefit of doing so. By recording the conversation in the medical record, the consulting physician demonstrates his or her diligence in seeking expert opinion and bolsters the credibility of his or her chosen course of action, both of which reduce the overall risk for a lawsuit.

Of course, it is possible that this benefit is derived at the expense of the consulted physician, for whom the chart entry may create liability. Although this is a common concern, the treating physician’s chart entry creates no actual liability for the curbside consultant. Actual liability cannot be created merely by writing another physician’s name in a medical record. Instead, it must arise from a doctor-patient relationship.

Although it creates no actual liability, placing the consulted physician’s name in the record does create the possibility that he or she will be unjustly named in a “shotgun” lawsuit, wherein everyone whose name is in the record is sued. Fortunately, the various tort reforms over the past decade, combined with the overall expense of litigation, have made shotgun lawsuits much less common. However, the scenario is not impossible. Of course, the mere fact that the consultant’s name is not in the record does not rule out the possibility that his or her involvement will be discussed at someone’s deposition. And the consultant could be added as a defendant at that time.

In short, documenting the specifics of a curbside consult provides significant medical-legal benefit and creates no actual liability. And because a consultant’s role will eventually be discovered in the course of any ensuing litigation, there is little to be gained by not documenting something that did indeed occur.

18. Reynolds v Decatur Memorial Hospital, 277 Ill. App. 3d 80, 86 (1996).