Healthcare RISK MANAGER
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Risk Management Issues in Telemedicine

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The use of telemedicine within the healthcare delivery system is experiencing unprecedented growth spurred by federal support, managed care demands, the decreasing cost of the technology and the opportunity to provide access to medical care to areas of this country where previously unavailable. Using technology that ranges from simple telephones to satellites to state-of-the-art video conferencing equipment and high-tech links, telemedicine has created a variety of applications today in patient care, education, research and public health. However, with this advance in healthcare delivery comes risk to patient care and professional liability exposures to physicians and other healthcare workers. Although not altogether new, these areas of risk and liability exposure have taken on a new look.

1. New Technology

- Providers must become comfortable and proficient with the technology they will be using during the telemedicine encounter. Where is everyone involved in the encounter on the learning curve with the technology?
- Minimum requirements for the technical specifications of the equipment used must be established and standardized to fit the type of encounter. For instance, a dermatology consult requires a high-resolution camera and monitor where a psychiatric consult does not. Equipment used for static image consults, such as in radiology, requires certain types of technology. The American College of Radiology has established standards for teleradiology, but who is setting the standard for the type and quality of the equipment being used in other specialties?
- Technology is changing so rapidly that, without minimum standards and specifications, the practice of telemedicine may not evolve congruently among the users. A standard which is established by the clinical community which utilizes telemedicine will protect practitioners and patients.

2. Credentialing and Qualifications

- What are the credentials of the healthcare worker or physician who is: presenting the patient? doing the consult for you and your patient?
- Who credentialed them, and what are their credentialing criteria?
- Is the working relationship between the two telemedicine providers compatible? Are styles similar enough that the encounter does not appear to the patient to have any conflict between the providers? Do the practitioners act as a team?
- Has the referring doctor or teleconsultant been trained and credentialed in the use of the technology?
- Is the staff at the referring site qualified to handle an emergency during a consult where you are directing treatment? Do they have proper emergency equipment?
- Is the referring physician comfortable with the credentials of the teleconsultant? In the face of an injury brought on by a teleconsultant, the referring physician may be held vicariously liable for their actions.
- As you have become comfortable with the

– *continued on page 2*

INSIDE:
Potential Risks Associated with Morbidly Obese Patients
Page 3

– Risk Management Issues, continued from page 1

credentials of physicians you consult with, now you must also become comfortable with the credentials and qualifications of your teleconsultants.

- Do hospitals that host telemedicine sites credential the presenting physicians and give them some level of privileges? The hospitals could have vicarious liability for physicians practicing in their facility, and the consulting physician should have the assurance the presenting physician is qualified to perform his/her duties.
- In a closed system, it is easy to set the qualifications and guidelines for those physician and non-physician practitioners working within the system. When telemedicine goes outside of a closed system, you lose control and should be at a higher level of awareness of the qualifications of those with whom you are working. You wouldn't send your patient to someone without knowing their qualifications; teleconsulting should be the same.

3. Informed Consent

- By most state laws, the patient does not have to give informed consent for a telemedicine encounter. However, with this new system of healthcare delivery, it is important that the patient have a complete understanding of risks, and realistic expectations of the benefits and limitations of telemedicine. Therefore, obtaining informed consent from the patient is advisable.
- Make the patient aware of treatment options to telemedicine, including traveling to the specialist and other acceptable alternatives.
- At this early stage of telemedicine where the public may be skeptical and their level of acceptance low, the physician may be held to a higher standard, as the courts may view telemedicine as experimental.
- Make sure telemedicine is appropriate for the situation.
- The patient needs to understand what the limits and benefits of telemedicine are in their treatment plan. Accept the limitations of telemedicine.

4. Document the Encounter

- Not only should the exam, findings, treatment and instruction be documented as they would with any patient encounter, but also document the environment used in the telemedicine encounter, including the equipment used and its specifications (i.e., resolution).
- All caregivers who treat the patient should generate and maintain a medical record on each patient they encounter.
- The rules for documenting patient care do not change with telemedicine. The record is still the first line of communication to you and subsequent treating practitioners and still the first line of defense in an allegation of professional liability.

5. When to Proceed; When to Stop

- Don't be afraid to stop a telemedicine exam or treatment if you, in your professional judgement, feel the patient would be best treated in person. Proceeding with an exam or treatment when there is a high possibility of misdiagnosis or treatment injury is a not a new liability exposure. However, proceeding with a telemedicine exam when a face-to-face encounter is indicated adds an extra problem when faced with an injury.

6. Responsibility for Patient Treatment

- As with any consult or referral, discuss and clarify the roles and responsibilities of each practitioner prior to the patient encounter and clarify the arrangement to the patient.
- Who has established the primary patient-physician relationship?
- A referring physician may be held vicariously liable for the negligence arising from the acts of the teleconsultant. This theory of negligent referral is not new as applied to telemedicine, it just emphasizes the need to know your consultant and feel comfortable with their qualifications.

7. When is the Patient-Physician Relationship Created?

- This is a fundamental issue with telemedicine that continues to be up to interpretation. It must be made clear to all, including the patient, as to who has responsibility for which part of the patient's care, treatment and follow-up. If the teleconsultant acts as an advisor to the treating physician, a relationship with the patient may not have been created. The treating physician is still the one making the treatment decisions based on the advisor. If the teleconsultant is actually directing care and treatment of the patient, there is no doubt that a patient-physician relationship exists.
- In most states, the existence of a patient-physician relationship is requisite to creating a legal connection between the parties, and thus a duty.

8. Personalize the System

- The teleconsultant must put forth an extra effort to establish rapport with the two-dimensional patient on the monitor.

– continued on page 4

Potential Risks Associated with Morbidly Obese Patients

By Jack F. Menendez, M.D.

There are six million morbidly obese people (100 pounds over weight) in this country. By definition, these people are sick. They have ongoing serious cardiac and hemodynamic problems such as hypertension, coronary artery disease and serious respiratory difficulties such as Sleep Apnea Syndrome (SAS) and Obesity Hypoventilation Syndrome (OHS).

Symptoms of Sleep Apnea Syndrome include loud snoring, nocturnal awakening, and daytime somnolence. SAS has the potential to be fatal, for example, if the patient falls asleep while driving. On examination, these patients have a fat tongue with fat deposits on the uvula and pharynx. Patients with SAS are at great risk of postoperative acute airway obstruction and respiratory arrest.

Patients with Obesity Hypoventilation Syndrome become hypoxemic and hypercarbic on room air. The causes of OHS are pulmonary mechanical and central. These patients frequently have cor pulmonale and are polycythemic. Patients with both SAS and OHS are affected with the most severe form, called Pickwickian Syndrome, causing the patients to be very difficult to intubate.

Morbidly obese patients are difficult to X-ray because the X-ray equipment found in most hospitals is not capable of producing useful studies in these patients. Plain films are frequently under penetrated, sonograms and CT-scans are not clear.

At the time of surgery, they are difficult to intubate, and are at great risk of postoperative acute airway obstruction and respiratory arrest. Surgical incisions in the morbidly obese have a high incidence of dehiscence and wound infection. Bleeding is difficult to diagnose; we recently had a case of a man, five feet tall, 380 pounds who bled following surgery and died after a heart attack, despite excellent care by his medical team. They had great difficulty diagnosing the intra-abdominal bleeding due to his obesity, and his coronary artery disease had not previously been diagnosed.

Morbidly obese mothers in labor have a greater incidence of C-sections overall and a higher incidence of emergency C-sections.

In short, the morbidly obese patient is sicker than the non-obese patient when seen for care. Every system in the body is affected either mechanically, biochemically, or both. Therefore, they have to be treated with greater care because there is no margin for error and the problems associated with the obesity affect both the quality and length of life of these patients.

Risk Management Issues

1. When morbidly obese patients present for any type of medical treatment, it is recommended that the physician evaluate the patient for not only the current complaints but for all the associated comorbidities that may be associated with the patient's obesity.
2. A complete physical examination, including routine biochemical and metabolic tests, diet and nutritional history, psychological assessment, and fitness assessment might be considered before any medical or surgical intervention.
3. The medical risks of obesity are heightened by the presence of concurrent illnesses, lifestyle habits such as smoking or physical inactivity, poor control of diabetes or high blood pressure, and coexisting dysfunctions of the organs or limbs due to obesity or other causes.
4. Physicians should be especially sensitive and astute when making a differential diagnosis of a patient who presents with various symptoms. It is highly recommended that physicians take into consideration the morbid obesity and complications associated with it, in addition to the ones they would come up with in a non-obese patient.
5. Because obesity is so prevalent, obese patients with problems requiring surgical intervention are common in most clinical practices. It has been found that obese patients are at increased risk for the development of several disorders that require surgical intervention. Those include gallstones, reflux esophagitis, osteoarthritis, and certain malignancies, such as breast, endometrial, colon, and prostate cancer. The possibility of impaired immune function and poor outcome with infection following any type of surgical intervention is increased as well.
6. During anesthesia and surgery, the morbidly obese patient is at an increased risk. The preoperative visit by both the anesthesiologist and the surgeon should include both verbal and written communication as to the planned procedures, the practical problems and the associated risks that the morbidly obese patient may face in the operating room and postoperatively. These risks should be outlined well on the consent form, and as usual, the patient should have a clear understanding of the risks in order to make an informed decision regarding the surgery and anesthesia.

– Risk Management Issues, continued from page 2

- The public may be accustomed to viewing TV, but they are not accustomed to real-time interaction.
- Design both the transmitting and receiving rooms to be similar and make reference to objects or charts in the room to give the patient more of a feeling that you are there.
- In some situations, the person uncomfortable with the encounter may not be the patient, but the physician or other practitioners.

9. Electronic Records and Confidentiality

- As part of a standard procedure, the teleconsultant and the referring physician must explain to the patient how telemedicine and the electronic transfer of medical information work. Explain the safeguards of confidentiality on the transmission of the actual encounter, any recorded information, and any hard copy documents.
- The patient must be told who is viewing the encounter. If they feel their cyber exam is being viewed by others, they may not be honest during the exam, or worse, may not seek care or follow-up.
- Properly designed electronic record systems can provide greater protection for sensitive information than paper-based records.
- Passwords on electronic record systems must be changed regularly and never shared. Employees should be asked to agree to and sign a Confidentiality Agreement.

10. Standard of Care for the Use of Telemedicine

- At what point will obtaining a telemedicine consult be considered a standard of care, and thus create a duty? Some say the duty may be created now.
- In Georgia, the requisite standard of care is defined as what is employed by the profession generally under similar conditions and like surrounding circumstances.
- Therefore, if a teleconsult is available in a rural area through a locally established telemedicine conferencing center, and that resource is not used as other physicians in the community utilize the resource, is this practicing below the standard of care? Is telemedicine, once established and proven effective, another resource that must be considered, and utilized if applicable, as you would refer to any specialist?

11. Licensure

- Telemedicine has the capability to substantially improve access to needed healthcare services and medical expertise. However, the technology of telemedicine has evolved faster than applicable law.
- Physicians and other healthcare workers are subject to the laws, rules and regulations of the state in which they practice. In most states, you are considered to be practicing medicine in the state where the patient is located. Therefore, if you teleconsult on a patient in another state, you are subject to their jurisdiction and fall under that state's licensure laws.
- The Federation of State Medical Boards and the American Medical Association have been in discussion as to the numerous licensure issues, but to date nothing has been decided upon toward the adoption of uniform standards and administrative requirements.
- Will you have coverage for professional liability claims if they occur from a telemedicine encounter and the suit is filed in another state?
- Which venue will the plaintiff be allowed to file the lawsuit in. The attorneys will likely choose the location most favorable to the plaintiff.
- At this time, it is advisable to be licensed in the state in which you reside and the state where the patient is being consulted. ●

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgement.

This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to hospitals and physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have any questions in any of the areas discussed in this publication, you should seek a qualified legal opinion.

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