

Hippocrates

Malpractice in telemedicine: the next challenge

The physician has always had to live with the constraints under which he practices. He is supposed to take them into account when seeking to make a reliable diagnosis and provide adequate treatment, and the community will as a rule make allowance for them if his performance is criticized or questioned. That applies to the knowledge, tools and materials available (or unavailable) to him as well as to the adequacy of his communication with the patient. Particularly where communication is concerned, legal and ethical standards have emerged, defining the physician's duties when faced with challenges ranging from the deaf and dumb patient to reliance on messages transmitted by telephone or through intermediaries. To that extent the new concept of telemedicine is not really new at all. The physical distance between the patient and his physician may in some cases have increased dramatically, but the quality of the communication in either direction is commonly at least as good as that attainable when they are both in the same room.

The essential reason for the current explosive growth in telemedicine is its ability to make medical services, and in particular specialized medical knowledge, more readily available. Patients can be examined, advised and treated by physicians to whom they would not otherwise have had access. There are some particularly spectacular examples of its usefulness. A general surgeon in the middle of the Antarctic may be enabled to carry out an emergency operation outside his normal field of experience by the minute-by-minute guidance and feedback provided by a specialized colleague on another continent; a surgeon may even perform an operation himself at a distance using telerobotics. High quality radiographic and other diagnostic images can be transmitted instantaneously over any distance to consultants experienced in their interpretation. Videoconferencing sessions in which all the relevant material is immediately available to all the participants render it possible to obtain well-informed consensus on particular problems and means of solving them. Telemedicine has rapidly become an integral part of medical practice. Three areas have been identified in which it is likely to develop significantly; the first is the transmission of aids to decision making (such as electrocardiograms), the second is remote sensing (e.g., remote monitoring of a pacemaker) and the third is the integral management of patients at a distance when they have no direct access to medical care at all.¹ Other areas such as telerobotics may grow more rapidly than we can yet foresee.

Perhaps because one is so accustomed to the notion that good medicine can only be practiced where the physician and patient have direct contact with one another, there have been some forebodings as to what may go wrong when medical care is provided in this way, and questions as to where the liability for fault will lie. Many of the problems which one might envisage can in fact be tackled on the basis of close analogies with other forms of communication which one is more familiar. There are well established rules on the need for a physician to ensure effective communication through any channel, including the provision of advice and instructions by telephone and the verification wherever possible of information received from a nurse or from a friend or relative of the patient. By extrapolation those rules apply

¹Statement by Dr Donald A.B. Lindberg, comprising testimony on VA Care and Communication and Information Technologies before the Subcommittee on Oversight and Investigations of the House of Representatives' Committee on Veterans' Affairs, 102d Cong (1994); published in 1994 WL 377915.

to telemedicine as well. A consultant who assesses a distant patient's X-rays on his computer screen should, for example, ensure that the images truly relate to the patient concerned, and that he is provided with all the relevant images available at the other end or a representative selection, e.g., serial images over a period of time. Again, he will need to limit his assessment to the material actually received; proper interpretation of a CT-scan may demand insight into other examinations performed as well as the patient's full history. There are also plenty of situations in which only patient face-to-face contact with an individual, observation of his demeanour, movements and dress, will provide a sufficiently complete picture to unravel his problems and find the right approach to them; even a videoconference is not likely to substitute fully for that.

Sooner or later, there is bound to be a spate of accusations regarding malpractice in telemedicine. One reason for that could be uncertainly as to who has actually accepted responsibility for the patient, if indeed anyone has done so. The fact that a patient has contacted a physician, whether in person or through some other channel such as electronic mail, will not be regarded by a Court as evidence that the doctor has agreed to take on the patient's case and assume responsibility for diagnosis or treatment. Sometimes he will explicitly agree to do so, sometimes he will equally clearly decline; more commonly one will have to determine in the light of the manner in which the contact evolved whether or not there was a physician-patient relationship. If the physician merely provides certain advice and the patient chooses to rely on that advice, this may or may not constitute a physician-patient relationship; that is an issue on which Courts in various countries (and States of the US) differ. This issue has arisen often enough in cases of both personal consultation and the seeking and giving of advice over the telephone. It seems very likely that if a patient seeks advice from a named physician through any electronic medium and the physician both listens to the patient and provides the advice a physician-patient relationship will be considered to exist, involving the usual duties of care and forming a basis for liability if those duties are breached. The situation is very different if, for example, a patient identifies on the Internet an agency providing medical information and advice of a general nature, follows this advice, and experiences unfortunate consequences. Here the situation is hardly different from that of advice given in a popular medical encyclopaedia. The reliability of information on the Internet is notoriously variable, much of it is contradictory, and to rely on it uncritically is to expose oneself recklessly to risk. There are however going to be numerous intermediate situations in which a patient is led to believe that he has sought and obtained in this way advice from a physician on which he is entitled to rely. No doubt wisely, websites providing health data and recommendations are now publishing explicit disclaimers to absolve themselves from liability for malpractice. Whether a physician claiming to give tele-consultations can cover himself in this way seems much more dubious.

A rather different set of circumstances arises where a patient X has a well defined relationship with a physician Y and the latter seeks expert advice on the case from a consultant or specialist S. In theory the legal relationships should be simple. Assuming that S is not put into direct contact with the patient and is reliant in supporting Y on data which the latter has provided, the fundamental patient-physician relationship will continue to be that between X and Y only. Y will continue to be responsible for all aspects of diagnosis and treatment, and if he makes serious errors (even on the basis of faulty consultant advice given by S) he or his employer will be primarily liable to the patient. S, being as far removed from the patient as (for example) a diagnostic laboratory which has examined a blood sample submitted to it by the responsible physician, is unlikely in most well-developed legal systems to be directly liable to the patient X for any error. If he has been grossly negligent, resulting in the physician Y being misled, he is likely to be liable to Y. Such is the theory which common sense would seem to dictate, but there is case law, particularly in the USA, which is relevant by analogy and which goes in the opposite direction. In an

American (Indiana) case, a surgeon had removed a tumour from a patient's leg and sent it to a pathologist for examination. The latter reported that it was benign. In fact it was cancerous. Despite the pathologist's protestations that he had no relationship to the patient, the Court of Appeal allowed the patient to sue him directly, considering that since the pathologist's advice had been sought with the express or implied consent of the patient and rendered on the latter's behalf there was a direct contractual relationship between pathologist and patient.² For similar reasons, a series of courts have allowed patients to sue radiologists whom they have never met but who interpreted their X-rays and were negligent in doing so. At least this approach has the merit of rendering possible a direct claim against the party making the error, rather than demanding cumbersome litigation in two phases.

It is not clear how this unresolved issue will further develop where telemedicine is concerned. Much is likely to depend on the manner in which the physician primarily responsible for the patient has chosen to consult his tele-colleague. There is a world of difference between seeking limited help on the interpretation of a particular finding and submitting the patient's entire case and file for expert assessment. However in practice it may be impossible to draw a line between these two approaches; again much is likely to depend on the facts of the case, and particularly upon the manner in which advice was sought and given.

The whole issue of responsibility in telemedicine now needs to be thrashed out both by health providers and lawyers. The type of situation least likely to give rise to conflict is likely to be that in which telemedicine makes it possible to obtain data as detailed and exact as those obtainable on the spot, and to provide patient care or detailed guidance to a colleague in a manner which renders the specialized medical care more accessible and more effective. If in such cases the performance or outcome can be criticized, the criteria for assessing them must take account of the fact that without telemedicine the care would probably not have been provided at all.

The use of telemedicine will be rather more questionable (and disputes will be more likely to emerge) if, from economic motives, the technique becomes widely used to save time and money in situations where direct patient contact would be feasible and is likely to be more effective. Current concern about the economics of medical care could all too readily lead health maintenance organizations to replace personal care by something less costly even where that means sacrificing quality. Telemedicine is and can be a tool enabling medicine to function better; it would be a disaster if it were to become an excuse for third-rate health care, snap diagnoses, and cookery-book treatment.

²520 N.E. 2d 468 (Ind. Ct. App. 1988).