

[MEDLAW]

PART 3

Avoiding Liability in Telemedicine: Liability & Malpractice

The COVID-19 crisis has created considerable confusion among doctors who are caring for patients virtually as to where they stand on liability for the quality of that care. The CARES Act limits liability for volunteers providing COVID-19 treatment, and some states have extended this to non-volunteer practitioners. Whether such laws apply to non-acute care outside a hospital, though, is uncertain and it is therefore prudent for physicians doing office telemedicine to assume that even if they do provide COVID-19 triage or follow-up that they will not be immunized.

This brings the matter to the general rule that standards of liability in telemedicine are the same as those that apply to in-person care. A telemedicine practitioner must use their clinical judgment to know when that modality is adequate and when it is exceeded.

This goes back to the legal analysis for evaluating all claimed medical negligence: was the action or inaction by the doctor reasonable under the circumstances? To the extent that telemedicine is used for routine check-ups and medication management, it is going to be low risk for liability, and even triage for emergency care does not carry more risk than evaluation through an audio phone conversation, while on-call would and is actually safer because of its video element. However, the scope of use of telemedicine is also where avoidance of malpractice intersects with following medical ethics.

In some cases, the Standard of Care for the applicability of telemedicine is under the control of the payor. In most situations, it is the practitioner who will have to make the decision. In this regard, some threshold points should be considered:

- How are the visual and audio quality of the system that you are using?
- If you will be receiving outside data, is your system optimized for that in terms of data capacity and speed?
- What clinical data can be collected?

You will be carefully documenting the personal and technical information exchanged with the patient during a telehealth visit, and it must be as sufficient to support a diagnosis or treatment as it would be in an in-person visit. Bear in mind that disclaimers about telemedicine's limitations or mentioning such during an informed consenting discussion before starting a telehealth visit do not act as malpractice liability shields. Remember that a relaxing of regulations during the pandemic is not a relaxing of standards of medical care.

If you nevertheless become involved in a malpractice case as a result of telemedicine, it can be based on any cause of action that can be brought based on standard in-person care. The physician performing the telemedicine is liable for their own negligence and an employer will have vicarious liability under the *respondeat superior* doctrine, as well as potential direct liability for negligent failure to supervise if their employee/practitioner is alleged to have been negligent. Make sure that you have clear policies in place and that everyone who may be encountering a patient remotely is trained in proper procedures.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney.



Comparing Treatment Strategies to Manage Children With Uncomplicated Appendicitis



Contributor
Peter C. Minneci, MD, MHSc
Professor of Surgery and Pediatrics
Department of Surgery, Division of Pediatric Surgery
Center for Surgical Outcomes Research
Abigail Wexner Research Institute
Nationwide Children's Hospital
The Ohio State University College of Medicine

Each year, more than 180,000 adults and 70,000 children undergo an appendectomy in the United States. "Although the surgery is curative, appendectomy is still a major operation that is associated with perioperative risks as well as postoperative pain and disability," explains Peter C. Minneci, MD, MHSc. "In addition, the recovery of patients undergoing an uncomplicated appendectomy will require a period of disability that can be difficult for patients and caregivers."

"Most children and adolescents with appendicitis are treated with an appendectomy, but it's possible that nonoperative management with antibiotics alone may be preferred by patients and their

caregivers," says Dr. Minneci. "This approach has the potential to effectively treat the disease with fewer negative effects on patients."

Assessing Nonoperative Management

For a study published in *JAMA*, Dr. Minneci and colleagues sought to determine the success rate of nonoperative management in children with uncomplicated appendicitis. The analysis also compared differences in disability days, HRQOL, complications, and patient satisfaction between an antibiotic alone approach and surgery.

Investigators enrolled 1,068 children aged 7-17 with uncomplicated appendicitis who were treated at 10 US children's hospitals between 2015 and 2018 and conducted a 1-year follow-up. Patients and their caregivers were given the option to receive nonoperative management or surgery after being counseled using a decision aid. Nonoperative management was selected by 370 patients (35%), whereas 698 (65%) opted for urgent laparoscopic appendectomy (within 12 hours of admission). The nonoperative management group was more likely to be younger, non-Caucasian, have caregivers with more education, and had undergone a diagnostic ultrasound.

Important Findings

An initial nonoperative management strategy with antibiotics alone had a success rate of 67.1% for

patients who completed the study follow-up (Table). "When compared with urgent laparoscopic appendectomy, nonoperative management was associated with significantly fewer disability days when assessed at 30 days and at 1 year," Dr. Minneci says. "Furthermore, the rates of complicated appendicitis and healthcare satisfaction scores were not significantly different between treatment groups."

The data echoes findings from previous research demonstrating the efficacy and safety of nonoperative management for uncomplicated appendicitis in adults and children. The results can be used to further characterize differences in the risks and benefits of surgery and nonoperative management to treat uncomplicated pediatric appendicitis.

Key Implications

An important aspect of the study was to obtain input from a multidisciplinary team to design the study to mimic clinical practice and measure outcomes important to patients and families, according to Dr. Minneci. "During the study, each site used a decision aid to explain to patients the risks and benefits of each treatment," he says. "All treatment decisions after enrollment were made by the clinical team using standardized protocols for each treatment with minimal involvement of the research team. As such, our study protocol should be straightforward to implement, because the decision aid and treatment algorithms can be easily translated into pediatric clinical practice."

Collectively, the study results support offering nonoperative management as a treatment option for uncomplicated pediatric appendicitis. "Giving patients and caregivers a choice in treatment may improve satisfaction with care," says Dr. Minneci. "As we gain more experience, we may be able to expand the criteria for offering nonoperative management and consider outpatient nonoperative management protocols in the near future."

One way to increase the potential benefits of nonoperative management would be to decrease or eliminate the hospital stay by performing outpatient management with a long-acting antibiotic and short period of observation in the emergency department. "This approach has been successfully reported in adult patients and continues to be evaluated, but studies are needed to determine if this approach is safe and effective for children," Dr. Minneci says.



THE TALK: It's Time to Move from Curative to Palliative Care

Written by



Andrea J. Wilson
President & Founder
Blue Faery Liver Cancer Association



Matthew Loxton, MKM, CKM
Principal Analyst
Whitney, Bradley & Brown
Board of Directors
Blue Faery Liver Cancer Assoc.

During the 2019 Liver Meeting, the Blue Faery Liver Cancer Assoc team had the opportunity to discuss hepatocellular carcinoma (HCC) care approaches with many physicians, nurses, researchers, and patient advocates. Several physicians reported that they had not typically explained the difference between curative and palliative plans to their patients, and in many cases, had not discussed end-of-life planning.

For some clinicians, there may be significant reluctance to specifically articulate a dismal prognosis to terminal patients. While the sentiment

to protect a patient from alarm or despair may have benign roots, the lack of counseling about palliative options and lack of clarity as to prognosis can lead to ineffective end-of-life planning and worse patient outcomes.

A lack of effective and comprehensive end-of-life planning often results in unnecessary pain and discomfort, as well as unrealistic expectations that are detrimental to a patient's quality of life. Patients who are kept on curative plans that have no significant likelihood of success often have a lower quality of life due to painful, expensive, and intrusive tests, as well as the effects of surgery, radiology, or drug regimens that can result in missed opportunities to be with family and friends and to enjoy what finite time they have left.

Likewise, patients who are terminal but unaware of their prognosis may fail to wrap up their affairs and may not execute legal documentation. As a result, there may be confusion about their intentions, and the patient or their family members may agree to expensive, painful, and disruptive medical interventions that are futile. When adult patients don't leave clear care preferences in legally executable instructions, other adults—often their children—may disagree on what to do, resulting in worse quality of life for the patient.

Futile curative care robs the patient and their family and friends of quality of life that palliative care may have afforded or enhanced. Physicians should make end-of-life planning and clear articulation of the options for palliative care part of their standard operating procedures for patients who are terminal.

Addressing HF-Exacerbating Medications



Contributor
Parag Goyal, MD, MSc, FACC
Assistant Professor of Medicine
Advanced Heart Failure
Director, Heart Failure
with Preserved Ejection
Fraction Program
Weill Cornell Medicine

Evidence suggests that while significant focus has been placed on ensuring that patients with heart failure (HF) are prescribed medications like beta-blockers and other neurohormonal antagonists that have been shown to improve outcomes, little attention has been paid to discontinuing medications that can worsen HF. For a study published in *JACC: Heart Failure*, Parag Goyal, MD, MSc, FACC, and colleagues sought to better understand the prevalence of harmful medication use in the setting of HF-related hospitalization.

The study team examined a cohort of older adults hospitalized for HF from 380 unique hospitals across the United States, identifying medications taken at admission and prescribed at discharge, cross-referencing these lists with the 2016 American Heart Association (AHA) Scientific Statement on 70 medications that can exacerbate HF, and analyzing the data to determine predictors for harmful prescribing practice.

"Medications that can worsen HF are commonly used in older adults with HF," says Dr. Goyal. Indeed, the study showed that nearly half of patients hospitalized for HF were on HF-exacerbating medications at the time of hospital admission, with 18% experiencing a decrease in the number of these medications by hospital discharge, 19% remaining on the same number, and 12% experiencing an increase. Upon multivariable logistic regression analysis, diabetes (odds ratio [OR], 1.80) and small hospital size (OR, 1.93) were the strongest, independently associated determinants of harmful prescribing practices.

"Despite possibly contributing to the hospitalization, these potentially harmful medications are often continued even upon hospital discharge," adds Dr. Goyal. "When older adults with HF are hospitalized, it is critical to perform a thorough review of all medications and to consider eliminating medications that could possibly worsen HF. To achieve this, it is important to increase awareness about how common potentially harmful medication use is, and for physicians to become increasingly familiar with which medications may be harmful. It is equally important for clinicians to also incorporate their own judgement and patient preferences when deciding whether to discontinue a medication that may be harmful in HF, since many of the agents listed on the 2016 AHA Scientific Statement may be first-line treatments for common HF comorbidities, like diabetes and COPD."



Table Patient Primary Outcomes

The table below depicts unadjusted and adjusted primary outcomes in a comparison of a nonoperative approach vs surgery for uncomplicated appendicitis.

Primary outcomes at 1 year	Unadjusted			Adjusted ^a			P value ^c
	Non-operative	Surgery	Absolute difference (99% CI)	Non-operative	Surgery	Absolute difference (99% CI) ^b	
Success rate	66.2%	—	—	67.1%	—	—	0.86
Disability days ^d							
Mean	6.5	10.9	-4.44	6.6	10.9	-4.30	<0.001
Median	4.0	7.0	—	—	—	—	—

^a Inverse probability of treatment weighting analysis, adjusted for age, sex, site, race, ethnicity, insurance payor, patient transferred to recruiting institution, highest education level of primary caregiver, total household income, household income source from single or double income, primary language spoken at home, white blood cell count, ultrasound performed, CT scan performed, pain duration at presentation to the emergency department, nausea at presentation, emesis at presentation, diarrhea at presentation, fever at presentation, anorexia at presentation, time of day of presentation to the emergency department, and BMI percentile.
^b Per the study design, the 5% was split so that the primary outcomes were tested at a 4% level (2-sided, 2% 1-sided) for the success rate of nonoperative management and a 1% level (2-sided) for disability days. The reported 99% and 96% confidence intervals reflect this.
^c P value for success-rate outcomes are 1-sided against the null of 70%.
^d Defined as the total number of days patient or caregiver were not able to participate in normal activities secondary to appendicitis-related care (n = 284 nonoperative; n = 522 surgery).
Abbreviation: CI, confidence interval; IQR, interquartile range.

Source: Adapted from: Minneci PC, et al. *JAMA*. 2020;324(6):581-593.