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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 its 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.

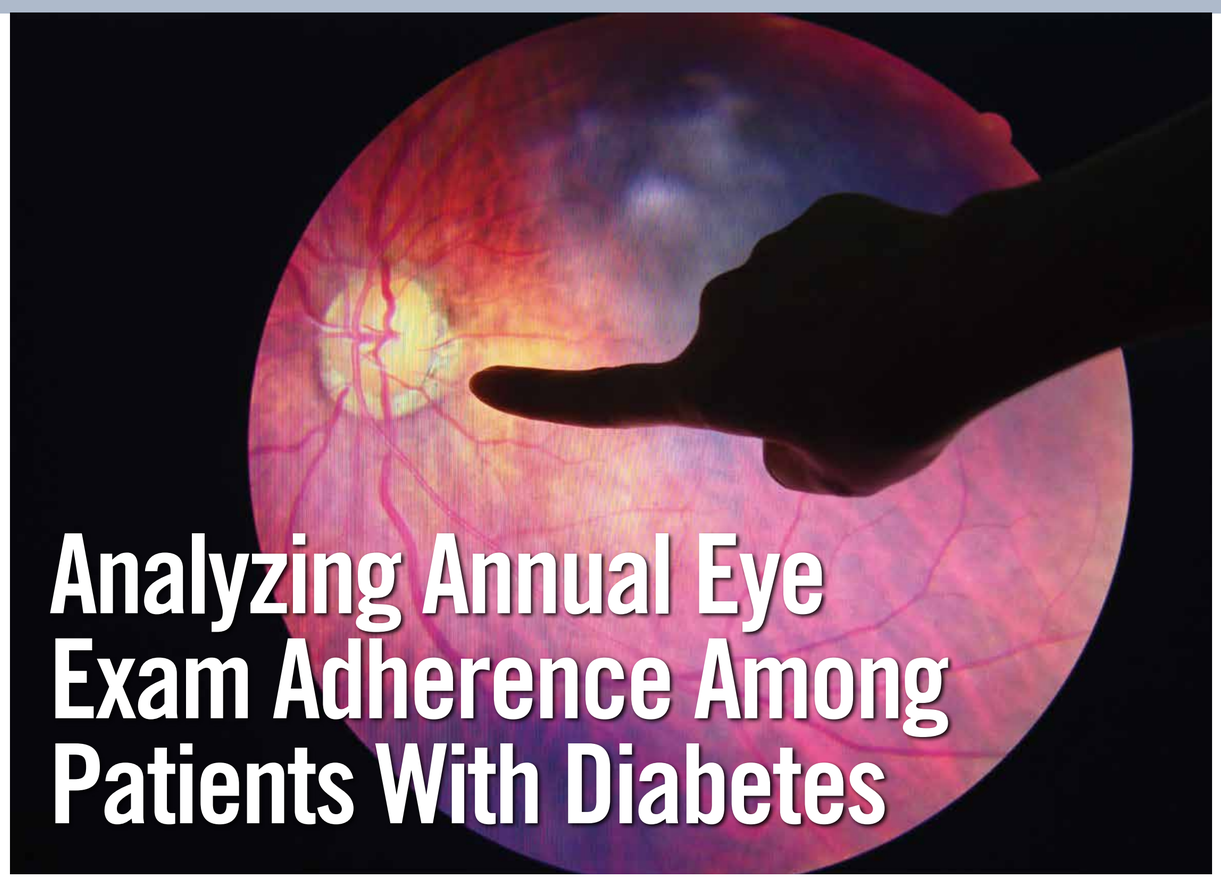
In some cases, the Standard of Care for the applicability of telemedicine is under the control of the payor. In most situations, it is the practitioner who will have to make the decision. In this regard, some threshold points should be considered:

- 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.



Analyzing Annual Eye Exam Adherence Among Patients With Diabetes

Written by
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Data indicate that diabetic retinopathy is the leading cause of new-onset, irreversible blindness in US adults younger than 75. Although screening is essential for early detection of diabetic retinopathy, and current treatments have been shown to be highly effective in preventing severe vision loss, evidence suggests that patient adherence to annual eye exams, as recommended by the American Academy of Ophthalmology (AAO), is poor. Prior studies, which have suggested adherence rates ranging from 23% to 65%, are limited to specific patient populations. For a study published in *Ophthalmology*, my colleagues and I were the first to examine adherence rates and how they differ by demographic using a nationally representative sample.

Data Analysis

The study was a cross-sectional secondary analysis using the National Health and Nutrition Examination Survey (NHANES) data from 2005 to 2016, which includes retinal photography. We selected participants aged 20 or older with a patient-reported diagnosis of diabetes, and we used univariate and multivariate logistic regression to determine characteristics associated with adherence to annual eye exams. Because NHANES uses a complex weighting scheme to produce estimates representative of the non-institutionalized civilian US population, our sample of 4,072 participants represents more than 20 million adults in the US with diabetes.

The total study population adherence rate for an annual eye exam was 63%. Although the proportion of participants with self-reported diabetes increased from 7.8% to 11.4% over the study period, there was no significant change in adherence rates, suggesting that a greater number of patients with diabetes did not receive annual eye exams. The populations least likely to have had an eye exam in the past year were younger, uninsured, low-income, and had a more recent diagnosis of diabetes. Individuals who denied receiving a diagnosis of diabetic retinopathy also had lower adherence rates. Insurance status carried the highest predictive value for adherence, with adherence among uninsured individuals found to be only 36%, compared with 76% for those with dual public-private insurance (Figure). These findings are likely unsurprising to most clinicians, as lack of health insurance is a well-known major barrier to all types of care, especially preventative medicine and screening.

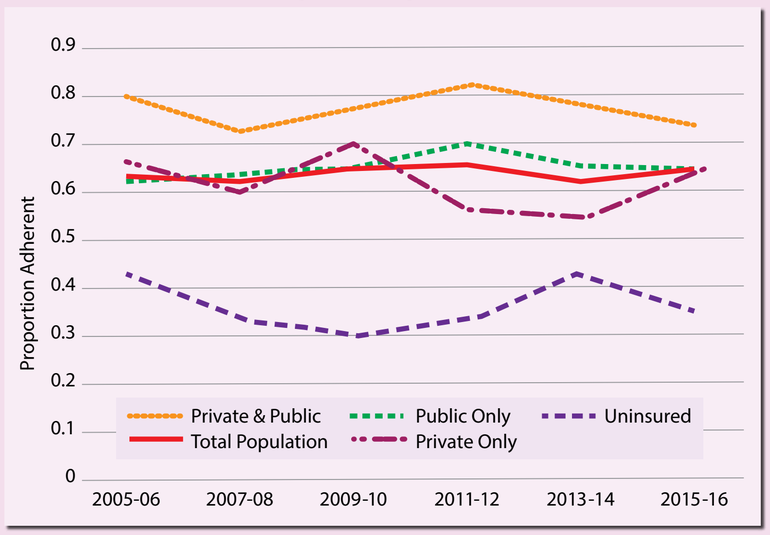
Education Needed

On the topic of diabetes education, participants had a poor understanding of whether they may have diabetic retinopathy. A surprising 70% of patients with evidence of retinopathy on exam denied having a diagnosis of retinopathy, and incorrect denials were twice as common as incorrect endorsements. Put plainly, most patients who had evidence of retinopathy on exam were unaware of their diagnosis. Interestingly, there was no significant association between correctly reporting one's retinopathy status and being adherent to the annual eye exam. Patients are evidently confused about diabetic eye disease screening, the diagnosis of retinopathy, and their own eye health. Every healthcare professional who interacts with such patients can play an integral role in helping their patients better understand their complex disease and empowering them to have an active role in preventing sequelae.

In addition to improved patient education, large-scale initiatives are likely required in order to improve adherence rates to annual eye exams among patients with diabetes. The implementation of retinal photography at primary care clinics, especially targeting vulnerable populations and those with the lowest adherence rates, may improve adherence by increasing accessibility and convenience, though further study is needed. With improved awareness of the patient populations that are at greatest risk of non-adherence to annual diabetic eye exams, providers and clinics can target certain patients who will benefit from additional support and education regarding diabetic retinopathy screening in order to reduce the burden of preventable blindness.

Figure Adherence to Screening Recommendations

The figure below depicts adherence rates (proportion) to American Academy of Ophthalmology annual diabetic retinopathy screening recommendations by health insurance for patients with diabetes in the US. From 2005 to 2016, there was no significant change in adherence.



Source: Adapted from: Eppley S, et al. *Ophthalmol.* 2019;126(11):1492-1499.

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To Wear a Mask Is to Be Brave. To Trust Your Doctors Is to Be Brave

By Abubakr Chaudhry, MD

The pandemic is a lie. I will not wear someone else's fear. This is all fake news. It is remarkable to see these statements littered across the news and social media. Individuals with a fairly decent level of understanding and intelligence pandering to these ideas just go to show how strong anti-science culture has become.

On January 19, the first American would test positive for the novel coronavirus. By early February, the hysteria would start to set in and social media would start increasing speculative reporting. By late February, the stress and arguments about who should take responsibility began to boil over. Then there was the increase in fear among healthcare exposure rates, conflicting case fatality reports, and frustrations with the CDC on the flip-flopping in guidelines.

We became tired of the complaining, fear, and misinformation, so we decided to pen a guideline for our hospital. Georgia went on lockdown April 3. Throughout March and April, the world seemed to trust us as the scientific community to lead them through this crisis.

By April, we saw our algorithms were working, and we had some of the best outcomes in the state. People were adhering to the guidelines by staying home. Businesses had shut down, the spread was contained, and we could see the light at the end of the proverbial tunnel. Then, on April 24—with 892 deaths and 22,147 infected in GA—the lockdown restrictions were eased in our state. We were one of the last to close but the first to reopen. We knew the world needed to open; we just didn't know our world would open like this. I remember wondering why we couldn't mandate masks, contact tracing, and social distancing when we reopened. The virus became political.

When I started writing this, I was upset at a social media comment I read from a friend that read, "This pandemic is a joke, I will not wear a mask because I will not wear their fear." Now, I see that he was afraid and uninformed. People, in general, are still afraid, if not of the virus, then of loneliness, poverty, or even subjugation. When people exhibit these fears, and if their voices are loud, the politicians must bend to their will. If our politicians are afraid and their voices alleviate our fears, then we bend to *their* will. My point is, it is OK to be afraid. I am a pulmonary and critical care doctor, my wife is a pediatric intensivist, we have a small child, and we are afraid. But to wear a mask is to be brave. To social distance is to be brave. To trust your doctors is to be brave. To those with doubts, know that you are correct in your feeling that the system is broken. I don't know how to fix it, but I know that it has to be done soon. Help us get through this so we can build a better world: a world built from understanding, not from fear.

Abubakr Chaudhry, MD is a pulmonary and critical care physician.

In Case You Missed It

Measures of Central Adiposity Linked to All-Cause Mortality

Several indices of central adiposity, including waist circumference and body adiposity index, are associated with an increased risk for all-cause mortality, according to a review published in *The BMJ*. Researchers conducted a systematic review and meta-analysis to quantify the association of indices of central obesity with the risk for all-cause mortality. Seventy-two prospective cohort studies with 2,528,297 participants were included in the final analyses. The summary hazard ratios were 1.11 for waist circumference (10-cm increase); 0.90 for hip circumference (10-cm increase); 0.82 for thigh circumference (5-cm increase); 1.20 for waist-to-hip ratio (0.1-unit increase); 1.24 for waist-to-height ratio (0.1-unit increase); 1.21 for waist-to-thigh ratio (0.1-unit increase); 1.17 for body adiposity index (10% increase); and 1.15 for A body shape (0.005-unit increase). After accounting for body mass index, the positive associations persisted. For men and women, a nearly J-shaped association was found between waist circumference and waist-to-height ratio and the risk for all-cause mortality. For waist-to-hip ratio and A body shape index, the association was positive monotonic. For body adiposity index, the association was U-shaped. "Our results suggest that measures of central adiposity could be used as a supplementary approach, in combination with body mass index, to determine the risk of premature death," the authors write.

Most People With SARS-CoV-2 Do Not Remain Asymptomatic

Most people infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) do not remain asymptomatic, and the secondary attack rate is lower among contacts of people with asymptomatic infection, according to a review published in *PLOS Medicine*. Investigators conducted a systematic review and meta-analysis to examine the occurrence and transmission potential of asymptomatic and presymptomatic SARS-CoV-2 infections. Data were included from 94 studies. The team found that 20% of people who became infected with SARS-CoV-2 remained asymptomatic throughout infection, with a prediction interval of 3% to 67% based on 79 studies; some evidence suggested that biases in participant selection influenced the estimate. Thirty-one percent remained asymptomatic in seven studies with defined populations screened for SARS-CoV-2 and followed. Due to heterogeneity, the proportion of people who were presymptomatic could not be summarized. In contacts of people with asymptomatic infection, the secondary attack rate was lower than among those with symptomatic infection (relative risk, 0.35; 95% confidence interval, 0.10 to 1.27). Based on modeling studies, the proportion of all SARS-CoV-2 infections resulting from transmission from presymptomatic individuals was higher than from asymptomatic individuals. "SARS-CoV-2 transmission from people who are either asymptomatic or presymptomatic has implications for prevention," the authors write. "Social distancing measures will need to be sustained at some level because droplet transmission from close contact with people with asymptomatic and presymptomatic infection occurs."