

**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.



## Exploring Monosensitization to Male Dogs



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With Can f 5—a protein expressed in the prostate of male dogs—as one of the several allergenic molecules making up dog dander, the theory arose that dog-allergic patients monosensitized to Can f 5 could tolerate female dogs, explains Ann-Marie Malby Schoos, MD, PhD. With confirmation of this theory in practice lacking, Dr. Schoos and colleagues conducted a double-blind, randomized clinical trial to investigate whether children monosensitized to Can f 5 show different reactions to provocation tests with male versus female dog dander.

### Testing Male- & Female-Specific Dog Dander

For the study, published in *The Journal of Allergy and Clinical Immunology: In Practice*, Dr. Schoos and colleagues enrolled patients aged 15-18 with a history of dog sensitization in the first-of-its-kind

study. Following assessment of skin-prick tests (SPTs), specific immunoglobulin E levels to dog dander (e5), and dog components Can f 1 (lipocalin), 2 (lipocalin), 3 (albumin), and 5 (arginine esterase, prostatic kallikrein), the study team performed SPT and conjunctival allergen provocation tests (CAPs) using dog dander collected separately from male and female golden retrievers according to standard extraction procedures for dander.

A dilution of the extracts was made to perform the SPTs with a concentration of 25 mg/mL. Histamine dihydrochloride (10 mg/mL) and physiological sodium chloride (9 mg/mL) were used as positive and negative controls, respectively. Double SPTs were performed on both volar forearms, including application of the positive and negative controls and the three extracts (dog, male dog, female dog), with the latter two blinded to both the investigator and patient through use of identical-looking bottles marked with a number on them. Final results used for analysis were an average of the two corresponding tests, with positive responses defined as greater than or equal to 2 mm than the negative control.

To perform the CAPs using the male and female dog extracts, Dr. Schoos and colleagues applied a droplet of extract with a concentration of 0.25 mg/mL, and every 15 minutes increased the concentration until a final concentration of 25 mg/mL or a positive response. During visits a minimum of 1 week apart, one eye was used as a control and installed with a drop of physiological sodium chloride (9 mg/mL). Positive responses were assessed with the Total Ocular Symptom Score, with evaluations of itchiness (0-4), redness (0-3), and tearing (0-3) and a total score of 4 considered a positive response.

### Dog Allergy Isn't So Simple

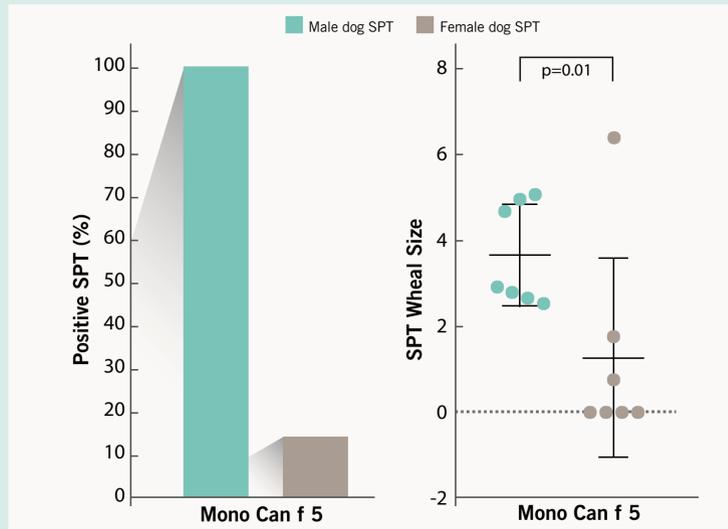
Among Can f 5 monosensitized participants, 100% had a positive SPT result to male dog extract, with an average wheal diameter to the male dog extract of 3.6 mm (Figure). Conversely, “none of the patients who were monosensitized to Can f 5 had a reaction to the female extract using the SPT,” explains Dr. Schoos, with an average wheal diameter to the female dog extract of 1.3 mm among these patients. One patient in this group who reacted to both extracts was found upon further testing to not be Can f 5 monosensitized. Among children with a mixed sensitization pattern, 62.5% responded positively to the male extract and 87.5% responded positively to the female extract. Respective average wheal diameters were 2.7 and 3.0 mm.

While none of the Can f 5 monosensitized participants had positive CAP test results to the female dog extract, most, but not all (71.4%) reacted to the male extract, “as we would expect,” says Dr. Schoos. “We found that the eye provocation test was a bit difficult to interpret.” No difference was observed between reactions to male and female dog extract provocation in children sensitized to a mix of the dog components.

“Dog allergy isn't so simple after all,” notes Dr. Schoos. “Many patients can actually tolerate female dogs, or neutered male dogs, which can often be verified in the patient's history if physicians ask questions regarding whether reactions are to only male dogs. If the patient also reacts around female dogs, there is no need to explore this any further.” With larger studies needed to confirm their results, blood tests being difficult to interpret, and the SPTs used in the study not available commercially, Dr. Schoos says the patient history is a good place to start.

**Figure Reactions to Male Vs Female Dog Extract**

The figure depicts a comparison between reactions to male dog skin-prick test (SPT) and female dog SPT allergen extracts. Mono Can f 5 refers to children who were monosensitized to Can f 5 of the dog components. The P value is from a t test.



Source: Adapted from: Schoos A, et al. *J Allergy Clin Immunol Pract.* 2020;8(5):1592-1597.

MEDPAGE TODAY'S

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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



### Gestational Weight Gain Tied to Childhood Allergic Conditions

Excessive gestational weight gain (GWG) may be a risk factor for childhood allergic diseases, according to a study published in *JAMA Network Open*. Researchers examined the association of maternal prepregnancy body mass index and GWG with the risk for childhood allergic diseases (asthma or wheezing, allergic rhinitis, eczema, and food or drug allergy) among 15,145 mother-child pairs. Excessive GWG was associated with higher risks for asthma/wheezing (19%), allergic rhinitis (11%), and eczema (10%) in children. In women who were overweight/obese before pregnancy, GWG extremely above the Institute of Medicine (IOM) guideline was associated with the highest risk for childhood asthma/wheezing (adjusted prevalence ratio [aPR], 1.42), allergic rhinitis (aPR, 1.32), and eczema (aPR, 1.24). Among mothers with normal prepregnancy weight, GWG below the IOM guideline was associated with a lower risk for childhood asthma/wheezing (13%), allergic rhinitis (11%), eczema (14%), and food/drug allergy (15%). Findings were similar for underweight mothers. “In view of the high prevalence of childhood allergic diseases and their effect on the health of children, it is recommended that women maintain appropriate weight before pregnancy and prevent excessive GWG as potential prevention measures for allergic diseases in their children,” the authors write.

### Inflammatory Bowel Disease Tied to Subsequent Rhinosinusitis

Personal history of inflammatory bowel disease (IBD) is associated with an increased risk for subsequent chronic rhinosinusitis (CRS), according to a study published in *Clinical Otolaryngology*. Investigators examined IBD and subsequent risk for CRS in a nationwide setting using data from the National Health Insurance Dataset of Taiwan with 8,313 patients older than 20 with IBD. A comparison group of 33,252 cases without IBD was randomly extracted, matching patients by age, sex, and index year. The researchers identified 521 (1.25%) cases of IBD in 295,007 person-years. The risk for developing CRS was increased 1.26-fold for the IBD group versus the comparison group; risks were 1.73- and 1.20-fold higher for ulcerative colitis and Crohn disease, respectively. In an analysis stratified by age, the risk was highest among IBD patients aged 50 to 64 (adjusted hazard ratio, 1.37). The risk seemed to be highest with a follow-up duration of less than two years in a follow-up-specific analysis. “Physicians should be aware that patients with IBD, especially the phenotype ulcerative colitis, had an increased risk of developing CRS throughout,” the authors write. “Careful identification of the sinus symptoms of IBD is necessary for the early diagnosis of CRS while primary disease and other associated comorbidities are treated.”

