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Malpractice Case Study - Teleoncology

Major Academic Medical Center (MAMC) in Grandville, Kansas offers teleoncology consultation services to patients in rural Oklahoma via a network of a dozen remote consultation sites. MAMC offers regularly scheduled teleoncology sessions and “as needed” consultations if necessary. Patients are referred to MAMC’s remote sites via their local attending physicians. Consultations take place using videoconferencing equipment that connects the remote site to MAMC via a T1 network connection leased from the local telecom company. The videoconferencing equipment is connected to the emergency generators at both the remote site and MAMC (to protect against power failures at either end) but there is no alternative T1 connection available in the remote site in the event of the telecom line going down.

Prior to the initial teleoncology consultation, the attending physician transfers all pertinent information, including letters and hospital discharge summaries, and laboratory, radiography and pathology reports to MAMC. These are reviewed by the consulting oncologist who will conduct the teleoncology session. A nurse employed by MAMC but located at the remote site and/or the attending physician attends the remote teleoncology sessions with the patient. The decision of who will be present with the patient at the session is made by the attending physician.

Upon the patient’s arrival at the remote consultation site, the MAMC nurse introduces the patient to the system and asks the patient to sign a comprehensive informed consent agreement. The patient is then seated in a telemedicine examination room in front of a large television monitor. Above the monitor is a television camera that is remotely operated by the consulting physician. At the outset of the consultation, the consulting physician takes a medical history. If and when required, the consulting physician conducts a physical examination with the local nurse or attending physician serving as a proxy examiner. A specially adapted electronic stethoscope is used to transmit respiratory and cardiac sounds over the network. The camera can be positioned to evaluate the patient’s gait and any signs of abnormal movements, such as tics or tremors. In addition, the camera lens can be focused from a distance to assess high quality detail of the patient’s appearance, such as skin condition (i.e. petechiae). The camera can also be attached to basic bedside instruments, such as an otoscope or ophthalmoscope, so that the consulting physician can evaluate the patient’s ears, eyes, nose, and throat from the remote location. Questions and concerns are elicited from both the patient and local nurse or physician at this time. Appropriate diagnostic studies and therapeutic interventions are discussed with the remote consultant, but all prescriptions for medication and diagnostic tests are written by the local providers.

A patient, Kay, lives in rural Oklahoma. She was diagnosed by her attending physician, Dr. Local, with lung cancer and, upon Dr. Local’s recommendation, has been participating in

MAMC's remote teleoncology clinic in Kay's hometown. Kay's consulting oncologist at MAMC is Dr. Grand. After the initial consultation and review of the labs and radiologic studies that have been done to date, Dr. Grand prescribed a course of chemotherapy to Kay and has asked to see Kay at three-week intervals.

Three months into her chemotherapy, Kay calls Dr. Local to report that she is feeling more fatigued and sicker than she has felt since starting treatment. She has also lost a significant amount of weight. He tells her to schedule a special remote session to discuss her symptoms with Dr. Grand. Kay schedules a special session but misses it because of a family emergency. Neither Kay nor MAMC inform Dr. Local that Kay missed the special session and Dr. Local does not follow up to check if she made the special appointment. At her next regularly scheduled teleoncology session, Kay is accompanied by a nurse from Dr. Local's office because the MAMC's nurse is on leave. This nurse has 10 years experience working with cancer patients but no training in teleoncology. Kay tells Dr. Grand about her symptoms. Dr. Grand asks the nurse who is accompanying Kay to examine the patient for signs of lymphadenopathy and to specifically to palpate the patient's abdomen for any signs of hepatomegaly (enlargement of the liver). During the examination, the internet connection is lost and videoconferencing is no longer possible. Dr. Grand and the nurse complete the consultation via cell phone. No lymphadenopathy or hepatomegaly was reported. Dr. Grand does not get to "see" the patient since the video feed is lost. At the end of the consultation, Dr. Grand makes some changes to Kay's chemotherapy regime and says he will discuss her progress at their next consultation in three weeks (noting that Kay should call the remote center or her attending physician if she experiences any distress in the meantime).

Two weeks after this consultation, Kay is found at home unconscious by her husband and is brought by ambulance to a local hospital and subsequently transferred to MAMC via helicopter. At MAMC, she is examined by Dr. Grand. After examining the patient himself for the first time and ordering the appropriate labs and studies, Dr. Grand diagnoses the patient with lung cancer that has now metastasized to the liver. Additionally, Kay is diagnosed with pneumonia and sepsis, resulting in multiple organ failure. Despite aggressive treatment in the ICU and being placed on a respirator, Kay dies a few days later.

Assuming something could and should have been done differently that would have saved Kay – this situation could lead to claims of malpractice.

Consider the above facts as a backdrop to the questions below:

1. Can Kay's estate sue Dr. Grand in Kay's home state? Whose law regarding standard of care applies?
2. With which of the providers has Kay formed a provider-patient relationship that might be the basis of a malpractice suit?
3. Who (including MAMC) is liable for an inaccurate diagnosis or inappropriate treatment? Is the standard of care the same for an in-person oncology consultation vs. a teleoncology consultation? Would it be helpful to establish telemedicine practice guidelines to help define/set the standard of care in a telemedicine consultation?

4. Are the requirements for informed consent different with telemedicine? What additional or different information, if any, should patients have for a telemedicine consult, and who should make that determination? Does a patient have to be informed that the provider might be out of state? If so, why?
5. Are a patient's responsibilities vis-à-vis their own treatment the same with in-person oncology treatment vs. teleoncology treatment for purposes of contributory negligence?
6. Does telemedicine present unique challenges for malpractice insurers?
7. If fear of liability inhibits arrangements such as the MAMC teleoncology clinic – what regulatory or legislative actions can be taken to handle this risk? Is this an area where a no-fault compensation fund might be appropriate?
8. If telemedicine becomes the standard of care in a rural area such as Kay's is a local physician negligent for not recommending it?
9. Who, if anyone, is responsible for the failure of the equipment or internet connection? Can any steps be taken to minimize risks and responsibilities for communications failures – such as prohibiting telemedicine consultations when a communication failure could lead to serious injury or death? What degree of internet availability should be required for telemedicine and who should make that determination? Does it depend on the type of telemedicine service being offered – i.e. a higher degree of availability for telesurgery vs. teleradiology?

Prior to the roundtable, we would appreciate it if you would jot down your reactions to some or all of these questions. Please limit your comments to 3-5 pages.