

Potential Liability in E-Health

March 12, 2008

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Document Status:

- | | |
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| <input type="checkbox"/> Published Paper | <input type="checkbox"/> Practitioner's Pointers |
| <input type="checkbox"/> Working Paper | <input type="checkbox"/> Briefing Note |
| <input type="checkbox"/> Report | <input type="checkbox"/> Research Tool |
| <input type="checkbox"/> Draft | <input type="checkbox"/> Overview |
| <input type="checkbox"/> Presentation | <input checked="" type="checkbox"/> Review |

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Potential Liability in E-Health

(This review does not constitute legal advice.)

This review concerns possible areas of liability for the delivery of health care at a distance. We shall assume that there are at least two practitioners involved – one at the local site who has direct contact with the patient and one at a distance who does not have direct contact. We do not here address liability for health information for websites or for cybermedicine where there is no local physician and diagnoses are made over websites or via email.

In order to find that negligence has occurred, the law requires that the following conditions be established:

1. **Duty of Care:** Does the healthcare provider owe a duty to the patient? Generally this is established by showing that a doctor-patient relationship exists between the parties. Physicians owe a duty to their patients to act within the standard of care.
2. **Standard of Care:** Generally, in order to meet the standard of care, a physician has to show that they provided the level of care that a reasonable and prudent healthcare provider would provide in similar circumstances.
3. **Causation:** The plaintiff must show a connection between the healthcare provider's failure to meet the expected standard of care and the injury. That is, the plaintiff must show that a breach of the standard of care caused the injury.
4. **Harm:** The plaintiff must show that the injuries have caused losses for which they ought to be compensated.

The two conditions that I shall focus on are duty and standard of care and I shall discuss how technology can have problematised these two concepts with respect to healthcare providers providing care to patients at a distance.

Duty of Care

Physicians and their patients are generally considered to have entered into a therapeutic relationship where the physician has agreed to use their skill and training to the best of their ability to attend to the patient's needs. Whether a duty of care exists between parties is determined as a matter of law by looking at whether there is sufficient proximity between the parties and whether it is foreseeable failure to meet the standard of care on the part of the doctor will have consequences for the patient. For the most part, establishing whether a duty of care exists between a physician and a patient is fairly easy; has the physician agreed to accept the person as their patient, has the physician examined the patient and rendered a diagnosis?

Scenario 1: A patient goes to their GP with a medical difficulty. The GP is stumped and seeks a consultation with a reputable specialist located in the same city. The health records are forwarded to the specialist who reviews the records and examines the patient. The specialist misses an obvious sign of a potentially fatal condition. Harmful consequences result to the patient. What liability issues arise?

In this case, it is clear that both the GP and the specialist owe the patient a duty of care as they have both entered into a therapeutic relationship with the patient; both have examine the patient, reviewed their records, and intend on treating the patient.

There have been no telemedicine malpractice cases in either the US or in Canada. Commentators speculating about how the situation would be analyzed by a court have relied on an analogy from telephone consultation cases.

Scenario 2: A patient goes to a GP with a medical difficulty. The GP seeks a consultation with a reputable specialist located in another city. The GP phones up the consultant and relates the issues regarding the patient. The consultant asks questions and offers suggestions to the GP. The GP does a bit more research following on what the consultant has said. A misfortune occurs and the patient is left in a bad way.

The courts in the United States have been reluctant to impose liability on consultants in circumstances like these. In *Lopez v. Aziz*,¹ a consulting obstetrician had a telephone conversation with a patient's physician but never reviewed the chart or examine the patient. The court refused to attach any liability to the consultant.

In the US, various factors arising out of telephone consultations have been identified to determine whether a duty of care is owed:

1. Whether the consulting physician and patient ever saw each other;

¹ *Lopez v. Aziz*, 852 S.W. 2d 303 (Tex. App. 1993)

2. Whether the consultant ever examined the patient;
3. Whether the consultant viewed the patient's records;
4. Whether the consultant knew the patient's name; and
5. Whether the consultation was gratuitous or for a fee.²

Another factor that has been identified that may impose a duty on the consultant is the degree of control they exercised over the patient. If the consultant is merely providing advice to the GP who makes the final decision regarding treatment, then it can be argued that the consultant has not assumed responsibility for the patient and has not overseen treatment. If the consultant, however, exercises a greater degree of control, by ongoing contact with the GP for example, then a doctor-patient relationship may be found and liability may follow. Generally, however, when communication remains between physicians and the patient remains anonymous, a doctor-patient relationship between the consultant and the patient does not emerge.

A recent Canadian case, however, demonstrates a greater willingness to impose a duty of care for the advice provide even on the telephone. In a recent Ontario case, a defendant physician allegedly had a conversation with a Dr. Gillieson regarding treatment of a pregnant woman with diabetes. The defendant did not consider the discussion with Gillieson to be a consultation but, rather, something more akin to a hallway conversation. While the court found as a fact that the conversation did not take place, the court commented on the duty of those who provide advice even in less formal circumstances:

² *Clarke v. Hoek*, 219 Cal. Rpt. 845, 851-52 (Ct. App. 1985)

It is the position of the Defendants that the alleged contact between Drs. Penney and Gillieson was what is known as a "hallway conversation" or "corridor consult" and that such a conversation, even if an opinion is expressed and relied on, does not give rise to a duty of care for the person or persons whose care is being discussed. Notwithstanding that I am not required to rule on this question, in the circumstances of this case, had I concluded that a conversation did, in fact, take place and had I concluded that the advice given by Dr. Gillieson was negligent, in the absence of a clear disclaimer, I would have had no difficulty in concluding that a physician owes a duty to provide advice that meets the relevant standard of care and that a duty of care does, indeed, exist. In other words, I have serious doubts that there is, as the Defendants argue, a class of consultation known as a "hallway conversation" or a "corridor consult" attached to which there is no duty of care in favour of the patient for whom the advice or opinion is sought. I do not agree with the proposition of law to the contrary in *Reynolds v. Decatur Memorial*, 277 Ill. App. (3d) 80 (1996), 660 N.E. (2d) 235 (1996) or with the other American cases relied on by the Defendants.³

Whether this view will prevail in Canada is not assured. This seems an overly broad application of a duty of care. In this case, the mere giving of advice was sufficient for the court to impose the duty.

The Defendants submit that a physician's duty to exercise care with respect to a particular patient arises only in the context of a physician-patient relationship a relationship characterized by the physician agreeing to treat the patient. In my opinion, the Defendants' position is too narrow. I agree that a finding of negligence cannot exist absent a duty of care; however, a duty of care can arise in circumstances beyond the strict physician/patient relationship. If Dr. Gillieson was consulted by Dr. Penney for an opinion, he, Dr. Gillieson, was aware that Dr. Penney would consider and probably rely on that opinion. Therefore, had he been consulted, Dr. Gillieson would have known that any advice he gave would have an impact on the treatment that would be provided to the patient. Therefore, he would have been aware that there was a proximate relationship between him and the patient.

In this respect, physicians are no different, in my opinion, than other professionals, with respect to their possible liability to third parties. In this regard I rely on the comments of Picard and Robertson, *supra*, where the following appears at pp. 182-83:

The examples discussed above involve situations in which it is reasonably well established that a doctor owes a duty to a third party. In other

³ *Crawford (Litigation Guardian of) v. Penney*, [2003] O.J. No. 89.

situations, when deciding whether such a duty existed, the court would be guided by general principles of tort law, and in particular, the requirement of proximity. If it is reasonably foreseeable that negligence by the doctor may cause harm to a third party (whether identifiable or not), and if there is sufficient proximity between the doctor and the third party, a duty of care will arise (unless there are reasons of policy which dictate otherwise), and breach of that duty will result in the doctor being liable to the third party. (at para 255-56)

Since the court did not find that the conversation took place and thus absolved Gillieson of any wrongdoing, whether this broad an application of the duty of care could stand further judicial scrutiny is unknown. Obviously, practitioner should not give advice recklessly but there may be policy reasons to not extend the application of the duty. In the American case of *Lopez*, the court remarked that “To expose physicians...to liability for simply conferring with a colleague would be detrimental in the long run to those seeking competent medical attention and is contrary to the public policy of this state” (at 307).

What is clear is that the facts of the case will determine whether a duty of care exists between a patient and as consultant.

Scenario 3: A patient goes to their GP with a medical difficulty. The GP seeks a consultation with a reputable specialist located in another city. The doctor, using the clinic’s computer system and programs, electronically transmits the patient’s relevant health information to the specialist. The specialist downloads and analyses the information on another computer program purchased by the hospital from which she operates. The specialist never examines the patient herself but makes recommendations. The GP reviews the specialist’s recommendations and

follows the specialist recommended course of treatment that turns out to have harmful consequences for the patient.

In this case, it is possible that a duty of care will attach to the consultant. They now have established a greater proximity to the patient and the foreseeability criterion has been strengthened by the consultant's direct knowledge of the patient's medical history. Nonetheless, the question of control over the patient's course of treatment will still be an important question in establishing liability.

Scenario 4: As above except that the consultant is connected via video teleconferencing technology to the patient. They ask the patient questions and essentially conduct an examination to the extent that the technology permits.

In this case, it is likely that a duty of care will attach to the consultant. Indeed, the technology has closed the distance gap so that in many respects, this kind of doctor patient interaction more closely resembles a traditional visit to a specialist. The significant difference is, of course, the inability of the consultant to physically examine the patient but that speaks more to the standard of care than to whether a therapeutic relationship will be found.

Institutional Duty of Care

The use of technology in this case has also widened the parties that now owe the patient a duty of care that goes beyond the duty imposed in a doctor-patient relationship. Medical

institutions have a duty to provide and maintain equipment adequate to the services being performed there (Picard at 379). The GP used the computer apparatus at the clinic and the consultant used the computer system at the hospital. This fact implicates both the clinic and the hospital as parties that owe the patient a duty of care for, if the technology fails in some way that causes injury to the patient, the possibility of harm is foreseeable.

As well, health information managers, clinical data specialists, document managers and data security officers who interact with and maintain the system could face liability for any medical misadventure attributable to technological malfunction. Of concern to clinics and hospitals, is that failures on the part of information specialists, could reflect adversely on the institutions that employ or contract with them due to the principle of vicarious liability. Casting the net even wider another possible party would be the network that transmits the information. As an Australian report put the problem:

The involvement of external parties in the creation of the technical infrastructure which facilitates the clinical interaction can complicate duty of care analysis in numerous ways; increasing the number of potential defendants; generating new forms of claims, such as “transmission malpractice”; and leading to increased reliance upon and scrutiny of the relevant contractual arrangements between external suppliers/consultants and the healthcare institution.⁴

Standard of Care

⁴ Report for the Department of Human Services (State of Victoria), *Telemedicine: Creating Virtual Certainty out of Remote Possibilities* (available at <http://www.dhs.vic.gov/ahs/archive/telemed/5.htm>)

Generally

Once a duty of care is established, the attention then shifts to whether the standard of care has been met. The standard required is not perfection. Mistakes are allowed to happen so long as the mistakes are reasonable. Whether a mistake is reasonable in the circumstances is a question of fact which courts decide based on expert evidence. The courts rely on experts to inform them of the expected standard of care and whether the testimony as to what the standard of care is and what is understood to be appropriate treatment.

The accepted legal principle for the appropriate standard of care to be exercised by a physician comes from *Crits v. Sylvester*:

The legal principles involved are plain enough but it is not always easy to apply them to the particular circumstances. Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required than of one who does not profess to be so qualified by special training and ability.⁵

It is also established that the greater the degree of risk of a procedure, the greater the standard of care. As Picard and Robertson state:

The standard of care is influenced by the foreseeable risk. As the degree of risk involved in a certain treatment or procedure increases, so rises the standard of care expected of the doctor. The principle was expressed succinctly in one case as follows: the "degree of care required by the law is care commensurate with the

⁵ *Crits v. Sylvester*, [1956] O.R. 132 at 143 (C.A.).

potential danger."⁶

The standard of care imposes certain duties on a practitioner. While not an exhaustive list, amongst these duties are the following:

1. The duty to be competent (which includes the duty to keep up one's knowledge and skills);

2. The duty to diagnose. Picard and Robertson explain this duty:

The duty to diagnose requires doctors to take a full history, use appropriate tests and consult or refer if necessary. They must take reasonable care to detect signs and symptoms and formulate a diagnosis using good judgment. They cannot act only on what they are told, nor ignore what they are told. Sophisticated tests and continuing knowledge of disease must be employed when appropriate. (at 245)

3. The duty to refer when the doctor is unable to properly treat the patient; and

4. The duty to inform the patient of all material risks.

It is unclear exactly how technological applications will affect the standard of care analysis but it seems clear that technology could affect the duties just enumerated. It may be that very soon the duty to be competent may require practitioners to become proficient in telehealth technologies. How will the ability of practitioners to "examine" a patient at a distance alter the requirements for the duty to diagnose? Will there be an increased expectation that practitioners will refer now that referrals can be made more expeditiously? What aspects of the technology will have to be explained to the patient in order for health care providers to meet the duty to inform the patient?

At this point a consensus has not yet developed to establish clear standards and it is unclear how far the established standards can guide practitioners in newer areas. Some

⁶ E. I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 2nd ed. (Scarborough: Carswell, 1996) at 193.

professional organizations are developing standards and guidelines to guide their members. In Manitoba, for example, the College of Physicians and Surgeons have issued guidelines for the provision of telemedicine services. There it states: “The College of Physicians and Surgeons Manitoba expects a physician who provides telemedicine services to have the same standards of practice as a physician who sees patients directly.”⁷ The guideline attempts to set out a standard of care for doctors in Manitoba by imposing duties on them. Two, in particular, are interesting. The first appears to impose a new duty on Manitoba doctors:

Awareness of the Telemedicine Treatment Option: Physicians treating remote or mobility-limited patients must be aware of the telemedicine treatment option and its potential application to their patients.

Arguably, the wording of this provision is broad and suggest that the duty to consider telemedicine falls on all physicians including those who do not currently practice in that manner.

Adequate Equipment: Any physician delivering treatment or gathering information through electronic means should take reasonable steps:

- to ensure the hardware and software being relied upon is functioning properly, including ensuring that:
- any support staff involved in operating the equipment are adequately trained and competent to use the equipment, and
- equipment is up to date and reliable.
- in the case of computer equipment, to ensure that the possibility of computer viruses and malfunctions is kept to a minimum.
- in the case of an urgent medical or surgical procedure being conducted by a telemedicine process, to ensure a backup system is in place to protect the patient in the event of an equipment malfunction.
- where the patient controls some component of the equipment used in the telemedicine intervention, such as a computer or monitoring device, to ensure that:
- the patient understands the importance of that equipment to the process, and

⁷ College of Physicians and Surgeons of Manitoba, Guidelines and Statements: Telemedicine, 2002.

- the patient is competent to handle it properly and to advise the appropriate person or facility in the event of a malfunction or an inability to operate it.

Where a physician participates in a telemedicine process as part of a team or for a specific health care facility, it is the physician's responsibility to determine who will be responsible for the technical aspects of the telemedicine intervention.