MEDICAL MALPRACTICE IN THE 21ST CENTURY:
LEGAL IMPLICATIONS OF TELEMEDICINE

Stan Thiebaud
Mike Yanof
Stinnett Thiebaud & Remington
4800 Fountain Place
1445 Ross Avenue
Dallas, Texas 75202
(214) 954-2200
(214) 754-0999 (fax)

ADVANCED MEDICAL MALPRACTICE 2001
March 15 & 16, 2001
Santa Fe, New Mexico

Chapter 3
# Table of Contents

I. INTRODUCTION .................................................................................................................. 1  
   A. Scope of Article.............................................................................................................. 1  
   B. The Evolution of Telemedicine .................................................................................. 1  

II. The Empowered Patient .................................................................................................... 2  
   A. Altered Roles ................................................................................................................ 2  
   B. Lack of Regulation ...................................................................................................... 3  

III. PROVIDER WEB SITES .................................................................................................. 4  
   A. “Ask the Doctor” Websites ....................................................................................... 4  
   B. Prescriptions over the Internet .................................................................................. 7  
      1. Filling an already ordered prescription ................................................................. 7  
      2. Doctors ordering medications ............................................................................... 7  
      3. Ordering drugs without a prescription .................................................................... 8  

IV. ELECTRONIC CHART ..................................................................................................... 8  
   A. Reluctance to Fully Embrace ..................................................................................... 8  
   B. Potential for Abuse .................................................................................................... 9  
      1. Alteration of electronic charts ............................................................................. 9  
      2. Use of medical records in litigation ..................................................................... 10  

V. CONCLUSION ....................................................................................................................... 10
MEDICAL MALPRACTICE IN THE 21ST CENTURY: LEGAL IMPLICATIONS OF TELEMEDICINE

I. INTRODUCTION
   With the age of the computer and Internet in full swing, the question regarding telemedicine is no longer when it will arrive, but rather what ways it already has – and will – change the practice of medicine in the future. It obviously creates tremendous potential for benefits, including utilizing the best technology in areas once impossible to reach, long-term financial savings for health care providers and patients alike, and a patient’s ability to obtain information which in the past was impossible or at a minimum was extremely inconvenient. But with these benefits, tremendous risks exist which have resulted in the public’s and even the medical community’s reluctance to always embrace all aspects of telemedicine. It also creates the potential for numerous legal implications never before seen.

A. Scope of Article
   It is not the purpose of this article to weigh the benefits and risks of telemedicine and make a recommendation as to whether telemedicine should be embraced. First, it is a foregone conclusion that telemedicine is changing – and will continue to change – the practice of medicine. Second, it is difficult to argue that the risks outweigh the benefits for at least some aspects of telemedicine, as they would provide opportunities for improving medical care and saving lives in areas of the United States and the world that traditional health care could not always reach.

   Rather than discuss whether it is a good idea, this paper focuses on some issues that may be faced by health care providers in the practice of medicine while utilizing telemedicine and attorneys in the context of handling medical malpractice cases. The liability issues are almost endless, but certain situations either have already occurred or appear likely in the future. Unfortunately, however, the issues have not yet evolved to the point where clear guidance has been given by legislatures or courts to attempt resolving the issues. Therefore, this article, while generally not able to provide clear answers as to how these issues have been resolved, also attempts to discuss these possible implications in light of existing case and statutory law in Texas.

B. The Evolution of Telemedicine
   Physicians, hospitals and medical schools have been exploring the uses of telemedicine for decades. It did not gain significant momentum and public attention, however, until the 1990s. In 1991, a report was published by a task force of the Institute of Medicine (“IOM”) of the National Academy of Science discussing the shortcomings of paper-based medical records. See AMA, "Electronic Medical Systems" (undated) at 1. This report recommended a movement towards electronic records and laid the framework for a published paper entitled “The Computer-based Patient Record: An Essential Technology for Health Care”, which has in large part fueled the movement towards electronic medical records. Id.

   While electronic records are the most publicly debated topic on telemedicine, it is only a small aspect of it. As long as the Internet has been commonly used, telemedicine has been present by marketing and advertising of drugs, medical products and services. More recently, services are actually provided over the Internet through various websites ranging from “ask the doctor” to websites wherein a prescription may be obtained from a physician without any face-to-face or office contact.

   Additionally, the medical community, as with any other industry, has utilized e-mail communication for years. From obtaining consultations to providing diagnoses, some doctors and hospitals have long utilized e-mail as a method to quickly communicate with other doctors and patients. While these communications broaden the potential

---

1 The American Medical Association (“AMA”) generally defines “telemedicine” as “the provision of health care consultation and education using telecommunication networks to communicate information. See AMA, “Electronic Medical Systems” (undated) at 1.
geographic range of a physician's contact with patients, it also creates the potential for new legal implications. While telemedicine has quickly evolved in recent years, it has not evolved to the point where definitive answers exist as to these potential legal implications.

II. THE EMPOWERED PATIENT

The development of computer technology and widespread use of the Internet has provided patients increased power to obtain information that at one time was generally obtained only through physicians. This does not even include the potential now and in the future for a patient to review his or her medical records over the Internet, a topic discussed later in this paper.

For example, a patient may obtain information about a prescription drug that a friend has indicated may be beneficial for a particular problem. A patient also may research alternative forms of treatment for illnesses which may not even be offered by his or her treating physicians.

A. Altered Roles

This ability to obtain information and services has the potential to alter the roles of physicians, patients, and manufacturers. Traditionally, the manufacturer’s role might include research of a drug or product, obtaining approval from the Federal Drug Administration, and marketing of the drug or product to health care providers through representatives. The doctor generally would then decide whether to utilize the drug or product and offer it to patients when warranted. The patient, in turn, would generally defer to the physician and/or discuss the drug or product with the physician before making a decision with the physician to take the drug or use the product.

Should litigation result from an adverse result after use of a drug, a plaintiff generally might sue the physician and manufacturer. Traditionally, the manufacturer would assert the learned intermediary doctrine as a defense. The learned intermediary doctrine is premised upon a patient relying on the physician to weigh the benefits of the drug or product against the harm imposed and, based on weighing the potential benefits against the harm, determine whether the patient is a candidate for the drug or product. See Bean v. Baxter Healthcare Corp., 965 S.W.2d 656, 663 (Tex. App. – Houston [14th Dist.] 1998, no pet.). It presumably is further premised upon the manufacturer’s inability to relay information to the patient. See id.

But what if the manufacturer has in fact relayed information to the patient through advertising. The patient has in turn relied on this information, which may include explaining the drugs indications and contra-indications, in deciding that he or she may benefit from the drug. The patient could even examine the PDR on a drug and review other information regarding the drug on the Internet, with no guarantee that this information is related to the manufacturer's website. This scenario certainly could have occurred long before widespread use of the Internet through television and billboard advertising. But the Internet has the potential to disseminate much more information to a targeted audience who may be seeking particular treatments for particular conditions.

The physician certainly bears responsibility to act reasonably should a patient who has obtained information regarding a drug or product over the Internet visit the physician. The unsettled issue, however, is whether the learned intermediary doctrine applies in these situations. Particularly when the manufacturer has already in essence marketed the benefits and risks to the patient through the Internet before the physician ever recommended the drug or product, questions could arise as to the applicability of the learned intermediary doctrine.

At a minimum, the Internet and scenarios like the above-noted create the potential to erode the learned intermediary doctrine over time because manufacturers are taking a more active role in marketing drugs and products directly to the public. This more active role in turn may result in patients going to doctors and “self-prescribing” drugs which the manufacturer has already marketed as indicated for what the patient views to be his or her condition. Manufacturers certainly will argue that the physician, regardless of the information available, remains in the best position to determine the individual needs of each particular patient and determine whether the drug or
product is indicated. When the patient, however, has already reviewed information regarding the drug and has determined in reliance on representations by the manufacturer that he or she believes that the drug is indicated, the critical information traditionally relayed and contemplated by the doctor may have already been relayed by the manufacturer. Therefore, while the Internet may not result in the immediate demise of the learned intermediary doctrine, it certainly creates the potential for creative arguments by counsel for physicians and plaintiffs as against manufacturers raising this defense in certain cases.

B. Lack of Regulation

Patients obtaining information regarding drugs and medical products on the Internet also creates the potential for other problems not traditionally faced in medicine. To date information on web sites is not monitored by any medical regulatory agency. Accordingly, it is oftentimes difficult to determine which sites addressing a drug are “official” sites (i.e. from the PDR) versus other “non-official” sites addressing, among other things, the indications and contra-indications for a particular drug. The latter type of site is not monitored in any way to ensure that the persons providing the information are qualified to provide accurate information about the drugs generally or, more specifically, that the indications and contra-indications are accurate. Furthermore, many of these non-official sites fail to indicate from where they obtained the information provided.

With all of this information available, it not only risks relaying of erroneous information but reliance on erroneous information by patients. While the physician to whom one of these patients obtaining information on the Internet might visit certainly bears responsibility to act reasonably in prescribing any drug, in reality the physician who is presented with a patient who has “self-diagnosed” the condition and “self-prescribed” the medication places the physician in a very difficult position.

While most websites providing medical information are not monitored, the AMA has taken steps to regulate websites with which it is affiliated. In this regard the AMA has promulgated regulations that not only apply to AMA websites but also any website “with which the AMA’s name is associated in any way other than a simple link to any of the AMA Web sites.” See Winker et al., “Guidelines for Medical and Health Information Sites in the Internet”, JAMA (March 22/29, 2000) (“AMA Guidelines”) at 4. The guidelines cover the following areas: content, advertising and sponsorship, privacy and confidentiality, and e-commerce.

As to content, the AMA’s guidelines attempt to ensure that the information is useful, in a usable form, and forthright. For example, the AMA provides that the site ownership and sources for content should be provided. Further, the guidelines instruct that dates of posting, revising and updated are to be provided. This information obviously is very important, as the information sought is oftentimes only useful if it is very current. Unfortunately, many non-AMA websites providing medical information fail to state the last time the information was updated, thus creating uncertainty as to whether it is providing the most recent obtainable information. The AMA also instructs that linking be provided so as to provide a means by which users may link from one site to another. While these guidelines are not very restrictive as to content, they certainly would go a long way towards an attempt to ensure that medical websites provide useful, usable information.

In promulgating guidelines as to advertising and sponsorship, the AMA sought to “ensure adherence to the highest ethical standards of advertising and to determine the eligibility of products and services for advertising.” Winker, AMA Guidelines at 8. Unfortunately, however, these AMA guidelines may constitute nothing more than “preaching to the choir”, as the websites most likely to violate these rules regarding advertising and sponsorship would not be affiliated with the AMA or any medical organization.

Furthermore, these AMA guidelines are not very instructive regarding the ethical nature of advertising for medical products, medications, and services generally. Rather, they appear to address the AMA’s attempt to ensure that its websites are not construed to endorse or indicate an affiliation with such services, products or drugs. Therefore, the AMA guidelines provide
little instruction as to specific guidelines which may be applied to advertising of medical products, drugs and services on the Internet.

The AMA guidelines likewise provide general guidelines regarding privacy and confidentiality. However, privacy and confidentiality, both generally and specific to websites which collect patient information, are issues probably best left to federal and state legislatures so as to apply uniform standards, regardless of whether these websites are affiliated with the AMA or any medical organization. Finally, the guidelines for e-commerce do not appear to be any more onerous than the standards applied by most websites through which products or services are purchased.

But even these AMA guidelines do not govern websites by doctors or healthcare providers unless the site is affiliated with the AMA. Further, as discussed above, many of their guidelines appear to be designed as a means to protect the integrity of the AMA in terms of not promoting drugs, products or services. Therefore, these guidelines are unlikely to significantly change the nature of telemedicine websites.

The AMA has also provided Guidelines for Physician-Patient Electronic Information. See Appendix A. However, the guidelines are not very specific and simply appear to be a common sense approach to e-mail communication generally.

In sum, while the Internet provides the opportunity to empower the patient like never before, the Internet also has the potential to alter roles traditionally ingrained and well-established. Further, the lack of regulation on the Internet, even with the AMA Guidelines as to websites affiliated with it, has the potential to place physicians in difficult positions by providing information to patients that was once left to the physician, with no guarantee that the information is accurate.

III. PROVIDER WEB SITES

The number of web sites set up by health care providers prescribing drugs and providing advice over the Internet grows daily. There are web sites that a person may ask a question regarding a medical issue, and these websites generally indicate that a doctor or health care provider will respond. Likewise, many drugs, including Viagra and Meredia, are being prescribed over the Internet. Many of these drugs, however, have serious side effects that in some cases are contra-indicated in many patients. Further, there is no guarantee that a doctor may determine whether a patient has a contra-indication solely through a questionnaire over the Internet. It goes without saying that the legal implications of these types of web sites are limited only by one’s imagination.

Further, established case law generally adapts to new legal implications which arise in the face of technology. Therefore, while statutes may be tailored to specific issues, case law generally provides some guidance as to the most likely direction the law will take in light of the new scenarios.

With telemedicine, however, the potential legal issues which may arise in the future may not necessarily be sufficiently addressed through existing case law. Some of these issues are so narrowly tailored to the computer age that established case law provides little or no guidance in examining where the law may fall. Accordingly, predicting the potential outcomes of the legal implications of telemedicine is at times futile.

A. “Ask the Doctor” Websites

There are now numerous “ask the doctor” websites which offer services in the form of questions submitted to doctors who then respond. Some of these sites provide invaluable information such as product recalls for children’s medications. But others could raise potential legal problems should an adverse outcome result. The following are but two examples of not so far-fetched potential scenarios:

I. “Ask the Doctor” generally

A doctor sets up an “ask the doctor” website which olds itself out as being available 24 hours a day.2

2 There are numerous “ask the doctor” websites which make these or similar representations regarding availability 24 hours a day.
A “patient” inquires as to whether he should continue with athletic activities in light of the symptoms he is currently experiencing. The doctor responds that he does not believe the symptoms are serious but that “the patient” should go see his family practice doctor soon. “The patient” later sends another e-mail indicating worsening symptoms, but the doctor’s server is down. Thus, he fails to respond for a few days. By the time his server is functioning again and he sees the second e-mail, he immediately responds that the patient should go to an emergency room. Unknown to the doctor, “the patient”, not having heard from the doctor the second time, exercises and dies from a condition which is generally accompanied by symptoms consistent with the worsening symptoms he was experiencing when he inquired.

Obviously, the doctor is a potential defendant. But was a physician-patient relationship initiated? This scenario is not much different from a potential patient calling a doctor’s office after hours and indicating that he has certain symptoms. Under this scenario, it could hardly be argued that a physician-patient relationship existed without a prior physician-patient relationship.

But in the hypothetical above, the doctor held himself out as available 24 hours a day and initially responded, thus creating a physician-patient relationship. “The patient” above may argue that, based on equitable principles, a physician-patient relationship was created because the doctor held himself out as being available 24 hours a day and initially responded, thus creating a physician-patient relationship. “The patient” may further argue that he acted reasonably in assuming that if the doctor were concerned about his new worsening symptoms, then he would have responded to the second e-mail, in light of having previously responded to the first e-mail.

The doctor may respond that even if the physician-patient relationship arguably existed as to the first communication, he cannot be expected to provide continued care over the Internet, particularly in light of worsening symptoms. Rather, he may argue that he discharged his duty by recommending that “the patient” visit his family practice doctor. Further, the doctor may argue that he acted timely and appropriately when he first recommended that “the patient” visit his family practice doctor. Further, the doctor may argue that he acted reasonably in assuming that if the doctor were concerned about his new worsening symptoms, then he would have responded to the second e-mail.

Existing Texas case law regarding creation of a physician-patient relationship provides little guidance under this scenario. While undertaking an affirmative act to treat may create a
physician-patient relationship, the doctor clearly indicated to "the patient" that he was merely providing "advice" and that a reasonable patient would understand (and could read in his disclaimer) that there is no substitute for face-to-face contact. Even under Texas law wherein courts are reluctant to extend the physician-patient relationship, it is likely that doctors who provide advice are opening themselves up to potential medical malpractice claims.

Existing Texas case law likewise may provide little guidance as to the potential liability of another party - the server. This potential liability could be tempting to a plaintiff's attorney, as claims against the server would not fall under Article 4590i and its damages cap. While the server might have some type of indemnity clause in the agreement with the physician, it is doubtful that the physician's malpractice liability policy would cover such indemnity, thus creating the potential for a precarious situation as to the doctor and server.

2. “Ask the Doctor” out of state

A doctor living and practicing medicine in Oklahoma provides medical advice or prescribes a drug dispensed in Missouri to a patient in Texas.

Addressing first the situation wherein a doctor solely advises the patient rather than prescribes a drug, the doctor is undisputedly a non-resident. However, the Texas Long-Arm Statute authorizes the exercise of jurisdiction over non-residents “doing business” in Texas. See Guardian Royal Exchange Assurance v. English China Clays, P.L.C., 815 S.W.2d 223, 226 (Tex. 1991). Included within the acts sufficient to satisfy this standard is committing a tort in whole or in part in Texas. See Tex. Civ. Prac. & Rem. Code § 17.042 (2) (Vernon 2000).

The location of the tort in the hypothetical above is not clear. While the advice undisputedly was submitted from out-of-state, the patient undisputedly received it in Texas. Texas courts have held that when a physician treats a Texas resident in another state yet fails to “purposely direct” activity towards Texas, the exercise of specific jurisdiction by a Texas court in a medical malpractice case is improper. See Odem v. Marrs, 880 S.W.2d 451, 457 (Tex. App. – Texarkana, no writ); Clark v. Noyes, 871 S.W.2d 508, 516 (Tex. App. – Dallas 1994, no writ). Furthermore, the mere fact that the defendant physician is aware that the treatment might have some consequences in Texas is insufficient to warrant specific jurisdiction. Id.

But arguably a doctor offering advice over the Internet to Texas residents “purposely directs” activity toward Texas. See id. Additionally, the court’s rationale in Clark for refusing to hold that specific jurisdiction existed was the fact that the patient traveled to the foreign state and received treatment. See Clark, 871 S.W.2d at 516. As the court noted, alleged medical malpractice is not a “portable tort that [the patient] could take with him wherever he chose to go . . . . The patient traveled to receive the treatment and he should expect to travel to complain of any alleged improperly rendered treatment.” Id. Accordingly, it is not entirely inconceivable, based upon the reasoning of these courts, that a Texas court would exercise jurisdiction over the physician in the hypothetical above.

Further, because the statute also provides for “other acts that may constitute doing business”, the Texas Supreme Court has held that the Long-Arm Statute reaches as far as federal constitutional requirements will allow. See Guardian Royal Exchange Assurance v. English China Clays, P.L.C., 815 S.W.2d 223, 226 (Tex. 1991). Accordingly, Texas courts also inquire whether the non-resident has purposely established “minimum contacts” with Texas and whether the exercise of jurisdiction comports with “fair play and substantial justice.” Id.

This analysis provides for “general jurisdiction” rather than looking solely at where the acts giving rise to the lawsuit occurred. But once again the current case law may not answer the question of where jurisdiction lies in the hypothetical above. The problem with this analysis regarding the hypothetical above is that traditional factors examined by courts may provide little guidance. Some of the factors examined by Texas courts in determining whether minimum contacts are satisfied include
residence, principal place of business, location of offices, residence of employees, location of assets, where taxes are paid, location of bank accounts, location of business meetings, and conducting systematic business. See generally Guardian, 815 S.W.2d at 226.

It is conceivable that a non-resident physician offering services to numerous Texas patients may never satisfy any of these criteria. While the last factor listed above, conducting systematic business in the forum state, at least arguably may be satisfied if the physician renders advice to enough patients in Texas over the Internet, Texas courts generally do not find minimum contacts as to general jurisdiction solely on the basis of one type of contact.

In light of the uncertainty of where jurisdiction might attach in these types of case, some states have examined legislation governing interstate health care. The Texas Administrative Code contains a section regarding telemedicine. See 22 Tex. Admin. Code § 174.1 et seq. (2000). It does not, however, address jurisdictional issues regarding telemedicine.

B. Prescriptions over the Internet

Patients are utilizing prescriptions over the Internet for a number of reasons, including cost and convenience. Obtaining a prescription over the Internet may be as simple as e-mailing the prescription already ordered or may include doctors actually ordering prescriptions over the Internet without having first seen the patient. Both situations, however, create potential legal implications.

1. Filling an already ordered prescription

At first glance, simply dispensing a prescription over the Internet appears to be fairly harmless. However, in recent years there has been a movement to extend a pharmacists potential liability beyond that of simply correctly filling the prescription. Therefore, pharmacists, at least in some jurisdictions, may not necessarily fulfill their obligations solely by virtue of correctly filling prescription.

2. Doctors ordering medications

Many websites now offer medical consultation and prescription of certain drugs. One of the more popular drugs obtained by this method is Viagra. Examination of some of these sites reveals that the questionnaire inquires very limited information regarding the patient’s current condition. At a minimum, an initial history and physical examination may be warranted because recent studies show that there may be a statistical link between Viagra and coronary artery disease.

Unfortunately, websites prescribing Viagra and other drugs are not necessarily complete in their histories obtained via the Internet. For example, while a question may be asked as to any medications or conditions for which the patient is currently being treated, there is no inquiry as to the patient’s current blood pressure. And even if such a reading were required, there is no guarantee that the patient is being truthful in providing the information. This may be contrasted with a patient who, admittedly may lie regarding some risk factors such as family history of heart disease, cannot lie about his blood pressure when it is taken at the doctor’s office. A doctor certainly obtains information similar to a history and physical prior to prescribing the drug.

The legal implications of prescribing drugs over the Internet could potentially reach beyond traditional medical malpractice claims, even as against the prescribing doctor. Particularly when these sites market drugs as “the newest” or “best” drug for a particular problem or condition and provide testimonials (and many of them do), prescribing doctors potentially subject themselves to allegations of Uniform Commercial Code and deceptive trade practices allegations. See Sorokolit v. Rhodes, 889 S.W.2d 239, 242 (Tex. 1994).

The potential of asserting these types of claims under Texas law, rather than “health care liability claims”,3 would preclude application of the cap on damages for health care liability

---

3 Under Texas law, a “health care liability claim” as a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care or health care or safety which proximately results in injury to or death of the patient, whether the patient’s claim or cause of action sounds in tort or contract.” See Tex. Rev. Civ. Stat. Art. 4590i, § 1.03 (Vernon 2000).
claims. See Tex. Rev. Civ. Stat. art. 4590i, § 11.02 (Vernon 2000). Additionally, a plaintiff who prevails in asserting deceptive trade practice allegations automatically recovers costs of court and attorneys’ fees. See Tex. Bus. & Com. Code § 17.50 (d) (Vernon 2000). Finally, because these claims would fall outside of Article 4590i, a plaintiff would not have to obtain an Article 4590i expert report pursuant to Article 4590i, Section 13.01.

Texas courts have been very reluctant to hold that claims against physicians by patients fall outside of Article 4590i. But prescribing medication over the Internet at least creates the potential for asserting such claims because the physician, through the website, might market the product or drug by guaranteeing a result or otherwise making express representations in marketing.

3. Ordering drugs without a prescription

Some websites even offer drugs without a prescription. These drugs range from allergy drugs to stroke medications. Such websites advertise that the drugs are legally obtained and dispensed because they are shipped, for example, from overseas. They further advertise that no medical consultation is necessary prior to dispensing the drugs. The pitfalls and potential legal implications of these websites are far reaching and will not be addressed in this paper, as it appears that doctors prescribing drugs over the Internet proceed at their own peril.

IV. ELECTRONIC CHART

The potential for uniform electronic charts, their enactment, and implications on patient privacy have been a topic of national interest and debate in recent years. One of former President Clinton’s last acts as president was signing legislation regarding the privacy rights of health information.

Electronic charts have been used for years at some hospitals and teaching institutions. But in recent years the possibility of uniform, far-reaching databases has become more realistic technologically. The potential benefits of such a system, however far-reaching, to lower long-term costs of health care and improve patient care are undisputed. The potential for abuse, however, is also undisputed.

A. Reluctance to Fully Embrace

Concerns ranging from potential for abuse to short-term cost of implementation have resulted in a reluctance of the public and portions of the medical community to openly embrace uniform electronic charts. While patients no doubt will always “own” their medical records, the creator of the record still possesses the documents themselves. With electronic medical records, issues arise as to who controls the possessor rights of these records because it is not always clear where they were “created”.

In the context of litigation, this may have implications as to the difficulty of a party in attempting to limit disclosure, as the records are not limited to one location. Furthermore, because the records may be created from more than once source at different times, issues arise as to what constitutes the entire medical record. While these potential issues may be addressed, at least in part, through legislation, the perception by the public does not exactly instill confidence in a system of uniform electronic charts.

Accordingly, patient advocacy groups

---

4 The Texas Supreme Court, however, has recently held that this cap on damages does not apply to an award of punitive damages. See Horizon/CMS Healthcare Corp. v. Auld, ___ S.W.3d ___, 2000 WL 1199263, * 8 (Tex. 2000).

5 Although claims asserted outside of Article 4590i do not require an Article 4590i expert report, there remains the potential a plaintiff may still be required to obtain an expert based upon the claims requiring testimony or opinions beyond those of a layperson.

6 This legislation implements the privacy requirements of the Health Insurance Portability Accountability Act of 1996 (“HIPPA”) and is effective February 26, 2001. See 45 C.F.R. §§ 160-164. Compliance, however, would not be required for two years. While the scope of this article does not address this new legislation, suffice it to say that it would be far-reaching and will raise further legal implications once implemented.
oftentimes are unwilling to embrace the concept of electronic medical records, particularly when the patient information is posted through a website.⁸

The AMA, however, has already taken steps in preparation for the implementation of uniform electronic medical records. In a speech presented on February 25, 2000, Robert Musacchio, Ph.D., senior vice president of publishing and business services for the AMA, discussed the AMA’s working with Intel Corporation to implement electronic credentials for physicians. See Robert Musacchio, Ph.D., “Statement of the American Medical Association to the National Committee on Vital and Health Statistics Subcommittees on Privacy and Confidentiality” (Feb. 25, 2000) (“AMA Musacchio Statement”).

The statement indicated that Digital Credentials will provide access for those with credentials. Id. The AMA Musacchio Statement, however, recognized that it “is essential that the use of computers does not undermine the confidence of the patient in the way the information is handled. In addition, it must be absolutely clear to the patient that only authorized personnel can access their information.” Id.

But the issue remains as to who is included as “authorized personnel”. As discussed below, the fact that only “authorized personnel” may access a patient’s electronic medical records may be small consolation in some situations where the personnel accessing the electronic medical record may be “authorized” by the physician (i.e. a medical assistant) to access certain information but accesses other information outside the physician’s chart. It is difficult to envision a system which ensures that only “authorized” information is viewed by medical personnel when the intended purpose of the electronic chart is the ability to review all information.

There is no doubt, however, that there is a movement towards electronic charts. Therefore, the more important considerations are the potential legal implications from abuse rather than whether or how electronic charts will be implemented.

B. Potential for Abuse

The author of this paper does not intend to imply that electronic charts are not beneficial or that the risks of abuse outweigh the potential benefits. As discussed above, the potential benefits are tremendous, both in terms of long-term cost of health care and providing better patient care.⁹ However, the potentials for abuse could have an impact on both implementation of uniform electronic charting and its implications once implemented, particularly in the context of medical malpractice litigation.

I. Alteration of electronic charts

There certainly exists the possibility for alteration of medical charts, regardless of whether the chart is in electronic form. But alleged alteration of medical records in paper form may be distinguished from possibilities of alteration as to electronic charting in two primary ways: (1) in paper form the health care provider can only alter a chart that he or she had in his or her constructive possession at some time and (2) the alteration oftentimes may be identified as being different or distinguishable from the existing record.

A health care provider obviously cannot alter a patient’s records in paper form that he or

---

⁷ Additionally, choice of law issues are just as applicable in terms of confidentiality provisions as they are regarding medical malpractice claims resulting from telemedicine. In this regard, federal and state laws are far from uniform, thus creating the strong possibility that conduct may be lawful in one state and unlawful in another.

⁸ Some surveys have reported that as high as 75% of those seeking health information are "concerned" or "very concerned" about registering personal health information on a website. See Robert Musacchio, Ph.D., "Statement of the American Medical Association to the National Committee on Vital and Health Statistics Subcommittees on Privacy and Confidentiality" (Feb. 25, 2000) ("AMA Musacchio Statement").

⁹ For example, the ability of a radiologist to review diagnostic images transmitted by computer may provide for quick interpretation from virtually anywhere.
she cannot readily gain access. This might include records from prior admissions to other hospitals or other doctors. With the electronic chart in its broadest form, the health care provider theoretically could have access to the patient’s entire chart from every doctor or health care provider (or at least every doctor or health care provider that falls within the parameters of the electronic chart). Accordingly, the entire electronic chart, rather than only the portion that the health care provider has access to, is open to potential alteration.

This potential for abuse creates obvious problems. First, identifying when the alleged alteration occurred is very difficult. Second, identifying who made the alteration is equally difficult. With every health care provider potentially having access to a patient’s electronic chart, any health care provider in theory could alter the medical records. Making a determination as to who may have altered records when, for example, a health care provider testifies that he or she did not make a certain entry that now exists, is difficult if not impossible.

2. Use of medical records in litigation

Another potential complication is the ability of a health care provider with “digital credentials” to obtain a person’s electronic chart. One purpose of electronic charts is providing a health care provider the opportunity to immediately obtain a patient’s medical records from other doctors or health care providers. But in the course of litigation, plaintiffs certainly do not want the defendant-doctor to be able to obtain all of their medical records, particularly those which it is asserted do not relate to the issues involved in the lawsuit. While some plaintiffs’ attorneys and defense attorneys may disagree as to the discoverability of certain records in litigation, a method exists whereby the battle for these records currently occurs in the courtroom before the records are revealed through a motion to quash a subpoena/deposition on written questions and/or a motion for protective order. In the case of electronic charts, a plaintiffs’ attorney may have no remedy to protect records of a plaintiff which he or she does not believe are discoverable. Additionally, it is not inconceivable that a defendant’s medical records may be obtained by another co-defendant.

While computer technology may exist to protect against this potential abuse, it is unknown at this time whether steps will be taken to restrict access even as to “authorized personnel”. The AMA Musacchio Statement referenced above certainly does not contemplate such limited access. Further, such limited access tends to be contrary to one of the primary purposes of electronic charts – providing access to health care providers of the patient’s entire chart so as to improve health care.

V. CONCLUSION

Telemedicine provides the potential for reducing the cost of health care and providing better health care and more services in areas that once could not be reached. With these potential benefits, however, come tremendous risks for blind reliance on electronic systems which, if not functioning, may place patients at risk, as well the potential for abuses.

The development of the law in these areas cannot keep up with the technology. Therefore, as medical services, products and drugs are offered in different forms and by different methods almost on a daily basis, lawyers are provided with little guidance as to how courts may resolve potential litigation that may result. While this may create uncertainty, it also creates the opportunity for creative arguments by plaintiffs’ and defense attorneys alike in advocating groundbreaking law.