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Geri Amori: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and I'm here today with Danielle Ofri, MD, Stacy Nigliazzo, RN, and malpractice defense attorney Jake Kocienda. Welcome, and thanks for joining in the conversation today.

Now, although telemedicine has been around for quite some time, the pandemic opened the door for its mainstream use and in many cases is preferred to an in-person visit. Now that things are moving back towards a new normal, our question today is where will telemedicine utilization end up?

So, Jake, I know you've spoken a lot on telemedicine and on the potential malpractice risks. What kind of claims and lawsuits have you seen so far related to telemedicine?

Jake Kocienda, JD: Well, thank you. And I have spoken back when the pandemic first started, there was a mad rush for offices, hospitals, all types of facilities in the medical delivery world to get telemedicine online. It had been either dabble with or not even thought of in many cases. And so, all the risks associated with this were brought to the attention and started rising.

It was interesting to find out what actually has materialized as risks. Interestingly, there has been limited involvement with the telemedicine world in new claims that are being brought. A lot of the malpractice claims take 2 to 3 years before they have to be brought, so they're not quite ripe yet although they're becoming.

What I have seen a lot more of are DPH, Department of Public Health, claims against clinicians regarding telemedicine. And those claims often parrot the same as you'd find in a medical malpractice liability claim. And a lot of the cases I've been seeing all center… The commonality is they center around communication.

The fact that this is a new technology not just for the clinicians, as I mentioned, and the facilities but the patients. And so, what to expect is a main feature in anything that's rolled out in any world actually for new patients or customers. And in medicine, it's no different.

And so, patient expectations/management ended up resulting in, in many cases, poor expectations or completely unrealistic expectations. And so what we've seen as claims are that the messages or the information of what the patients expected—the type of care—was not available. And what that means is that they did or didn't do things or acted in different ways that they thought were appropriate or relevant to the communication that was going on through telemedicine, and it ended up being a disconnect.

Clinicians expected one thing. The patients expected another. And because of that disconnect, care didn't get delivered the right way. Things were missed. Follow-up didn't

happen. Patients didn't think they ever had to come into the office again. And so, a lot of the claims center around that.

I've seen things where patients have claimed that they didn't have their blood pressure taken during the telemedicine visit. I don't know how that was supposed to happen, but some of the patients thought it was going to happen. Physical exams—they thought they could get a physical exam. They would just stand in front of the camera and be able to show parts of their body, and the clinicians did their best, but the limitations of the office visit via telemedicine weren't explained well or maybe not interpreted well.

And so, those are the types of claims I've been seeing. Very rarely do they seem so far to have resulted in injury. But the claims and the complaints and the frustration has been really centered on that communication gap.

Amori: Thank you. Dr. Ofri, you recently wrote a really interesting article for *The Atlantic* saying how you went from a sceptic to a believer. Can you tell us more about that?

Danielle Ofri, MD: When telemedicine first kind of showed up on the horizon, you know 10, 15 years ago, I really thought it was ridiculous. Maybe it's good for rural medicine where you don't have specialists nearby and you have no other option. But otherwise, it was just like a poor simulacrum of real care. And who would ever want to do a video visit? It just seemed like a ridiculous small amount of care.

But then the pandemic happened—and I'm primarily an outpatient physician—and what happened during the pandemic is, all practices, we lost track of tens of thousands of patients in outpatient medicine. These were patients not necessarily sick from COVID, but they were missing their insulin, their chemotherapy, their blood pressure medicines. It was crazy.

And so, trying to track them down was initially by telephone and became a lifeline. And then when we started the video calls, it really made an enormous difference in getting people back in care. But even once the pandemic settled and it wasn't for this emergency situation, I found it incredibly beneficial. And although many people say it's not as good as in-person care—and I will buy that—but what I find that it really does is it makes up for care that otherwise we lost. And it's very hard for a lot of patients to get to the doctor. They work. They live far away. They've got childcare or eldercare responsibilities. It's very hard to do it.

And if you're paid in a gig economy, you take a day off from work to go to the doctor, you lose money. And many patients end up missing visits. But when they have the option to make a phone call or a 5-minute video, most can step out to take a break or on a lunch break and do that. And so, I have lots of care that gets caught that would otherwise have been missed. I would say, my patients with chronic medical conditions are getting better care now overall than they did before the pandemic thanks to the addition of telemedicine as one of the many options in healthcare today.

Amori: That's an interesting perspective. And I would say, as a patient, I would have to agree with that. It's really been very helpful. Stacy, what has been your experience with telemedicine?

Stacy Nigliazzo, RN: Well, I've only really used it in an inpatient hospital setting as a nurse, and we used it for primarily—or I should say the first experience was—with acute stroke management to engage an offsite neurosurgeon in real time for potential emergent administration of thrombolytics and planning possible thrombectomies. And there, you would have a nurse present at the bedside to lead the exam with the neurosurgeon on the screen.

We've also used it for behavioral health evaluations, when appropriate, though this can be tricky if a patient has delusions involving technology, of course. We were instituting both of these measures prior to the pandemic, and they were very beneficial to our patients. And even during the pandemic, we used those portals for virtual visits for family—so maybe not even for healthcare purposes, but just for the purpose of bringing people together for consultation and the fact that we already had the mechanism in place was incredibly helpful.

Amori: I can see that. Jake, the use of telemedicine has changed during the pandemic, and now we have more experience on how to use this technology both humanely and effectively. Telemedicine has created a way to do things quicker, better, and faster. And given that, that's one of the main complaints that patients have about healthcare is that they can't get what they want when they need it, do you think this will help reduce some of the common complaints that contribute to malpractice claims?

Kocienda: I think in some part, yes. I think you're absolutely right although the reverse ends up being true and that's just maybe a cynical view that no one's ever satisfied. But the world of instant gratification entering into the medical field through telemedicine sort of perpetuates that instant "I want everything at my convenience."

Now, for some cases, in a lot of patients that could be great—you can't get time off from work, you can take maybe 15 minutes. You can take a half-hour. You can go somewhere in private, and you can have that visit if it's an appropriate one, and you can find the right space. There's a lot more availability. There's less travel time. There's a lot of reasons why this is really a good thing as long as it's used appropriately.

But the complaint of "I'm not getting enough attention from my physician or my clinician." The complaints of "I'm not getting the right focus." Those types of things are not going to go away. In fact, telemedicine might actually perpetuate that. But you also have the reverse problem, which is a lot of patients don't want to come in when they need to—when they're going to be advised we cannot do this telemedicine. But now, in the world of instant gratification and convenience because of technology, they are less understanding as to why they have to come in. And they're going to insist on those telemedicine visits and not like to hear, no we can't do this telemedicine.

There's also the issue of when you're in the middle of a telemedicine visit and you realize it has to be transitioned to an in-office visit, and you want the patient to come in. They might not be happy about that either. So I think what we end up having is a different set of problems that will result in medical malpractice or at least if not medical malpractice the thought process of being upset with the clinician and then moving towards that question, "Do I have a claim if something goes wrong?"

I actually have two cases pending right now where the patient thought—and admittedly the clinician initially thought—this telemedicine visit was absolutely appropriate. As they discovered the information and they go through the visit, they realize the patient needs to come in. And the patient didn't come in. And then, some things happened that maybe could have been avoided had the patient come in. There wasn't necessarily follow-up. So that's something that never would have happened before telemedicine.

You're in the office, you're in the office. If you don't show up for the visit, you don't show up for the visit. But these quasi-half-visits that weren't completed, that's a new phenomenon. And that's probably going to happen a little bit more as clinicians figure out what can and can't be done telemedicine and as the dynamic practice of medicine requires a change from telemedicine to in-the-office visit, these patients have to accept that and understand that things may change. They do have to adapt and maybe have to go into the office when they didn't want to or didn't think they should have to.

Amori: So for every new improvement, there's a new potential for something wrong or something bad to be. Dr. Ofri, before I ask you you're next question, would you like to respond to that? I mean what do you think based on what you're seeing.

Ofri: You know, it's interesting. I would say that they are many ways to connect with patients. And the connection is the most important thing. And I think it's helpful that we have now a variety of ways to do that because one size does not fit all. What we're missing right now though is some regulatory support.

What things are appropriate for telemedicine and what things are not? And do we have any way of leaning on some backdrop of support, of guidance of what make sense and what doesn't. So we can say to the patient for this kind of thing we can't do this, and here's why—not just my opinion but here's actually the regulation of our hospital, our statewide health system.

And the third thing that we're obviously not going to get into here, of course, is reimbursement. Do we value that in the same way? What about other aspects of non-in-person care like patient messaging? That's another thing that's not reimbursed, and yet a lot of healthcare guidance—medical care happens via email through the secure patient portals. Is that considered valuable enough to reimburse? Is that protected in the same ways? There's kind of a whole menu of things.

And one could imagine that if we thought about reimbursing medical care for taking care of the patient in what we'd call a capitated way as a whole and whether it's some in-person, the occasional phone call, the video, the nurse visit—all these things in between as opposed to the old-fashioned just come every 3 to 4 months to see your doctor in person…So I think we can be more flexible because it isn't so straightforward for every patient.

Amori: Jake, you want to add to that?

Kocienda: Yeah, I agree with a lot of what Dr. Ofri mentioned, but the one thing I think I have to push back a little bit on is the idea of regulation being a solution to the problem with video teleconferencing because medicine, from my vantage point, is too dynamic and too patient-dependent and circumstantially dependent. I mean, the definition of standard of care in my world is what a reasonable physician or a prudent physician would do under all relevant circumstances. And every patient and every encounter presents with a different set of circumstances.

Regulation has, in my experience, taken away or risks taking away that autonomy of clinicians to be flexible and decide what needs to be done at any given moment. It also sometimes can hamstring or tie up a clinician's decision-making. But also it creates an expectation of how to do things. And every practice group is different. Clinicians have their own personal view of these things. And regulatory body making rules, I think, could end up causing problems with following standards of care but also patient flow, workflow and that sort of thing.

My view from a liability exposure standpoint, the more flexibility clinicians are given and allowed in deciding what is appropriate for their patient, at a given moment, is a better—at least from an exposure standpoint—a better way to go than regulations which really just often are used to, in my world, berate or hold clinicians to an inappropriate standard without taking circumstances into consideration.

Amori: Danielle, back to you.

Ofri: Yeah, I do agree. I think that a lot of our regulations are constricting. What I was thinking and maybe I wasn't as clear as I meant to be—one big fear of telemedicine is that there could be a lot of abuse of it.

There can be a number of excessive follow-up visits from unscrupulous systems that can just be trying to make extra money. So could there be some regulations about whether in order to have a televisit at some point in the year there has to be an in-person visit, which would make sense for most real medical practices. They don't just do telemedicine. And there are ways to help us with a patient who doesn't ever want to come in. Maybe it's a billing requirement that you do have to have one in-person for every three or four—something that's loose enough to not be constricting but to give us some backup for the patients who say, "I don't want to come in anymore. I don't want to waste my time."

Amori: Yes. That's really wonderful. And for those physicians right now who, like you, are still being very skeptical or like you were, do you have any words of wisdom to them as they step into this telemedicine world?

Ofri: Yeah, I think that our patients are just as nervous as we are. So we're all kind of learning together. But the fact that we can connect in a variety of ways is so helpful. And one way that I use it a lot—I'll have an in-person session and the patient didn't make it. I'll call them. There's always a reason they couldn't make it. Rarely, do they say, oh I just don't want to come.

They have a childcare crisis or a work crisis and we just convert it to a telemedicine visit on the spot. And then, we get to do the care and not lose it. So I think the way I would convince someone is that we get to recoup the missing lost care that patients who are lost to follow-up, we can now bring them back into the fold. And that alone is worth the price of admission.

Amori: That's cool! So, Stacy, back to you. Now, taking off your virtual nursing cap and putting on your virtual sunhat as a patient—and we're all patients sometimes—have you had the opportunity to use telemedicine as a patient? And with all your medical knowledge and experience, how did you experience that?

Nigliazzo: I have not used telemedicine virtual visits. However, I have considered it, and I'm becoming a believer. You guys are making me come around. I will consider it in the future. And just in response to what we've been discussing here, I would say that I agree that physicians should always have a voice in what's appropriate for a virtual visit from the outset—what you should allow to begin with.

And I also believe that we should never discount the value of touching your patient, making that personal connection.

Amori: Danielle, you want to add to that?

Ofri: Yeah, I'll say, as a parent of high schoolers, one thing that's impossible to do is to get your high schooler to a medical appointment. They have sports teams. They have practice. And medical practices are not open after 9 pm and on weekends. But telehealth has been an amazing thing for the high school crowd—for mental health, as there's been a huge mental health crisis. I mean, to enable a 10th grader to do a therapy session from a quiet room at school as opposed to not getting to therapy at all or the follow-up for their primary care. There's so much that telehealth can do for this patient population that finds it very hard to make standard office hours.

Amori: Yep. That's a really good point. Okay, now we have to bring this home. So from your perspective, what is the one thing that you would like our audience both in healthcare and the general population to know? So let's start with you, Dr. Ofri.

Ofri: Sure. I would say that telemedicine is never going to replace in-person healthcare. And I firmly believe in the value of being together, the sixth sense, the touching, the communication. But I look at it as just one more additional way that we have. And how great is that we have now another way to complement our standard medical care so we've more ways to reach our patients and not less.

Amori: Very good. Thank you. Jake, would you like to comment?

Kocienda: Sure. I have two main points that I think should be taken away that are related. And one is to be careful of the expectations and limitations that the patients have so they know how to use, as Dr. Ofri mentioned, this new tool, this new technique that should be complementing medical care, as opposed to supplanting old care.

In context of that, this goes for both the patient and the clinicians—be very careful of the sway that convenience has on decision-making. Good medical care is good medical care, but we're also humans, and the convenience this offers sometimes might—and I've seen it—it lends people to accept the telemedicine visit because it's more convenient when really maybe an office visit is better and appropriate. And that goes with clinicians and the patients completely.

Amori: Thank you, Jake. Stacy?

Nigliazzo: I would just add that telemedicine is an invaluable, innovative resource in expediting care, but we must use this resource responsibly. There is no virtual substitute for the hands-on evaluation, the personal touch of a seasoned caregiver.

Amori: Thank you! That's a great way to bring us home. This has been a really great conversation. And I want to thank our panelists and our listening audience. I hope our discussion has provided you with some new insights. Thanks again for joining us, and until next time, this is *Perspectives 360*.

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