Peer Review/Medical Staff Concerns in Telemedicine Practice

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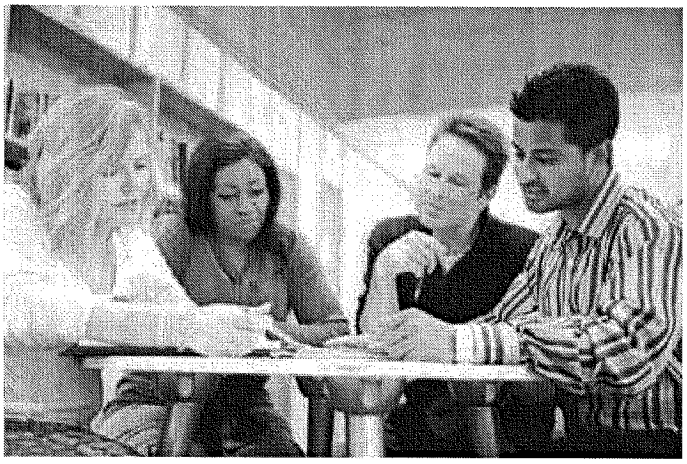
Much ink has been spilled over the last several years concerning the growth of telemedicine. Taking advantage of high-tech assets to examine and diagnose, indeed sometimes to treat patients who are remote from a provider's location, implicates many legal concerns. Licensure, multijurisdiction care standards, liability insurance, and informed consent are among them.

A physician in Cleveland treating a patient in New Jersey, either through audio only or through audiovisual communications, typically must be licensed in both states. Virtually no state exempts licensure, whether the patient self-presents or is referred to the telepractitioner by his in-state physician for diagnosis, consultation, or treatment. When physicians confer just to share thoughts and to obtain collegial advice, outside of a direct care relationship, licensure may not always be required. However, if the telepractitioner is rendering care to the patient, then licensure in the patient's state is generally necessary.

Just as there is no national physician licensure to support telemedicine activities, hospital medical staff privileges have not become centralized. This means that the busy telepractitioner caring for hospital patients will likely be required to obtain medical staff privileges at dozens of hospitals throughout the country. Business and contractual relationships with third-party physician agencies, such as nighthawk companies, will necessitate obtaining and retaining privileges in many hospitals even though the bulk of the practice may be focused on a dozen. The agency may re-credential its contract physicians at hospitals for which very few services are provided for its own business purposes.



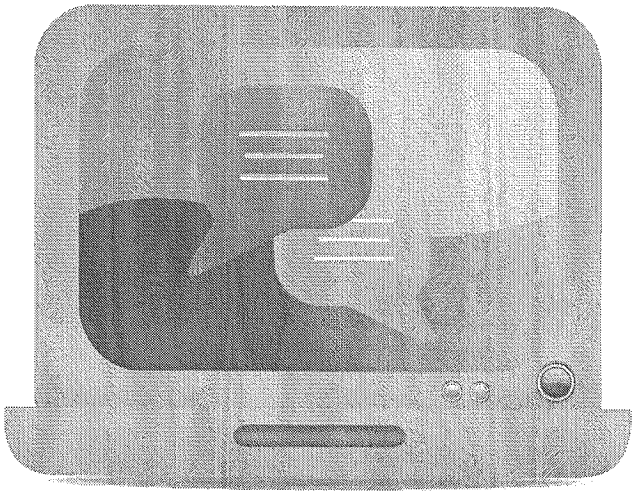
By virtue of the need to obtain medical staff privileges and appropriate delineations, the telephysician exposes himself to the vagaries of different medical staff bylaw provisions, department chairs' personalities, and demands as well as to the politics of multiple institutions. Departmental re-credentialing and peer review protocols typically do not exempt or treat telepractitioners differently than medical staff members who physically practice within the four walls of the institution. In fact, the telepractitioner may be vulnerable to more intensive and demanding peer review than he would face if he came to work every day at the hospital. Why? The telepractitioner does not participate in the give-and-take of the medical staff, and has no direct access to discuss and resolve errors collegially as they arise.

For example, a physician performing a robotic procedure from a distant point may receive more intensive scrutiny than surgeons who are providing direct surgical care at the same institution. The fact that the physician is not "hands on" in the operating room itself renders the telephysician more vulnerable to criticism—sometimes by competing hospital-based colleagues with their own personal or professional agendas. Beyond that, there may be a subtle bias in favor of active department members—who perform many more cases and are more likely to share peer review responsibilities with colleagues. By virtue of being part of the department on an ongoing and functioning basis, department "insiders" may be cut more slack than the outside telepractitioner who is unknown to the department and who may never have even met his "colleagues."

Teleradiologists, who frequently function as "nighthawk" reviewers with their "preliminary" evening readings overread the next day by in-house diagnostic imaging physicians, face a different issue. As a practical matter, the "overread" functions as virtually a 100% quality assurance (QA) review of cases. Although this may be desirable from a quality perspective, it can have the impact of singling out the nighthawk teleradiologist for more intensive peer review, since regular department members often have only a small fraction of their readings reviewed.

Against this backdrop, securing, renewing, and retaining hospital medical staff privileges may implicate immense legal as well as practical challenges for the telepractitioner.

Consider the independent contractual arrangement between a teleradiologist and the nighthawk agency that bundles the services of many radiologists in order to provide them to client hospitals. The agency contract will require the teleradiologist to maintain medical staff privileges at all hospitals served and, for efficiency reasons, will usually delegate the credentialing process to the agency. Most large telemedicine agencies are unwilling to depend on physicians to handle credentialing matters and prefer to process all documen-



tation to expedite physicians' availability for services. Likewise, QA activities also tend to be managed by the agency. However, from the perspective of the individual teleradiologist, these agencies may be perceived as being more concerned about managing and maintaining the contractual relationship with the institutional client than with how an individual physician is faring with respect to QA or medical staff/peer review activities.

The telepractitioner whose QA results are not deemed acceptable by hospital-based colleagues may face restrictions when privilege renewal is sought—or worse. The inherent limitations of practicing at a distance—i.e., the inability to dialogue effectively with reviewers whom one does not know and has never met—could put the telephysician at a disadvantage and create an inability to sway her (remote) hospital chair or peer review committee when questions arise that, in other settings, might not lead to privilege restrictions. Of course, when privilege restrictions are imposed, they will likely be reportable in all subsequent re-credentialing and re-licensure applications, and potentially, to the National Practitioner Data Bank. The cascading effect of such disclosures could have significant negative professional consequences for the reviewed telepractitioner.

In the worst-case scenario, a telepractitioner will face the institution of corrective action proceedings at a remote hospital. The prospect of retaining counsel in a distant state and flying across country to engage in costly hearings to defend oneself before unknown peers is likely to be distressing to any practitioner.

There are a number of ways that physicians who regularly practice telemedicine can mitigate and manage these risks. We suggest the following:

- Contract for services only with a reputable agency with a proven track record of careful credentialing practices, close collaboration with hospital-based QA and peer review activities, and that keeps the telephysician fully informed about all potential QA concerns;
- Avoid working for hospitals with poor departmental and QA leadership;
- Insist on contract provisions that the agency fully support you in all potential peer review issues, including retention of counsel;
- Require the agency to pay counsel fees if representation is required; and
- Insist that the agency indemnify you for any damages arising out of faulty credentialing, QA, or peer review oversight activity; and
- Consider limiting the geographic scope of distant hospital sites to be served so that you can periodically visit and interact with the department chair and peer review players. If they do not know who you are, your vulnerability to questionable peer review actions increases.

In short, physicians who provide their services distantly, through telemedicine services, can be disadvantaged in the peer review process, due to their remoteness, lack of personal presence in the hospital, and inability to interact directly with departmental leaders and peer reviewers on a regular basis. Physicians can help protect themselves from "arbitrary" peer review by building stronger contractual relationships with the telemedicine agencies through which they practice, and finding creative ways to develop a greater presence at the hospitals where those services are provided.

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