

California Nurses Association
Position Statement on
TELENURSING

I. Introduction

Telenursing is an emerging field that could have a major, if not a revolutionary, impact on the delivery of nursing care at intrastate, interstate as well as global levels. Questions surrounding the implications of telenursing have increased in intensity, particularly in the clinical practice settings and legislative and regulatory arenas.

As the development of telecommunication technologies continues its rapid evolution, particularly in health care, it is important that it is harnessed to best serve the individual health care, privacy and confidentiality needs of patients in California. Toward that end, the California Nurses Association has developed this position statement to reiterate its commitment to ensure that telemedicine is utilized to increase accessibility, quality, and affordability, and that registered nurses play a major advocacy role in the delivery of safe, therapeutic, effective and efficient patient care where confidentiality and privacy are protected.

The intent of this position statement is to emphasize the registered nurse's unique role in the health care delivery system, including that of a patient advocate, and that telenursing only be used to enhance and augment this unique role. It will also explore the potential of technology replacing human interaction in the delivery of health care and supplanting critical thinking and independent clinical judgment with critical pathways and other forms of artificial intelligence.

II. Statements of the Problem

The threshold questions are whether registered nurses in the State of California are authorized to practice telenursing. If so, how should the practice of registered nurses in telenursing be defined. Finally, are registered nurses authorized to assist physicians and others with the delivery of telemedicine and telehealth in intrastate, interstate, and global settings.

The practice of nursing over distance using telecommunication technology requires legal authorization within the state and across state lines. Multi-state regulations are currently being explored by the National Council of State Boards of Nursing, Inc., which would allow registered nurses to practice telenursing across state lines.

Under existing California law, in order to legally practice in this cross-state manner, registered nurses are required to be licensed in every state in which they are practicing telenursing regardless of where they are physically located. Clear authority is essential since registered nurses are directly responsible and accountable to the patients for the quality of nursing care rendered. Moreover, state government through regulatory authority has a vested interest in protecting the welfare and safety of the public.

Issues with critical implications involve accepting orders from physicians licensed in other states. In California a registered nurse is permitted to accept orders from California licensed physicians, dentists, podiatrists, or specified clinical psychologists, therefore precluding the taking of orders from the same providers licensed in another state.

A. Authority Under the Nursing Practice Act

The use of telenursing in providing nursing care is not specifically mentioned in the California Nursing Practice Act. Therefore, an understanding of the California Nursing Practice Act is essential in developing a response to these critical questions and in addressing the issues surrounding telenursing. Within the State of California, the statute provides clear recognition that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. The Act further provides clear legal authority for functions and procedures which have common acceptance and usage. It recognizes the existence of overlapping functions between physicians and registered nurses, and permits additional sharing of collaborative functions within organized health care systems.

The Act defines the practice of nursing as those functions, including basic health care, which help people cope with difficulties in daily living that are associated with their actual or potential health or illness or problem or the treatment thereof including basic health care.

A more specific interpretation of the statutory definition is as follows:

Nursing is the assessing, managing and caring of human responses to health and illness which require a substantial amount of scientific knowledge or technical skills (core).

Nursing practice includes, but is not limited to, data collection; assessment; nursing diagnosis; planning, developing, implementing and evaluating programs, protocols and care plans; intervention and evaluation in the promotion and maintenance of health and

wellness; triage; the case-finding and management of illness, injury, or infirmity; the restoration of optimum functioning; or the achievement of a dignified death (patient).

Nursing functions include provision of health assessment; direct care and treatment services; patient advocacy; teaching; counseling; advice; applied psychotherapeutic techniques; psychosocial, psychological or mental health assessment; administration; supervision; delegation; assignment; evaluation of practice; and consultation services (RN).

In general, telenursing activities, particularly telephone advice/consultation, triage and patient education, involve basic health care and relate to activities described in the definition of nursing.

B. Telenursing and the Nursing Process

Under the Standards of Competent Performance (California Code of Regulation Subsection 1443.5 (1), Title 16), the formulation of a nursing diagnosis is a two-step approach; (1) by observing the patient's physical condition and (2) by interpreting information obtained from the patient and others including the health team.

Furthermore, Subsection 1443.5 (5) mandates that RNs evaluate the effectiveness of the care plan through observation of the patient's physical condition and behaviors, signs and symptoms of illness, and reactions to treatment and through communication with the patient and health team members, and modifies the plan as needed.

What is problematic, however, is the delivery of clinical nursing care via cyberspace without the benefit of a face-to-face, direct observation, using all senses assessment. The nursing process is severely compromised when an essential assessment component such as data collection is limited to subjective data obtained from the patient/family/others and objective data obtained from one not trained in the arts and sciences of nursing/medicine, or based on an electronic facsimile of the patient images. Moreover, even if digitized images of the patient were to be transmitted to the RN for a nursing diagnosis, is electronic observation really an observation as intended by the Nursing Practice Act. It clearly is not, for the applicable provision of the Nursing Practice Act - Business and Professions Code Section 2725 (b) (4) - requires that direct patient care includes the following:

“Observation of signs and symptoms of illness, reaction to treatment, general behavior, or general physical condition, and (A) determination

whether the signs and symptoms, reactions, behavior, or general appearances exhibit abnormal characteristics; and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.”

Of greater concern is the delivery of critical care in the community or home care settings without the physical presence of a qualified registered nurse or physician. For example, diagnosis and management of cardiac dysrhythmia. At minimum, the physician (authorized and qualified to practice telemedicine in the State of California) should be assisted by a registered nurse with critical care background who has demonstrated competency in obtaining and transmitting digitized images of the patient.

Finally, cyberspace diagnosis complicates and obfuscates the nursing process. Therefore, formulation of a nursing diagnosis and evaluation of a care plan can only be accomplished through direct face-to-face observation by the direct care RN.

C. Telenursing and Patient Advocacy

The RN advocacy role delineated in Subsection 1443.5(6) of the California Code of Regulations (Title 16) clearly require that all RNs regardless of education preparation or credentialing including providers of direct and indirect care must act as patient advocates by initiating actions to improve health or to change decisions or activities which are against the wishes or interest of the patient. Telenursing driven care depersonalizes the relationship with patients. Unfettered telenursing will have a chilling effect on the RN's ability to act as advocate for her/his patient.

Advocacy takes a variety of form in telenursing. First, there are concerns surrounding qualifications and authorization of consulting and/or treating physicians. Then there are serious concerns about informed consent when the patient is informed by the physician about care via telemedicine, it must include information about the nature, extent and consequences of such care, the right to refuse, and the alternatives available.

The confidentiality of the patient's electronic medical records and the security of the patient's identify and image during the transmission must be preserved at all cost.

Finally there are concerns about the ethicality of tediagnosis and too heavy reliance on telemedicine since there is no substitute for face-to-face interactions with the patients. Undue reliance on remote diagnosis can jeopardize the accuracy of the diagnosis and may result in harm to the patient. Such reliance will also create erosion of skill for the next

generation of registered nurses who (unless stopped) will be trained in tasks instead of educated in skills.

As patient advocate the profession must avoid at all cost the repeat and/or perpetuation of the health care environment which existed after World War I, where working conditions were not conducive to safe and therapeutic nursing care nor for the professional development of registered nurses. Nursing became focused on tasks in order to take care of large numbers of patients. As a result, the patient's "humanism was mechanized; his organic whole was fractured into parts, his basic physiological and technical needs were reduced to a checklist on paper. Thus, he became an automated patient."

D. Conclusion

1. Registered nurses are authorized to practice intrastate telephone advice/consultation and triage under common nursing practice and the definition of nursing provisions of the Nursing Practice Act (Business and Professions Code Section 2725).
2. The use of electronic communication technologies to provide patient-specific clinical nursing care in community-based settings without an assessment based on direct observation contravenes the principles of the Nursing Practice Act.
3. Patients requiring acute and/or critical nursing care services are not qualified recipients of community-based telenursing. Such care must be provided in organized health care systems such as acute care settings.

III. Position Statements by Nursing and Health Care Organizations

In preparation for this project, CNA wrote to all nursing organizations (specialty and nursing societies) as well as other health care associations in California. Of the many responses received, only a few have dealt with the issue and therefore have not adopted an official position with the following exceptions:

A. Emergency Nurses Association (ENA) Position

ENA has a position statement regarding telephone advice in an emergency room setting (adopted in 1991). The ENA statement indicates that "nurses should not render opinions regarding diagnosis or treatment by telephone. Rather ER nurses should inform the caller that conditions cannot be diagnosed by telephone and the caller should either go to the emergency room or see a private physician."

The position statement does recognize that “telephone triage programs exist. ENA believes that these programs should be based on clearly defined protocols with medical direction by experienced, professional emergency staff members. A quality assurance program should be utilized to ensure quality control of the telephone triage program.”

B. National Rural Health Association

The Association “recognizes that there is an ongoing process of experimentation, evaluation, and implementation of telemedicine applications in many urban and rural locations around the country, and the advocates for these technologies are numerous and enthusiastic. However, the efficacy of these methods has not been fully demonstrated. Likewise, the potential effects of their widespread implementation on the health care delivery system are unknown.”

Looking at the current activities as a whole, the National Rural Health Association “believes that these technologies hold promise for improving access to health care services for rural patients.”

Accordingly, the Association “favors initiatives designed to systematically evaluate these methods to encourage the development throughout the country of the communication infrastructure that supports them and to encourage implementation of telemedicine programs that enhances rural health care.”

IV. Telehealth and Advance Practice Registered Nurses

Proponents of telemedicine cite its potential to improve access to specialized health care in under served rural areas. Advocates of the development of extensive intrastate and interstate telemedicine systems argue that the technology offers the rural primary care provider with rapid access to speciality consultation and eliminates the need for patients to travel to distant tertiary centers. Telemedicine offers the potential for advanced practice nurses to fill the void in primary care practitioners in under served rural communities. However, caution is required where referral and/or supervision may occur over state lines.

A. Authority to Practice Across State Lines

The threshold issue is the same for all registered nurses. Licensure in California does not provide authority to practice in any other state. Other states may exercise regulatory authority over nurses who provide telenursing services to patients located in that state from an out of state location. Courts have historically given states broad authority to

regulate out of state businesses and professionals engaging in conduct which affects residents of that state. Such authority is based on the premise that each state has an interest in protecting its residents from unqualified practitioners through its licensing system. Under such circumstances, courts will most likely uphold a state's requirement that out of state practitioners comply with that state's licensing laws, so long as such requirements are not more stringent than imposed on in state residents and compliance is not impossible for out of state practitioners. This is essentially a question of Constitutional law and is unlikely to change absent federal legislation preempting state regulation of nursing licensure and imposing a national or regional system.

B. Collaborative Practice

California has generally led the nation in expanding nursing practice to include essentially medical functions under standardized procedures jointly developed by nursing and medical staff in organized health care facilities. Nurses engaging in telenursing must exercise caution in performing those same functions in the context of telenursing across state lines. While the majority of states have enacted broadly worded nurse practice acts similar to that of California. Most do not codify the concept of standardized procedures. Therefore a nurse licensed in California, providing telephonic advice to a patient outside California pursuant to standardized procedures may be found to be practicing medicine without a license in another state. Notwithstanding that he or she is practicing appropriately within the bounds of the California Nurse Practice Act. Nurses engaging in telenursing activities must meet licensing requirements of states where patients to whom they offer advice are located. Moreover, their practice must conform with the parameters of RN practice in that state.

C. Professional Liability

1. Administrative Liability

The states have the legal authority to regulate health care. The Supreme Court recognized that "the states have a compelling interest in the practice of professions within their boundaries, and that as a part of their power to protect the public health, safety and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions." (Goldfarb vs Virginia State Bar (1975) 421 U.S. 773, 792). All states require the registered nurse to be licensed in that state in order to practice in that state. Failure to comply constitutes practicing nursing without a license. While the precise consequences of practicing without a license vary from state to state, the offense is generally punishable by a fine and/or imprisonment. In California,

practicing nursing without a license is a misdemeanor punishable by imprisonment for up to one year and a fine up to \$1000.00. (Business & Professions Code § 2799).

To date, few state boards of nursing have begun to address this issue directly. Medical Boards in several states have addressed the issue of out of state physicians practicing telemedicine in their state. For example, in 1995 Texas amended its' Medical Practice Act to require physicians practicing telemedicine in Texas from other states to be licensed in Texas. Texas exempts physicians from out of state whose contact within Texas occurs only episodically and at the request of a Texas physician. Some states have proposed completely eliminating statutory consultation exemptions for telepractitioners. Even states which permit consultation exemptions have tightened them by prohibiting out of state physicians from establishing telemedicine links within state hospitals and physicians. Given the current status of state regulation, change appears unlikely without federal action. For the present time, nurses practicing in a telenursing setting are well advised to be licensed in each state where they or their employer has regular contact with patients.

2. Civil Liability

Telenursing across state lines may expose the registered nurse to civil lawsuits by patients treated in other states. A lawsuit for professional negligence may be brought by an out of state patient in California. However, it is highly probable that the patient could bring the California registered nurse before the courts in another state. A single telephonic contact may be sufficient grounds to do so. Courts have found that intentional and recurrent contact by an out of state business or professional will be sufficient for the State to exercise jurisdiction over the business or individual located out of state.

The issue of professional negligence in telemedicine per se has not yet been addressed in any reported cases. However, the issues are similar to a number of cases, in several states, where the question of professional negligence involved telephone contact between patient and nurse or physician, or between referring and consulting physicians. Courts which have addressed the issue have found that a medical consultant who offers only an informal opinion or recommendations has not established a duty of care. This may be analogous to telephone situations where the nurse offers general information only, but does not give individual advice.

In contrast, in a number of cases courts have found that a physician consulting with or about a patient by telephone establishes a physician-patient relationship and can be sued for professional negligence. Those situations may be sufficiently similar to the conduct of a registered nurse in the context of telenursing to adapt some of the same criteria. A

nurse patient relationship, and thus liability for professional negligence, may be found where one or more of the following criteria exist: (1) the patient obtained or relied on advice from the nurse; (2) there was direct contact between the patient and the nurse; (3) the nurse performed an assessment, or had the opportunity to do so; (4) whether the patient was referred to the nurse for treatment or consultation; (5) whether the nurse reviewed (or had access to) the patient's medical record; (6) whether the patient was charged for the service; and (7) whether the nurse had any authority or control over the patient's care. Many of these criteria are applicable to telephone triage or advice line transactions, commonly occurring today. It is highly likely that a nurse and/or her employer would be held liable for negligent acts or omissions in telephone advice which cause a patient harm.

D. Reimbursement

The California Department of Health Services promulgated its initial Medi-Cal reimbursement policy for telemedicine consultations. Medi-Cal will only reimburse telemedicine providers if the DHS has verified that the services provided are equivalent to services which would be provided in a face-to-face setting. Telemedicine services Providers are required to use interactive audio-video systems. The health care provider must, at a minimum, be able to visually examine the patient's entire body, including ear canals, nose and throat, as well as the capability of hearing heart and lung sounds clearly using a stethoscope. In order to receive reimbursement, the DHS policy requires the provider to be licensed in California. If operating from outside California, the provider must also be licensed in the state from which they are operating. Providers with the ultimate responsibility for the patient's care must obtain verbal and written consent from the patient. Images or information cannot be disseminated without additional written consent of the patient. Telephone conversations, E-mail or facsimile transmissions between practitioner and patient are not deemed telemedicine and will not be reimbursed. DHS will review telemedicine programs individually, prior to authorizing reimbursement. The cost of telemedicine equipment and transmission is not reimbursable by Medi-Cal.

E. Federal Reimbursement

In October 1996 the Health Care Financing Administration (HCFA) started a three year, four state demonstrations project for Medicare telemedicine reimbursement. HCFA selected five networks as participants in the demonstration project, but only three are submitting claims. Medicare reimburses telemedicine consultants at the same rate as for an "in person" encounter. However, the presenting provider is paid only half of the standard rate. Demonstration networks also complain about slow reimbursement and a requirement for interactive audio-video teleconferencing capability. Critics site low

reimbursement and the expense associated with the necessary telemedicine equipment as reasons for limited participation in the pilot project.

V. Definition and Types of Telehealth, Telemedicine, Telenursing and Other Transactions Via Electronic Telecommunications

A working definition of telenursing is as follows: “Telenursing is the practice of nursing over distance using telecommunication techniques.” (National Council of State Boards of Nursing, Inc.)

Telemedicine has been defined as: “The use of information technologies such as satellite transmission, video conferencing or electronic data transfer for health care education, consultation and delivery.”

Examples of Common Electronic Transactions:

Telephone triage, advice and consultation are becoming extremely common.

Videoconferencing for grand rounds and medical education between major teaching hospitals and satellite hospitals.

Electronic stethoscopes, microscopes and imaging equipment that transmit results to remote locations for reading, interpretation and analysis are used in many states and remote clinics.

The use of new devices which monitors ECG and oxygen-saturation levels through a transmitter. This device also allows physicians to monitor a patient's status in real time through a remote PC.

The creation of a joint venture in Florida between prisons and nearby medical facilities. The aim of the project is to reduce the number of transfers of inmates and so save on costs. This is to be achieved through the use of electronic measurement and assessment then transmission of tests to a central hospital location where the results are assessed by a nurse.

The use of an at-home monitoring device by many elderly people. This device gives voice commands to the person on how to use its vital sign monitoring equipment. It then transmits the information to a central nurse's station, either in a hospital or a home health agency. In addition, this telemedicine device asks or reminds patients at scheduled intervals to take their medication, eat properly, and

change dressings on wounds. The device is programmed to contact the nurse when vital signs do not meet parameters or the patient does not respond. The nurse can see video of the patient, though the company admits that currently the standard of video is not high.

A. Regulation of Telehealth/Telemedicine

There is currently a limited body of law which regulates or governs transactions which occur solely in cyberspace. Before a state has regulatory jurisdiction over a telehealth/telemedicine provider, it is important to discern where the treatment, consultation, or any other transaction occurred.

Where the transmission occurs within the state of California involving providers or entities licensed by the State of California, the regulatory jurisdiction is clear. The question is whether California can find some means to legally justify imposing its regulatory jurisdiction on an out of state provider or entity. In 1994 California introduced the first ever legislation regulating telemedicine. Subsequently California enacted the Telemedicine Development Act of 1996 which, amongst others, requires the Department of Health Services to prepare a report for the Legislature by January 1, 1999 regarding the quality of health care provided by telemedicine. The proponents argued that the new law will greatly enhance the quality and comprehensiveness of health care services to homebound patients.

Effective January 1, 1997, private health insurance and managed care plans are required to integrate telemedicine into their existing reimbursement policies and procedures. This is presumably a flexible approach which will allow private payers to phase in telemedicine reimbursement and treat telemedicine in a similar manner as traditional face-to-face care. California's Medi-Cal Program is also required to have a telemedicine reimbursement policy in place by July 1, 1997. Face-to-face contact between the health care provider and the patient is no longer a requirement.

Another chaptered piece of legislation introduced by the Medical Board of California (SB 2098-Kopp) addresses the issue of telemedical practitioners. The new law authorizes the Board to develop a registration program to permit out-of-state physicians to practice in California via telemedicine. The Board is charged with the development of a Registration Program to be approved by the Legislature.

The main concerns are patient protection and minimum qualifications requirements. A further concern is that telemedical practice can be conducted outside the scope of existing

peer review mechanisms and the practice of medicine across state lines can create risks to efficient quality control and enforcement by the Board.

So far only a handful of states have taken a position on licensure requirements of Telehealth providers (Florida, Nevada, Texas to name a few). In contrast, there are no existing requirements on licensure of telehealth providers other than physicians.

B. Conclusion

Until further clarification and analysis of applications and implications of the Medical Board's of California physician registration program, registered nurses are precluded from accepting orders from physicians, dentists, podiatrists or clinical psychologists not licensed in the state of California.

VI. Artificial Intelligence in Medicine and Nursing

There are many presumed appropriate applications of artificial intelligence in medicine and nursing.

Artificial Intelligence has been defined as a multi-disciplinary field encompassing computer science, neuroscience, philosophy, psychology, robotics, and linguistics: devoted to the reproduction of the method or results of human reasoning and brain activity.

The application and form of electronically stored medical information have a direct impact on the design of any health care delivery system. The PC based multi-media biomedical library developed for NASA was originally intended for long term space missions where complete isolation support was a distinct possibility.

One fact is certain; machines are only good for storing information. Machines cannot think, analyze or reason as health care professionals do, nor are they educated or capable of critical thinking or capable of making split second judgments in crisis intervention situations. Machines are capable of quantifying data but it will take a qualified professional to interpret the data otherwise it is meaningless. At issue here is will the profession control technology or will technology control the profession.

Certain artificial intelligence software packages like "expert systems," represent an attempt to use a computer to store and apply the knowledge of an expert. They have been tried extensively in medicine, especially for diagnosis and prognosis.

A. Medical Expert Systems

Expert systems can be divided into three groups:

1. Medical Diagnostic Programs

Diagnostic programs have been around since the 1950s. From hardware to software this artificial intelligence program is used by physicians to diagnose diseases. The physician enters the symptoms, test results, and medical history into the program, which then suggests a list of possible diagnoses.

These “knowledge-based” computer software programs are known as medical expert systems (MESs) and are becoming more widely available to the public. While MESs allow medical diagnosis with the touch of a finger, the widespread use of MESs carries the risk of product caused injuries to users particularly when used without physician supervision. The most obvious danger of unsupervised patient at-home use is incorrect diagnosis by MESs, resulting in patients improperly treating their ailments.

2. Protocol Programs

Standardized care using patient protocols or routines have been around since the mid-1970s. Clinical pathways are also called critical paths, care maps, collaborative plans of care, multi disciplinary action plans (MAPS), and anticipated recovery paths are interdisciplinary patient care plans that delineate assessments, interventions, treatments and outcomes for specific health-related conditions across a designated time line. As a case management tool, they can be developed for surgical procedures, medical diagnosis, and health related interventions.

3. Prognostic Programs

These programs are used to calculate the chances of a critically ill patient survival for a given disorder or predicting patient outcomes based upon patient physiology. The program recommends withholding of any treatment if the chances of survival fall below the percentage calculated by the program. Thus, in accordance with the current economic politics of corporate health care, it is generally used as a means to deny care thereby generating revenues. Furthermore, the large scale exclusion of negative

events from the data systematically corrupts quality data, ultimately resulting in artificial inflation of quality outcomes (also known as elegant mathematics).

B. Medical Informatics

Medical informatics are not simply medical computing, telecommunications, or information engineering, but presumably a dialogue among physicians, patients, and medical informaticians --specialists in medical information. Medical informatics claims to be a science that seeks and develops new knowledge, which purportedly builds new theories, and organizes principles and solutions based on results of previous experiments. Because informatics are so essential to the practice of medicine and develop tools to solve real problems in every day clinical practice, investigators in cognitive sciences and artificial intelligence have often sought this arena for exploring their hypothesis.

Although there is not a widespread use of nursing informatics, the challenge for the nursing profession is to define the appropriate means by which the potential uses of such informatics is realized.

C. Demand Management and Information Therapy Also-Known as the “No Care Zone”

Proponents of demand management are celebrating the demise of managed care and are welcoming the long awaited demand management health care delivery system where a self diagnosis and self triage is accomplished through the use of hardcopy and/or software medical information systems. Demand management uses decisions and self-management support systems to mobilize consumers and help them decide how, where, when, and why to use health care services by incorporating teleservice technologies, triage, algorithm-driven care guidelines, and provider data bases.

In the future demand management may very well link up with “Information Therapy” a term first utilized in 1992. Information therapy is described as the use of medical information as a form of therapy similar to drug therapy, physical therapy or any other form of medical therapy. Studies indicate that information and the process of seeking medical information can empower patients as well as improve medical outcomes while lowering medical costs. This is an area which demands further investigation and it is anticipated that information therapy will become an important therapeutic concept in the near future.

VII. Telepresence Surgery

There have been other applications for medical technology:

This type of surgery is a novel technology that will allow procedures to be performed on a patient at locations that are physically remote from the operating surgeon. This new method provides the sensory illusion that the surgeon's hands are in direct contact with the patient. In its experimental stage, vascular surgeons studied the feasibility of the use of telepresence surgery to perform basic operations in vascular surgery, including tissue dissection, vessel manipulation and suturing.

VIII. Privacy and Protection of Individually Identifiable Health Information

Private health information is being shared, collected, stored and transmitted across state lines without state and/or federal safeguards. Currently only credit, video, and motor vehicle records are protected from unauthorized disclosure by federal privacy safeguards (Federal Privacy Act).

Revolutions in both health care communications (computerized medical records) and biology (genetic information/research to help prevent disease) caused the federal government to strongly urge Congress to develop and adopt a comprehensive measure to protect the privacy of medical records, to guarantee to consumers the right to inspect their records and to punish unauthorized disclosures of personal health data by hospitals, insurers, health plans, drug companies and others.

Problem Statement

There have been many instances where the patient's or consumers' privacy were violated:

Electronic records make it easier to snoop or engage in chart browsing which creates some concerns since hospital mergers have made it more likely that employees will receive medical care from their own institution. The most likely targets are certain patients, hospital employees, celebrities, and patients with sensitive diagnoses.

Electronic medical records are pooled for nonmedical reasons such as cost containment studies; financial viability (a banker on the board of a state health commission retrieves the names of cancer patients with loans at his bank and calls in the loan).

Drug companies are using electronic medical records to market new remedies to people suffering from a specific condition and health plans and life insurance companies looking for new costumers.

Most disturbing is the potential for misuse (genetic discrimination) of information gleaned from genetic testing since scientists are now able to predict, with increasing regularity, the genetic abnormalities that may affect a person's health. For example, genetic information used to identify a person's remains may be disclosed to another source and then used to deny insurance for that person's relatives. Such information being released without their knowledge and consent. As more genetic links to disease and behaviors are discovered, this information becomes more precious to insurers and others.

RECOMMENDATIONS

1. Oppose any and all technologies which are developed to maintain a health care system driven by private interest rather than the individual health care needs of an entire population; information systems which do not provide for competent human intervention; computers/software or medical equipment which is used to supplant instead of supplement health care providers/givers skilled judgment.
2. Oppose any or all forms of automation which replace health care professionals with technology or force them to keep pace with machines or interfere with the face-to face, hands on “therapeutic touch” by health care professionals.
3. No disclosures of health information or genetic information without informed consent of patient and affected parties. Health care and genetic information about consumers should be disclosed for health purposes and/or research only. Under no circumstances can health information be used for hiring, firing, promotion or to deny affordable health insurance or in any other way infringe on one’s civil rights.
4. Individuals or entities who legally receive health information must be required to safeguard the information or be subjected to legal or disciplinary sanctions when trading such information for economic gains or undue advantage.
5. There will be no sanctions against registered nurses or other health care workers for disclosing health information or records to authorized public officials for the purpose of patient advocacy and protecting the public interest
6. Encourage the use of technical security safeguards like audit trails, security codes, scrambling devices, passwords or electronic blocks. Encryption of confidential information transmitted via Internet or other on line means. Support legislation to classify Medical Expert Systems (MESs) as products, not services, giving injured patients the right to litigate any injuries resulting from the use of such systems in the courts, pursuant to product liability principles.
7. Sponsor or support regulations or legislation to assure the strictest regulation of Medical Expert Systems (Class III) medical devices, where such systems are to be marketed to the consumer for use without the supervision and intervention of a registered nurse or physician.

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SELECTED DEFINITIONS

Administrative Agency - a governmental body charged with administering and implementing particular legislation. Examples include the California Board of Registered Nursing and the California Medical Board.

Administrative Liability - liability which may be incurred by the individual who holds a license to practice as a registered nurse, physician, or any other profession licensed and regulated by a given State. Administrative liability involves a violation of laws, regulations, rules, orders or decisions promulgated by an administrative agency charged with the authority to regulate the practice of the licensee's profession. Administrative action is taken by the State against the licensee as a form of consumer protection.

Artificial Intelligence - a multi-disciplinary field encompassing computer science, neuroscience, philosophy, psychology, robotics, and linguistics: devoted to the reproduction of the method or results of human reasoning and brain activity.

Civil Liability - liability which may be incurred by one individual for damages or injury he or she has caused to another person. In the health care context civil liability commonly involves an allegation of professional negligence against a nurse, physician or health care facility. Civil liability may also include allegation of intentional bad acts, not limited to assault, battery, and infliction of emotional distress.

Demand Management - uses decisions and self-management support systems to mobilize consumers and help them decide how, where, when, and why to use health care services by incorporating teleservice technologies, triage, algorithm-driven care guidelines, and provider data bases.

Information Therapy - the use of medical information as a form of therapy similar to drug therapy, physical therapy or any other form of medical therapy.

Nursing Practice - those functions, including basic health care, which help people cope with difficulties in daily living that are associated with their actual or potential health or illness or problem or the treatment thereof including basic health care.

Telehealth - the use of electronic communications networks for the transmission of health information and data.

Telenursing - the practice of nursing over distance using telecommunication techniques.

Telemedicine - the use of electronic communication networks for the transmission of information and data related to the diagnosis and treatment of medical conditions.

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