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# MEDICAL CALL CENTERS PERFORMING TELEPHONE TRIAGE: IS THE DOCTOR IN? LIABILITY ISSUES AND THE NEED FOR REGULATION

*Steven J. Katz\**

*More than anything else, 800 numbers are a way of saving money. . . . Nurses' education does not qualify them to give advice over the telephone without making a diagnosis. . . . If someone has abdominal pain, it can be anything from gas to appendicitis. How is a nurse at the other end of an 800 line going to advise someone about this, and what is the advice based on?*<sup>1</sup>

## INTRODUCTION

The explosive growth of managed care<sup>2</sup> in the United States has fueled the development of medical telephone triage<sup>3</sup> performed

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\* Brooklyn Law School Class of 2001; B.B.A., University of Miami, 1983. This Note is dedicated to my wife, Estee, for her love and encouragement.

<sup>1</sup> Susan Gilbert, *Companies Say Hotline Triage Reduces Emergencies, Comforts Patients; Nurses Help Determine Whether Callers Need Immediate Medical Care*, DALLAS MORNING NEWS, Nov. 26, 1995, at 12A (quoting Dr. James Todd, Executive Vice President of the American Medical Association).

<sup>2</sup> 29 AM. JUR., *Proof of Facts* 3d § 1 (1995) [hereinafter *Questions and Answers*]. Managed care is defined as a system that integrates the financing and delivery of appropriate health care services to covered individuals by: structuring arrangements with providers to furnish comprehensive health care services; establishing criteria for selection of health care providers; implementing quality assurance and utilization review programs for enrolled members; and offering financial incentives for members using the managed care plan's network of health care providers. *Id.* § 2.

<sup>3</sup> James F. Childress, *Triage in Neonatal Intensive Care: The Limitations of a Metaphor*, 69 VA. L. REV. 547, 548 (1983). Medical triage is "the practice of sorting patients according to the urgency of their needs under emergency

by nurses or allied health professionals<sup>4</sup> in a Medical Call Center.<sup>5</sup> This growth is directly attributable to the rising costs associated with the delivery of health care and, as a consequence, managed

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conditions in which such needs are likely to be urgent and medical resources scarce." *Id.* The word "triage" is French, meaning to sort, pick, or grade, and was first applied by the English in the context of classifying the different grades of wool according to quality. *Id.* at 549. The use of telephone medical triage is a variation of traditional triage techniques performed in emergency rooms in that patients are triaged over the telephone without being seen by a nurse or physician. See Gilbert, *supra* note 1, at 12A. Today's advances in telemedicine equipment including combined audio/video components are breaking down the barriers associated with medical triage and early diagnosis of illness. See Steven J. Katz & Stanley H. Kornhauser, *Anatomy of a Telemedicine Call Center*, MEDICAL ELECTRONICS, Sept. 1997, at 65. Computerized systems are used for telephone triage to guide the nurse by identifying the illness and suggesting a course of treatment. See Emily Rhinehart, *Demand Management Moves into the Tech Era*, MANAGED HEALTHCARE, Dec. 1, 1998, at 20. This Note focuses primarily on the specialized form of medical triage known as "telephone triage," which limits patient interaction with the health care professional to the telephone.

<sup>4</sup> See AMERICAN RED CROSS/CPR FOR THE PROFESSIONAL RESCUER 3 (Mosby Lifeline 1993). "Allied health professionals" is a term used to describe the various groups of medically trained individuals involved in the health care industry. *Id.* Examples include: medical assistants; physical therapists; respiratory therapists; and x-ray technicians. *Id.*

<sup>5</sup> Kerry A. Kearney, *Legal Liability and Risk Considerations for a Medical Call Center*, HEALTH LAW., 1996, Vol. 3, at 15, 16. A Medical Call Center is an industry term for a call center that operates, usually 24 hours a day, to give patients "an opportunity to make informed and more cost effective health care choices." *Id.* A registered nurse or allied health professional answers patients' questions and guides the caller through urgent medical situations, often recommending a visit to the emergency room or other alternative health care option, such as a future visit to the patient's primary care physician, depending on the severity of the caller's condition. *Id.* The Medical Call Center also discusses treatment options and responds to a variety of patient inquiries with the goal of giving the most up-to-date medical information to patients by allowing them to make more informed choices about their health. *Id.* Medical Call Centers may be called "nurse-triage lines, demand management call centers, or nurse-on-call centers" but all terms essentially refer to the same basic services of telephone triage and health care information. *Id.* The goals of these centers are to reduce demand for emergency health care by allowing a worried patient to receive instantaneous phone advice about a medical symptom and reduce unneeded and expensive visits to the local emergency room or urgent care center. *Id.*

care is expected to be the preferred health care delivery model for most Americans in the new millennium.<sup>6</sup> Medical Call Centers, which are typically staffed by registered nurses<sup>7</sup> twenty-four hours a day, receive telephone calls from patients who describe their medical symptoms and receive advice<sup>8</sup> as to the most appropriate

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<sup>6</sup> Kenneth E. Thorpe, *The Health System in Transition: Care, Cost, and Coverage*, 22 J. HEALTH POL. POL'Y & L. 339, 341 (1997) (citing Foster Higgins, *National Survey of Employer Sponsored Health Plans* (1994)) (discussing the growth of managed care generally in light of rising health care costs). A national survey of employer health plans conducted in 1995 concluded that an estimated 71% of employees working in firms of 10 or more employees were enrolled in some form of managed care plan, as compared to 52% in 1993, nearly a 50% increase in just two years. *Id.* Although economists tend to measure growth in health care costs that have been steadily rising, many industry surveys tend to measure health care spending in terms of spending per employee or changes in premiums. *Id.* at 347. Therefore, although actual medical costs have risen, the migration of employees from more expensive fee-for-service traditional insurance plans to lower cost managed care plans has reduced the growth of overall health care spending. *Id.* at 348. The United States Government is also encouraging Medicare and Medicaid patients to join the managed care revolution by continuing to expand its coverage in such programs. *Id.* at 340. The Congressional Budget Office estimates that the number of Medicare beneficiaries enrolled in managed care plans should increase to 24% by the year 2002. *Id.*

<sup>7</sup> Julie Appleby, *Who Do You Call: 911 or Your HMO? Kaiser Plan Widely Watched*, USA TODAY, Aug. 24, 1999, at 1A. Although most Medical Call Centers are staffed by registered nurses, who are usually supervised in some fashion by a physician acting as a Medical Director, a recent and alarming trend is occurring in the industry where call center employees have either minimal medical training, such as paramedics or emergency medical technicians who are licensed to perform limited emergency medical procedures in the field under the direct supervision of a physician, or no medical background at all. *Id.* Kaiser Permanente, a national managed care company, recently announced that they will require all plan members to call their Medical Call Center for approval of emergency room visits and to use the call center as an alternative to dialing 911. *Id.* These calls will be handled by telephone dispatchers with no medical training at all, except for a four week in-house training program. *Id.* See *infra* notes 20-21 (discussing nurse qualifications in New York State).

<sup>8</sup> See Rhinehart, *supra* note 3, at 20. Early Medical Call Center systems relied primarily on a nurse's own judgement and experience in handling a call without the benefit of computers or automation. See Rhinehart, *supra* note 3, at 20. The nurse had access to certain medical books and self-help guides dealing with common ailments and symptoms. See Rhinehart, *supra* note 3, at 20.

method of treatment.<sup>9</sup> The primary goal of a Medical Call Center is the reduction of unnecessary and expensive emergency room visits by redirecting patients to an appropriate level of care, such as a doctor's office or self-care<sup>10</sup> measures at home, for those with non-emergent symptoms.<sup>11</sup> The primary beneficiary of this cost savings is the Health Maintenance Organization ("HMO")<sup>12</sup>

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Recently, sophisticated computer software has been developed for the Medical Call Center industry, which streamlines most of the decision making processes for the nurse. See Rhinehart, *supra* note 3, at 20.

Today's environment requires a computer-based clinical decision-support system with software that provides standardized algorithms, protocols and a documentation function. . . . The software is designed to provide a standard method of documentation of the encounter, optimize the intake of information, and provide a consistent approach to provision of information and directions for care.

See Rhinehart, *supra* note 3, at 20. For example, most software uses a question and answer protocol for specific illness and tracks a patient's previous calls to the center, thereby allowing the software to compare the current call to the patient's prior illnesses. See Rhinehart, *supra* note 3, at 20.

<sup>9</sup> See S. R. Poole et al., *After-Hours Telephone Coverage: The Application of an Area-Wide Telephone Triage and Advice System for Pediatric Practices*, PEDIATRICS, November 1993, at 670-79 (describing a statistical analysis of common types of calls by symptom). Callers may have questions about any type of medical ailment and complaints include hundreds of common symptoms ranging from headache to severe chest pain. *Id.*

<sup>10</sup> See THE CAREWISE GUIDE: SELF-CARE FROM HEAD TO TOE 4-7 (Acamedica Press 1995). "Self-care" describes a patient's ability to treat an illness by utilizing a three-step program: disease prevention; self-care participation including the use of home care remedies or over-the-counter medications without the aid of a physician; and education of self-care options. *Id.*

<sup>11</sup> Kearney, *supra* note 5, at 15. Many callers, especially new mothers with sick children, tend to be reassured by telephone triage nurses when symptoms indicate a minor illness. See Poole, *supra* note 9, at 678. Suggestions for fever might include increasing Tylenol or giving a lukewarm water bath to cool down a feverish child. See generally George Anders, *Telephone Triage: How Nurses Take Calls and Control the Care of Patients from Afar*, WALL ST. J., Feb. 4, 1997, at A1 (describing the telephone triage process at a typical Medical Call Center).

<sup>12</sup> See *Questions and Answers*, *supra* note 2 (giving a historical perspective of the HMO). There are several types of managed care provider arrangements. One of the most popular types of managed care organizations is referred to as an HMO. See *Questions and Answers*, *supra* note 2. HMOs "put together a

or employer who sponsors the Medical Call Center hotline for its own employee members. Industry analysts estimate that over 35 million Americans have access to a Medical Call Center, with an expected annual growth rate of twenty five percent.<sup>13</sup>

The large call volume<sup>14</sup> handled by Medical Call Centers assures that certain calls will be mishandled, resulting in litigation.<sup>15</sup> HMOs generally avoid liability for medical malpractice claims because of the preemption protection that the Employee Retirement Income Security Act of 1974 ("ERISA") affords.<sup>16</sup>

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network of physicians, hospitals, and other health care providers." See *Questions and Answers*, *supra* note 2. "While members can go outside of the network for services, there are financial disincentives for doing so, such as only partial reimbursement. . . . [HMOs emphasize] the Chinese tradition of paying physicians to keep members healthy instead of paying them to cure the sick." See *Questions and Answers*, *supra* note 2. There are also different types of provider arrangements within an HMO. See *Questions and Answers*, *supra* note 2. "Health care providers in an HMO may be paid on a 'capitation' basis; a set amount for each member who chooses them from a provider list, and are charged with the task of keeping their . . . [patients] healthy (and sometimes receive benefits for doing so)." See *Questions and Answers*, *supra* note 2. "Usually, members' health care costs are covered only if they use gatekeeper [pre-assigned] physicians and other network providers." See *Questions and Answers*, *supra* note 2. For the history of the development of managed care and the structure of HMOs, see James F. Henry, *Liability of Managed Care Organizations After Dukes v. U.S. Health Care*, *an Elemental Analysis*, 27 CUMB. L. REV. 681 (1996-97).

<sup>13</sup> Anders, *supra* note 11, at A1.

<sup>14</sup> Anders, *supra* note 11, at A1. Approximately 500,000 calls were handled by one of the largest call centers operated by Access Health in Broomfield, Colorado during 1996. Anders, *supra* note 11, at A1. Estimates for calls to this center in 1997 were 1,000,000. Anders, *supra* note 11, at A1.

<sup>15</sup> See *Adams v. Kaiser Foundation Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995) (involving a telephone triage nurse who recommended that a six-month old infant with high fever be driven to a Kaiser network hospital rather than the nearest available emergency facility). In *Adams*, the child suffered permanent injury including loss of his limbs. *Id.* A jury adjudged Kaiser liable for negligence and awarded the family in excess of \$45,000,000 in damages. *Id.* For a more detailed discussion of *Adams*, see Kearney, *supra* note 5, at 15.

<sup>16</sup> 29 U.S.C. §§ 1001-1461 (1994 & Supp. II 1996). The purpose of ERISA is to protect employees and their beneficiaries from conflicting state laws relating to employee benefit plans. Julie K. Freeman, *ERISA Preemption of Medical Malpractice Claims Against Managed Care Organizations*, 36 DUQ. L. REV. 863 (1998). This protection limits the ability of plan members to sue their managed

Recently, however, a federal district court, denying ERISA protection, allowed a direct negligence action to proceed in state court against an HMO for a misdiagnosis by the telephone triage nurse employed by the HMO.<sup>17</sup> Additionally, state courts are finding HMOs vicariously liable when their nurse lines give faulty medical advice under the theory that their nurses were rendering medical decisions.<sup>18</sup> Courts are finding liability even though the industry practice provides a disclaimer before beginning a telephone encounter, which states that the nurse's "advice" is not a medical diagnosis, but merely a recommendation of options from which the patient is free to choose.<sup>19</sup>

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care plan in state court for tort liability. *Id.*

<sup>17</sup> *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999) (holding that an HMO may be liable for negligence for faulty medical advice provided by a medical triage nurse without interpreting ERISA).

<sup>18</sup> *See id.* (holding that an HMO may be liable for negligence without interpreting ERISA); *Adams v. Kaiser Foundation Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995) (finding liability for faulty administrative advice by a triage nurse); *Starkey v. St. Rita's Med. Ctr.*, 690 N.E.2d. 57 (Ohio Ct. App. 1997) (holding that plaintiff met the burden of showing negligence by a hospital sponsored telephone triage line for misdiagnosing a heart attack, and allowed a new trial based on a newly recognized cause of action for lost chance of recovery or survival); *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998) (holding that plaintiffs made a prima facie case against an HMO for vicarious liability and corporate liability for negligent rendering of services by its telephone triage nurses).

<sup>19</sup> Most call centers follow certain guidelines in avoiding the appearance of giving medical advice. *See generally* Alan S. Goldberg, *Managed Care & Medical Call Centers: A Telemedicine Case Study* (last modified Dec. 1997) <<http://www.healthlawyer.com>> (suggesting protocols for Medical Call Centers regarding telephone triage disclaimers). Typically, centers utilize computer software with physician-created algorithms that nurses must follow with little room for adjustment, while nurses are instructed to never explicitly diagnose an ailment or formally outline a treatment plan, and, most importantly, the nurses must only recommend rather than prescribe a course of action. *See Rhinehart, supra* note 3, at 20. Although these guidelines are theoretically sound, in practice the triage nurse is often forced by circumstance to strongly recommend a particular outcome. *See Rhinehart, supra* note 3, at 20. If the nurse suspects a true medical emergency, prudence dictates that a forceful recommendation for an immediate trip to the emergency room is appropriate, both for the patient's safety and to avoid any liability. *See Rhinehart, supra* note 3, at 20. However,

These findings of liability pose challenges to the licensure of nurses operating telephone triage systems.<sup>20</sup> Although state nursing licensure statutes generally allow a nurse to speak with a patient about his or her medical condition under the direct supervision of a physician,<sup>21</sup> the Medical Call Center dynamic changes the nature of the physician-patient relationship.<sup>22</sup> Recent court decisions have predicated the HMO's liability on a nurse's "misdiagnosis" of the caller's conditions or the failure to properly respond to the medical condition.<sup>23</sup> Additionally, these court decisions have alluded to the fact that the nurses were acting

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a recent medical study has shown that nurses rarely follow the same protocol recommendations, even when faced with identical symptoms, indicating that the telephone triage process may have certain fundamental flaws that need further evaluation. See Peter Mitchell, *Latest Study on Telephone Triage Raises Doubts on Widespread Use*, LANCET, Apr. 10, 1999, at 1247.

<sup>20</sup> See, e.g., N.Y. EDUC. LAW § 6902 (McKinney 1999). Nurses are required to be licensed in the state in which they practice. In New York State, for example, the nursing profession is governed by state education statutes. *Id.*

<sup>21</sup> *Id.*

The practice of registered professional nursing by a nurse practitioner . . . may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician . . . provided such services are performed in accordance with a written practice agreement and written practice protocols.

*Id.* § 6902(3)(a). Other state licensing laws are similar to New York's. See, e.g., PA. STAT. ANN. tit. 63 § 212 (West 2000) (defining the practice of professional nursing in Pennsylvania).

<sup>22</sup> See, e.g., N.Y. EDUC. LAW § 6902 (McKinney 1995). It is clear from New York's statute regarding nursing licensure that the legislature intended for nurses to be closely supervised by a physician with respect to diagnosis of medical ailments. *Id.* When a nurse, however, converses with an out-of-state patient who has never been seen by the physician supervising that nurse about the patient's medical symptoms, the nurse may be exceeding his license if the patient is not under supervision of a physician who "collaborates" with the nurse on the patient's care. See Diane M. Glaneill, *Pa. Physicians Object to "Telenurses"*, AM. MED. NEWS, July 20, 1998, at 1 (discussing the need for local state licensure for out of state nurses handling calls from Pennsylvania callers).

<sup>23</sup> See cases cited *supra* note 18 (finding liability or prima facie evidence of negligence for faulty telephone triage advice).



outside the scope of their duties and abilities.<sup>24</sup> Consequently, the issue of criminal unauthorized practice of medicine by telephone triage nurses has been raised.<sup>25</sup> Indeed, potential criminal liability lurks behind every interstate telephone encounter, as many of these Medical Call Centers operate nationally via toll-free numbers.<sup>26</sup> For example, the Pennsylvania Board of Medicine<sup>27</sup> has recently begun to investigate whether out-of-state nurses require a Pennsylvania nursing license before receiving calls from Pennsylvania residents.<sup>28</sup> In addition, New York State has recently required an HMO that contracted for Medical Call Center services by a Colorado company to license its telephone nurses in New York before resuming operations, under threat of felony criminal prosecution for performing nursing activities without a license.<sup>29</sup>

The federal government has not yet taken an official stance on current interstate industry practices.<sup>30</sup> Although federal legislation

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<sup>24</sup> See, e.g., *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998) (holding that telephone triage is a "medical" service).

<sup>25</sup> See, e.g., N.Y. EDUC. LAW § 6512(1) (McKinney 1999). In New York State, the unauthorized practice of medicine is a class E Felony. *Id.* In considering whether an individual has violated this statute, courts have applied the following factors: whether there was a diagnosis determining a disease, infirmity, or physical condition; whether a remedy or treatment was prescribed; whether the acts performed by the defendant were such as to endanger the public health; and whether the defendant invaded the territory of the medical profession by specific actions solely within the province of a duly trained and knowledgeable medical practitioner. See also *People v. Kleiner*, 664 N.Y.S.2d 704, 710 (Sup. Ct. 1997); *People v. Rubin*, 424 N.Y.S.2d 592, 597 (Crim. Ct. 1979).

<sup>26</sup> See *Anders*, *supra* note 11, at A1. Most Medical Call Centers operate nationally via a centralized call center. See *Anders*, *supra* note 11, at A1.

<sup>27</sup> See PA. STAT. ANN. tit. 63 § 422.3 (West 2000) (establishing the state board of medicine). The Pennsylvania Board of Medicine is the governing body empowered by state statute to set guidelines and discipline physicians. *Id.*

<sup>28</sup> See *Glaneill*, *supra* note 22, at 1 (discussing the need for local state licensure for out-of-state nurses handling calls from Pennsylvania callers).

<sup>29</sup> See *Amber Smith, PHP Drops Colorado Telephone Nursing Service the Nurses, Who did Telephone Triage for the HMO, are in the Process of Applying for New York State Licenses in an Effort to Resume the Service*, POST STANDARD (Syracuse, N.Y.), Mar. 3, 1998, at D9.

<sup>30</sup> Most telemedicine practice issues (which, presumably, include telephone triage) are currently regulated at the state level. See *Kathleen M. Vyborny, Legal & Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 67 (1996).

regarding telemedicine and telehealth services is currently pending,<sup>31</sup> this legislation relates to reimbursement issues and other services providing medical diagnosis and treatment via the telephone in the context of physician communication with patients utilizing appropriate equipment that can facilitate the diagnosis over the telephone.<sup>32</sup> Medical Call Centers are generally considered not to be covered by such pending legislation because, presumably, no medical diagnosis or physician-patient relationship has been established.<sup>33</sup> Consequently, although equipment used by telemedicine services to facilitate diagnosis by the physician with the patient over telephone lines requires Food and Drug Administration ("FDA") approval,<sup>34</sup> the software used by many Medical Call

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These issues are legislated by individual states with varying standards. The interstate nature of telemedicine and telephone triage, however, lends itself to federal jurisdiction via the federal government's preemption of matters relating to interstate commerce under Article 1 of the United States Constitution. *Id.* at 93. Such federal powers derive from "common callings," such as medicine and medical commerce, which pass through many state borders. *Id.* at 94. This is especially true of telemedicine and telephone triage which utilizes telecommunications, an industry regulated primarily by the federal government, to facilitate patient encounters. *Id.* A recent House bill proposing to improve the Medicare telemedicine program will require the Secretary of Health and Human Services to prepare a report regarding telehealth licensure across state lines. *See* Telehealth Improvement Act of 1999, H.R. 3420, 106th Cong. (1999).

<sup>31</sup> *See, e.g.,* Comprehensive Telehealth Act of 1999, S. 770, 106th Cong. (1999) (proposing to provide reimbursement under the Medicare program for telehealth services); Promoting Health in Rural Areas Act of 1999, S. 980, 106th Cong. (1999) (promoting access to health care services in rural areas via development of telehealth networks); Triple-A Rural Health Improvement Act of 1999, H.R. 1344, 106th Cong. (1999) (promoting access to healthcare in rural area via development of telehealth services).

<sup>32</sup> *See supra* note 31 (describing pending telemedicine legislation).

<sup>33</sup> As more civil negligence actions establish that telephone triage is a medical service, it will be noteworthy to see whether or not the federal government's current views of the industry will change. *See, e.g.,* Shannon v. McNulty, 718 A.2d 828, 836 (Pa. Super. Ct. 1998).

<sup>34</sup> *See* Katz & Kornhauser, *supra* note 3, at 64. Such equipment includes any transtelephonic, electronic devices and the software necessary to operate such equipment. *See* Katz & Kornhauser, *supra* note 3, at 64. For example, heart patients can transmit their heart rhythms over standard telephone lines to a receiving station at a clinic or hospital for immediate evaluation by a health care

Centers that facilitates a recommended outcome for the telephone triage nurse is not currently subject to FDA oversight.<sup>35</sup> The American Accreditation Health Care Commission/URAC ("AAHCC/URAC"),<sup>36</sup> a non-profit organization established to set standards for the managed care industry, is the only national organization that has published a set of voluntary standards for the Medical Call Center industry.<sup>37</sup>

This Note analyzes the civil and potential criminal liability issues inherent in the Medical Call Center industry. Part I provides an overview of medical telephone triage services performed in Medical Call Centers and its origins in managed care. Part II discusses recent case law regarding civil liability for HMOs sponsoring Medical Call Centers and preemption issues surrounding ERISA. Part III examines licensure issues and potential criminal liability relating to Medical Call Center staff. Part IV discusses current government and FDA regulations applicable to telephone

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professional. See Katz & Kornhauser, *supra* note 3, at 64. Many such receiving facilities are free-standing, independent, physiological laboratories which require approval as registered providers before billing for services that rendered. See Katz & Kornhauser, *supra* note 3, at 64.

<sup>35</sup> See FDA POLICY FOR THE REGULATION OF COMPUTER PRODUCTS § III, Nov. 13, 1989; Food, Drug, and Cosmetic Act, 21 U.S.C. § 201(h) (1994). The Food and Drug Administration is the federal agency whose mandate is to regulate the food, veterinary, pharmaceutical and medical device industries, under authority of Congress. Food, Drug, and Cosmetic Act, 21 U.S.C. § 393 (Supp. IV 1998). For an in-depth discussion regarding the FDA's current policy exempting telephone triage software, see Telephone Interview, *infra* note 240. For a discussion of current software available for medical triage, see Rhinehart, *supra* note 3, at 20.

<sup>36</sup> See *Health Call Center Standards*, AMERICAN ACCREDITATION HEALTH-CARE COMMISSION/URAC (visited March 30, 2000) <<http://www.urac.org/-summaries.htm>> [hereinafter *URAC Standards*].

<sup>37</sup> *URAC Standards*, *supra* note 36, at 36. Examples of some standards include requiring: medical triage to be performed only by licensed registered nurses; clinical oversight by a licensed physician; a full time board certified medical director; and full written documentation of triage encounters. *URAC Standards*, *supra* note 36, at 36. Currently, several Medical Call Centers have received voluntary accreditation from the URAC commission including Access Health, the nation's largest Medical Call Center. See *AAHCC/URAC Website* (visited Mar. 30, 2000) <[http://www.urac.org/accred\\_abc.htm](http://www.urac.org/accred_abc.htm)>.

triage and the equipment used to effectuate a triage encounter. Finally, Part V proposes statutory and legislative solutions necessary to create a uniform industry standard for HMOs and Medical Call Centers utilizing telephone triage. This Note concludes with recommendations for proposed regulations in the Medical Call Center industry based, in part, on standards proposed by the AAHCC/URAC. At the federal level, the FDA should regulate the medical triage computer software used during a triage encounter. Additionally, Congress should allow states to regulate the HMO industry without the interference of federal ERISA preemption issues and allow states uniformly to legislate licensure statutes, emphasizing interstate nursing practices and standards, thereby adequately protecting consumers with practical regulation and legislation in this new era of managed care cost cutting initiatives.

#### I. MEDICAL TELEPHONE TRIAGE AND ITS ORIGINS IN MANAGED CARE

Medical telephone triage developed as an outgrowth of rising health care costs faced by large corporations during the 1980s.<sup>38</sup> While early efforts to inform corporate employees about their health began with printed medical literature, corporate wellness programs, and self-help guidebooks,<sup>39</sup> these efforts soon shifted to the development of Medical Call Centers where patients could ask health related questions to live operators.<sup>40</sup> Today, Medical Call Centers are staffed, in most cases, by registered nurses, and handle a variety of health questions from callers on a twenty-four

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<sup>38</sup> See Linda A. Johnson, *Triage: Medical Hot Lines Are Hot Commodity, But Liability Gives Some Shivers*, ST. LOUIS POST-DISPATCH, Feb. 16, 1997, at 13A. The pharmaceutical industry was one of the first to begin using information lines and other methods of consumer involvement in the 1980s as a way of promoting wellness and marketing their products. *Id.*

<sup>39</sup> See Julie Brienza, *Civil Rights Lawyers Ask, 'What's the Skinny on Wellness Benefits Programs?'*, 34 TRIAL 13 (1998). These initiatives include wellness programs such as preventive care education seminars, on-the-job health screenings for high blood pressure and high cholesterol levels, and smoking-cessation classes that have become more popular since the early 1990s. *Id.*

<sup>40</sup> See Johnson, *supra* note 38, at 13A.

hour basis, seven days a week and utilize sophisticated computer software.<sup>41</sup> The challenges facing Medical Call Centers include limiting civil liability for mishandled calls<sup>42</sup> and ensuring proper licenses for all operators<sup>43</sup> while avoiding the appearance of “diagnosing” callers’ medical symptoms, which may have additional ramifications, including potential criminal liability for the unauthorized practice of medicine.<sup>44</sup>

### A. *Origins of Telephone Triage*

The concept of medical telephone triage evolved in the early 1980s when employers, providing health insurance benefits as part of compensation packages for employees, began experimenting with various cost-saving initiatives to reduce costs.<sup>45</sup> Many large employers utilized self-insurance for most, or all, of their health insurance risks.<sup>46</sup> A major component of the health insurance cost

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<sup>41</sup> See, e.g., Anders, *supra* note 11, at A1 (describing the telephone triage process at Access Health, one of the nation’s largest Medical Call Centers).

<sup>42</sup> See, e.g., Crum v. Health Alliance-Midwest, Inc., 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999); Adams v. Kaiser Foundation Health Plan, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995); Shannon v. McNulty, 718 A.2d 828, 835 (Pa. Super. Ct. 1998).

<sup>43</sup> See Glaneill, *supra* note 22, at 1 (discussing the need for Pennsylvania state nursing licenses for out of state nurses handling calls from Pennsylvania callers).

<sup>44</sup> See Goldberg, *supra* note 19 (discussing potential criminal liability for unauthorized practice of medicine for nurses diagnosing patients’ symptoms).

<sup>45</sup> See Brienza, *supra* note 39, at 13. These initiatives include wellness programs such as preventive care education seminars, on-the-job health screenings for high blood pressure and high cholesterol levels, and smoking-cessation classes. Brienza, *supra* note 39, at 13.

<sup>46</sup> See Bryan Ford, *The Uncertain Case for Market Pricing of Health Insurance*, 74 B.U. L. REV. 109, 123 (1994). Many companies with large employee populations utilized self-insurance as a means of reducing health care costs. *Id.* Statistically, a larger group of individuals (assuming a large percentage of healthy people) whose health insurance premiums were pooled were able to subsidize a greater percentage of the overall population health insurance costs of the company for minor illnesses, from an actuarial risk perspective. *Id.* Traditional indemnity insurance would still be purchased by the company, but only for serious illnesses costing over a certain amount of base premium level, or stop-gap level. *Id.* The larger the company’s employee population, the more

was needless emergency room and doctor visits that employees took indiscriminately, as there was no limitation on coverage and no disincentive for multiple visits, even for minor ailments that could have been treated at lower cost.<sup>47</sup> Employers soon realized that providing employees with relevant health information and education would reduce overall health care costs.<sup>48</sup> Employers initially supplied their employees with such health care information in the form of self-care guidebooks, health care risk assessments<sup>49</sup> and wellness programs.<sup>50</sup> Eventually, those early efforts were streamlined into a live Medical Call Center where employees could obtain health information and ask medical questions of trained personnel in a confidential setting.<sup>51</sup> In disseminating this valuable information, employers generally sought the expertise of independent companies whose only focus was operating a Medical Call Center that could be contracted to handle the calls of their clients' employees.<sup>52</sup>

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risk it could absorb in its self-insurance pool. *Id.*

<sup>47</sup> See Poole, *supra* note 9, at 670-79 (discussing the cost of emergency room care versus doctor visits or self help at home for a typical ailment).

<sup>48</sup> See Brienza, *supra* note 39, at 13.

<sup>49</sup> See Brienza, *supra* note 39, at 13. A health care risk assessment is a screening test used to identify certain inherent risk factors for major diseases such as heart disease and high blood pressure, similar to an on-the-job health screening. See Brienza, *supra* note 39, at 13.

<sup>50</sup> See Brienza, *supra* note 39, at 13. A wellness program combines smoking cessation classes, illness screenings, and preventive care education seminars. See Brienza, *supra* note 39, at 13. The pharmaceutical industry was one of the first to begin using information lines and other methods of consumer involvement in the 1980s as a way of promoting wellness and marketing their products. See Johnson, *supra* note 38, at 13A. A self-care guidebook is a medical text listing symptoms of common ailments and simple, home-care remedies that patients can use without physician intervention. See, e.g., THE CAREWISE GUIDE: SELF-CARE FROM HEAD TO TOE, *supra* note 10.

<sup>51</sup> See Dixie L. Griffin, *Dialing for Doctors*, COLO. BUS. MAG., Feb. 1997, at 20. The Medical Call Center industry started out with a few diverse companies offering telephone triage services such as Informed Access, Access Health, and Health Decisions International LLC. *Id.*

<sup>52</sup> *Id.* at 20. The industry has recently undergone a huge consolidation with McKesson HBOC's purchase of Access Health, the nation's largest independent Medical Call Center provider. See John Morrissey, *FHS Hooks Up with Access Health Group: HMO Will Outsource its Telephone Medical Advice Services to*

With the rising popularity of managed care,<sup>53</sup> employers began to realize that significant cost savings could be achieved by switching their employees from traditional indemnity plans or self-insured policies to managed care plans with networks of plan physicians, whose service contract rates were discounted by volume patient referrals.<sup>54</sup> The managed care plan or HMO soon experienced the same cost savings pressures originally placed on employers to reduce healthcare costs in order to improve profitability.<sup>55</sup> As a result of these financial pressures, many smaller HMOs began contracting for Medical Call Center services with independent companies, while larger health plans established their own in-house call centers due to larger economies of scale.<sup>56</sup> Hospitals, which had been offering telephone physician-referral lines<sup>57</sup> to community members within their geographic catchment area,<sup>58</sup> began adding telephone medical triage as an additional service.<sup>59</sup>

Today, telephone medical triage services are offered primarily by HMOs, either in-house or as a contracted service by independent companies, by hospitals or physician groups as a value-added

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*Colo. Company*, MOD. HEALTHCARE, Jan. 25, 1999, at 36. Access Health now has 34 million enrollees, close to 13% of the United States population. *Id.*

<sup>53</sup> See Thorpe, *supra* note 6, at 340 (discussing the growth of managed care in light of rising health care costs).

<sup>54</sup> See Henry, *supra* note 12, at 687 (discussing the historical development of managed care and the structure of HMOs).

<sup>55</sup> See generally Thorpe, *supra* note 6, at 339.

<sup>56</sup> See Morrissey, *supra* note 52, at 36. Economies of scale are a primary factor in running a successful Medical Call Center. See Morrissey, *supra* note 52, at 36. Recently, one of the largest HMOs in the nation, FHS, closed its in-house call center in favor of a contracted service with Access Health due to lack of sufficient size to justify the cost of operating a successful center. See Morrissey, *supra* note 52, at 36.

<sup>57</sup> See DIRECTORY OF MEDICAL CALL CENTERS 4 (Faulkner & Gray 1st ed. 2000) [hereinafter DIRECTORY]. A physician-referral line is a service in which the hospital refers patient callers to its own network of physician specialists or primary care doctors. *Id.* This service is useful as a marketing tool for the hospital and strengthens the commitment of network physicians. *Id.*

<sup>58</sup> A catchment area is the surrounding area served by an institution. AMERICAN HERITAGE COLLEGE DICTIONARY 221 (3d ed. 1993).

<sup>59</sup> See DIRECTORY, *supra* note 57, at 4 (discussing the evolution of Medical Call Centers).

neighborhood or regional service, or by independent companies that contract out their call center services to employers, HMOs and hospital networks.<sup>60</sup> These services may be either voluntary or mandatory. While some are offered daily during only working hours, others are offered twenty-four hours a day. Although a few services still use books and written manuals for patient information,<sup>61</sup> most have access to the latest computer software with algorithmic capabilities.<sup>62</sup> Staffing policies vary by center, with most call centers hiring registered nurses, while a few are staffed by unlicensed telephone operators who are given only four weeks of company training before handling live calls.<sup>63</sup> Charges for Medical Call Center services also vary depending on the type of service,<sup>64</sup> ranging from a per-call charge to a capitative, per-month fee for a given call population.<sup>65</sup>

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<sup>60</sup> For a survey of the different types of Medical Call Centers operating nationally, see *DIRECTORY*, *supra* note 57, at 257-362.

<sup>61</sup> See *Adams v. Kaiser Foundation Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga.) (finding civil liability for the improper advice given by a triage nurse who did not use a computerized telephone triage system). In *Adams*, the Kaiser telephone triage service did not use any computers, but relied on books and manuals to assess patients. *Id.*

<sup>62</sup> See Rhinehart, *supra* note 3, at 20. Medical triage software utilizes "algorithms," a computer term describing a process of deriving the proper result from the application of a series of questions and answers, similar to a computer flow chart. See *DIRECTORY*, *supra* note 57, at 560.

<sup>63</sup> See Appleby, *supra* note 7, at 1A. Kaiser Permanente, a national managed care company, has recently implemented a dispatch and triage system using non-medical telephone operators with limited administrative training. See Appleby, *supra* note 7, at 1A.

<sup>64</sup> See Katz & Kornhauser, *supra* note 3, at 64. A number of additional services have been developed by Medical Call Centers to satisfy the demands of managed care and hospital clients. See Katz & Kornhauser, *supra* note 3, at 64. Examples include: health risk appraisals and surveys for corporate wellness programs; 24 hour interactive voice-response health information libraries for patient education; disease-state management and outcomes measurement; and proactive, outbound calls for compliance counseling and medication monitoring of homebound and chronically ill patients. See Katz & Kornhauser, *supra* note 3, at 63.

<sup>65</sup> See Katz & Kornhauser, *supra* note 3, at 63. Most call centers that contract out services for corporate clients have a per-member, per-month fee ("PMPM") covering the client's entire population of subscribers. See Katz &



### B. The Telephone Triage Process

A typical telephone medical triage encounter begins when a managed care member calls the Medical Call Center information line.<sup>66</sup> Usually, the member first will hear a pre-recorded, scripted disclaimer stating that it is an advice line only and a medical diagnosis will not be given.<sup>67</sup> The member is also warned that if the call pertains to an immediate medical emergency, he should hang up and immediately dial 911 or contact the nearest emergency room facility.<sup>68</sup> After this brief recorded disclaimer, callers are typically placed in a telephone queue to await the next available operator.<sup>69</sup> The wait time before speaking with an operator can vary greatly by center and is affected by the amount of staff on call, time of day, volume of calls, and time of year.<sup>70</sup> In some circumstances, a caller is given the opportunity to listen to a pre-recorded message concerning a particular health topic prior to

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Kornhauser, *supra* note 3, at 63. Rates range from fifty cents to two dollars PMPM, depending on the range of services being offered. See Katz & Kornhauser, *supra* note 3, at 63. For smaller contracts, a per call rate is charged that may exceed ten dollars because of the cost of providing a triage call, which averages between eight dollars and ten dollars per call. See, e.g., Michael Menduno, *Calls Forwarded*, HOSP. & HEALTH NETWORKS, July 1, 1999, at 14 (describing the cost structure of telephone triage calls at Medical Call Centers).

<sup>66</sup> See DIRECTORY, *supra* note 57, at 19 (describing what happens when patients dial into a Medical Call Center).

<sup>67</sup> See DIRECTORY, *supra* note 57, at 199.

<sup>68</sup> See DIRECTORY, *supra* note 57, at 199. For example, some recordings warn "if this is a medical emergency, hang up and call 911 immediately." See DIRECTORY, *supra* note 57, at 199.

<sup>69</sup> See DIRECTORY, *supra* note 57, at 19. In a typical Medical Call Center, 90% of all calls are answered by a nurse within 20 seconds of going into a call queue. See DIRECTORY, *supra* note 57, at 19.

<sup>70</sup> See Anders, *supra* note 11, at A1. At Access Health, the preferred maximum wait time for callers is 20 seconds. Anders, *supra* note 11, at A1. During early morning hours, call volumes increase to the point where callers are placed on hold for close to three minutes, far exceeding Access Health's own guidelines. Anders, *supra* note 11, at A1. Most Medical Call Centers have reduced call volumes after 2:00 A.M., but pick up volume in the morning and remain busy throughout the day and early evening. Anders, *supra* note 11, at A1.

transfer to a live operator.<sup>71</sup> In such instances, the caller is usually able to return to the live operator telephone queue after listening to the pre-recorded health information.<sup>72</sup>

The actual encounter is initiated by the operator who typically obtains the callers pedigree information, including membership number, to verify eligibility for the service.<sup>73</sup> The caller then describes his symptoms and a question and answer dialogue ensues.<sup>74</sup> An average call lasts six to ten minutes,<sup>75</sup> and usually ends with the operator's suggestion of various options for the caller to consider.<sup>76</sup> If, during the course of the call, the operator suspects that the call is an emergency, the operator immediately recommends that the caller go to the nearest emergency room.<sup>77</sup>

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<sup>71</sup> See DIRECTORY, *supra* note 57, at 19. Members typically receive booklets with reference numbers for hundreds of different medical topics upon enrollment, which they can access on their own without speaking to a nurse, or which they can listen to before, or after, a live triage encounter. See DIRECTORY, *supra* note 57, at 20.

<sup>72</sup> See DIRECTORY, *supra* note 57, at 19.

<sup>73</sup> Pedigree information includes items such as a caller's name and medical identification number. See DIRECTORY, *supra* note 57, at 43. Most Medical Call Centers require membership information before handling the call. See DIRECTORY, *supra* note 57, at 43. See also Goldberg, *supra* note 19 (describing suggested policies that call centers should implement to reduce liability while handling triage calls).

<sup>74</sup> See DIRECTORY, *supra* note 57, at 43.

<sup>75</sup> See Anders, *supra* note 11, at A1. At Access Health, the average call lasts just eight and a half minutes, requiring much skill on the part of the triage nurse to successfully handle the call in a short time. See Anders, *supra* note 11, at A1. See also DIRECTORY, *supra* note 57, at 101 (describing a 1995 workload analysis of inbound and outbound calls with talk time averages).

<sup>76</sup> See generally Raymond C. Baker et al., *After-Hours Telephone Triage and Advice in Private and Nonprivate Pediatric Populations*, ARCHIVES OF PEDIATRIC & ADOLESCENT MED., Mar. 1, 1999. There are generally three options given by triage nurses to their callers: an immediate emergency room or urgent care visit; a doctor office visit; or self-help. *Id.* See *id.*, for an in depth statistical analysis of call dispositions in a controlled setting. A recent study found that even within the same Medical Call Center, triage nurses rarely agree on the advice they give to callers, when faced with similar symptoms and rigid protocols. See Mitchell, *supra* note 19, at 1247.

<sup>77</sup> See Rhinehart, *supra* note 3, at 20. This suspicion may arise either from the nurse's intuition and experience or from a recommendation that the computer

After the call is completed, the operator completes some administrative entries for record keeping purposes, faxes or mails the patient follow up information as requested, or transmits a record of the call to the member's health care provider or emergency room, if applicable.<sup>78</sup> Depending on the sophistication of the Medical Call Center, appointments for doctor visits or directions to a local hospital can be given to the caller while they are still on the phone.<sup>79</sup> Usually, all calls received by a Medical Call Center are thoroughly documented and many centers record the entire conversation.<sup>80</sup>

Most Medical Call Centers operate on a voluntary basis and take calls from any member of the subscriber's immediate family.<sup>81</sup> An emerging trend in the Medicaid managed care arena is to require a mandatory phone call to a Medical Call Center operator prior to visiting an emergency room or doctor.<sup>82</sup> This mandatory call is similar to the authorization requirements of many

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system suggests after the nurse enters in all of the patient's medical symptoms. See Rhinehart, *supra* note 3, at 20. However, there have been instances where triage nurses have failed to advise the caller to proceed to the nearest emergency room because of cost concerns where the nurse wants the patient to stay in the HMO network sponsoring the triage line. See, e.g., Adams v. Kaiser Foundation Health Plan, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga.) (finding civil liability for the improper advice given by a triage nurse who did not use a computerized telephone triage system).

<sup>78</sup> See DIRECTORY, *supra* note 57, at 20. See also Poole, *supra* note 9, at 672. Communications with physicians are usually tailored to the individual physician and may vary between follow-up phone calls, voice-mail, fax, or regular mail. Poole, *supra* note 9, at 672.

<sup>79</sup> See DIRECTORY, *supra* note 57, at 6.

<sup>80</sup> See Goldberg, *supra* note 19. Recording calls helps insure that documentation exists in case of a lawsuit against the center. See Goldberg, *supra* note 19. Such documentation is also helpful for quality assurance as tapes can be reviewed by Medical Call Center supervisors. See Goldberg, *supra* note 19.

<sup>81</sup> See Anders, *supra* note 11, at A1.

<sup>82</sup> See DIRECTORY, *supra* note 57, at 94 (discussing the challenges of telephone triage for the Medicaid population). Georgia has recently invited telephone triage services to make information-only presentations to the Georgia Department of Medical Assistance, a state Medicaid agency, for the purpose of drafting a Request for Proposals ("RFP") for mandatory telephone triage services for the Georgia Medicaid population. See COMMERCE BUS. DAILY, Nov. 4, 1998, Issue no. PSA-2215.

HMOs, by which patients are required to obtain clearance before having certain procedures or visits completed.<sup>83</sup> Unlike the insurance authorization call, however, the mandatory Medical Call Center telephone encounter involves obtaining clearance and a preliminary medical opinion from an operator, who may not have any formal medical training, prior to the member being permitted to receive any medical treatment.<sup>84</sup>

### C. *The Current State of the Medical Triage Industry*

The simplicity of the medical triage concept in cutting medical costs by giving millions of families access to a telephone triage operator has led to its increasing popularity in the United States.<sup>85</sup> It is precisely this simplicity, however, which may lead to an increase in direct and vicarious liability for the many Medical Call Centers in operation today.<sup>86</sup> Because the industry does not utilize physicians in the triage encounter, the medical "advice" given to the caller, usually by a triage nurse, is not subject to the physician-patient relationship.<sup>87</sup> Therefore, the medical triage industry is not

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<sup>83</sup> See Anna-Katrina S. Christakis, Comment, *Emergency Room Gatekeeping: A New Twist on Patient Dumping*, 1997 WIS. L. REV. 295, 314 (discussing how telephone triage in a Medicaid managed care environment poses significant consequences for health care delivery systems and patients).

<sup>84</sup> See Appleby, *supra* note 7, at 1A (describing how operators do not have any formal medical training in handling triage calls).

<sup>85</sup> See Anders, *supra* note 11, at A1.

<sup>86</sup> See *Adams v. Kaiser Foundation Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995) (finding liability for negligent advice by a triage nurse); *Starkey v. St. Rita's Med. Ctr.*, 690 N.E.2d. 57 (Ohio Ct. App. 1997) (holding that plaintiff met burden of showing negligence by hospital sponsored telephone triage line for misdiagnosing a heart attack, and allowed a new trial based on a newly recognized cause of action for lost chance of recovery or survival); *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998) (holding that plaintiffs made a prima facie case against an HMO for vicarious liability and corporate liability for negligent rendering of services by its telephone triage nurses).

<sup>87</sup> See Goldberg, *supra* note 19. A physician-patient relationship is generally required for recovery for medical malpractice as a result of an express or implied contract. See Barbara J. Tyler, *Cyberdoctors: The Virtual Housecall—The Actual Practice of Medicine on the Internet Is Here: Is it a Telemedical Accident*

being treated as a medical service, but merely as a general health information service without any accompanying state or federal oversight or regulation.<sup>88</sup> The industry has slipped beneath the regulatory radar scope by a careful use of terminology and semantics, thus avoiding any appearance of practicing medicine.<sup>89</sup> There are many physicians and medical organizations, however, that feel that such language parsing is inappropriate and perhaps somewhat misleading.<sup>90</sup> There are even some nurses who clearly feel uncomfortable with the term "nurse triage" as distinguished from "telephone advice" and have raised concerns that the Medical Call Center industry, in many instances, is crossing over a bright line in the medicolegal<sup>91</sup> and professional skill sets of nurses by allowing them to perform "telephone triage."<sup>92</sup> As more patients receive poor "advice" from inexperienced or poorly trained triage operators, the incidence of legal liability in the guise of litigation certainly will increase.<sup>93</sup> In at least one instance, a court has ruled

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*Waiting to Happen?*, 31 IND. L. REV. 259, 265 (1998). The practice of telemedicine poses a duty of care dilemma because it blurs the lines regarding the nature of the physician-patient relationship. *Id.*

<sup>88</sup> See, e.g., Comprehensive Telehealth Act of 1999, S. 770, 106th Cong. (1999) (proposing to provide reimbursement under the Medicare program for telehealth services); Promoting Health in Rural Areas Act of 1999, S. 980, 106th Cong. (1999) (promoting access to health care services in rural areas via development of telehealth networks); Triple-A Rural Health Improvement Act of 1999, H.R. 1344, 106th Cong. (1999) (promoting access to healthcare in rural areas via development of telehealth services). Although telemedicine is currently being considered for regulation, the proposed legislation does not specifically discuss telephone triage. *Id.*

<sup>89</sup> See DIRECTORY, *supra* note 57, at 194 (discussing the semantics differentiating the definition of a nursing diagnosis and a medical diagnosis).

<sup>90</sup> See Glaneill, *supra* note 22, at 1 (discussing the views of certain Pennsylvania physicians who question telephone triage's legality).

<sup>91</sup> "Medicolegal" is a term of art describing the merger of medical and legal issues. STEDMAN'S MEDICAL DICTIONARY 1076 (26th ed. 1995).

<sup>92</sup> See Cherine Woolrich, *Letter to the Editor: Nurse Telephone Triage is Not the Same as Telephone Advice*, PULSE, Sept. 5, 1998, at 47 (addressing nurses' concerns regarding telephone triage and the effects of a nursing diagnosis in a telephone triage setting).

<sup>93</sup> See, e.g., Adams v. Kaiser Foundation Health Plan, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995) (finding liability for negligent rendering of telephone triage advice); Starkey v. St. Rita's Med. Ctr., 690 N.E.2d 57 (Ohio

that medical triage services are, indeed, a “medical” service.<sup>94</sup> The ramification of this ruling for the industry and the need for greater government regulation will likely cause Medical Call Centers to pay closer attention to their potential exposure to civil and criminal liability.

## II. CIVIL LIABILITY ISSUES

The primary concern facing Medical Call Centers is civil liability for mishandled telephone triage encounters that result in some harm suffered by the caller.<sup>95</sup> Because of the number of variables involved in every medical triage encounter, however, even the best recommendations given by a triage nurse may lead to unfavorable results through no fault of the Medical Call Center. Although many HMOs operating their own call centers face straightforward negligence actions for faulty advice given by their telephone triage nurses,<sup>96</sup> HMOs also may be held vicariously liable for the use of contracted services provided by an independent Medical Call Center. Until recently, federal statutes seemed to protect HMOs from liability for medical malpractice claims. A recent court decision, however, may signify the start of an erosion of such protection with attendant liability for HMOs, whose telephone triage services provide poor quality care.<sup>97</sup>

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Ct. App. 1997) (holding that plaintiff met his burden of showing negligence for misdiagnosing a heart attack via telephone triage, and allowed a new trial based on a newly recognized cause of action for lost chance of recovery or survival); *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998) (holding that plaintiffs made a prima facie case against an HMO for vicarious and corporate liability for negligent rendering of telephone triage).

<sup>94</sup> See *Shannon*, 718 A.2d at 835 (describing an HMO’s use of triage nurses as a “medical” service).

<sup>95</sup> See *DIRECTORY*, *supra* note 57, at 185 (describing the trend in malpractice liability exposure for Medical Call Centers).

<sup>96</sup> See *DIRECTORY*, *supra* note 57, at 185.

<sup>97</sup> See *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999) (holding that an HMO may be held liable for negligence for faulty medical advice provided by a medical triage nurse without interpreting ERISA).

A. *Potential Liability Lurking Behind Telephone Triage Encounters*

A successful triage encounter occurs when a caller with medical symptoms clearly communicates his medical concerns to a professionally trained health care operator who then recommends a suggested outcome that is carefully followed and concludes in the patient's health being improved.<sup>98</sup> There are, however, a number of variables in the triage encounter that could, and often do, lead to a less than favorable disposition for the caller.<sup>99</sup> Additionally, the inherent tension faced by Medical Call Centers, whose goals are to deliver quality health information and advice to patients on the one hand, while aiming to reduce "unnecessary" hospital and doctor visits on the other, increase the likelihood that triage nurses will dispense improper or negligent triage advice.<sup>100</sup>

As a preliminary matter, many callers find it difficult to properly describe their medical symptoms to a health care professional.<sup>101</sup> This is true of a telemedicine tele-video encounter where the patient and doctor, or nurse, have the benefit of actually seeing the patient's facial expressions and gesticulations.<sup>102</sup> Such visual cues are missing in a telephone setting, which increases the potential for callers to miscommunicate their symptoms to the

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<sup>98</sup> See Poole, *supra* note 9, at 670-79 (discussing telephone triage encounters for after-hours pediatric patients).

<sup>99</sup> See DIRECTORY, *supra* note 57, at 185 (describing the different types of liability issues arising from a triage encounter including: negligent undertaking; delay in treatment; failure to follow protocols or guidelines; misdiagnosis; practicing outside the scope of expertise; and licensure issues).

<sup>100</sup> Indeed, in *Adams v. Kaiser Foundation Health Plan*, a major cause of the triage nurse's faulty advice seemed to stem from a desire to have the patient go to an in-plan facility which would have been more cost effective for the HMO, even though it was further away than the nearer emergency facility which was not in the HMO network. Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995).

<sup>101</sup> See Poole, *supra* note 9, at 675 (discussing various types of triage encounter symptoms and chief complaints in a pediatric population).

<sup>102</sup> See Tyler, *supra* note 87, at 283 ("Current trends in case law suggest that a physician-patient relationship will be found between telemedicine practitioners and the patients they see.").

operator.<sup>103</sup> A lower right quadrant abdominal pain, which may be indicative of appendicitis,<sup>104</sup> could be described by an unclear caller as “my stomach hurts,” leading even a well-trained professional operator possibly to diagnose an upset stomach.<sup>105</sup> Although the potential for misdiagnosis exists in any medical encounter, where the patient cannot adequately show or express certain medical symptoms over the telephone, the potential for misdiagnosis is greater regardless of the skills of the health care professional.

A more common scenario is one where the triage operator fails to properly assess the caller’s symptoms due to negligence.<sup>106</sup> The caller may have given the most accurate description of the symptoms which would, in most circumstances, lead to an obvious and specific recommendation by any reasonably prudent health care professional.<sup>107</sup> An untrained operator with no medical training or even an inexperienced nurse operator may, however, give faulty medical advice leading to detrimental results.<sup>108</sup>

Finally, even the best recommendation by an operator can lead to a negative disposition if the caller fails to listen to, or follow

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<sup>103</sup> See Tyler, *supra* note 87, at 288. This is true not only with telephone triage, but also with a new trend in cybermedicine, where physicians on the Internet treat patients without seeing, listening to, or touching them before treatment occurs. Tyler, *supra* note 87, at 288. With the advent of two-way visual communications devices such as those currently being tested in telemedicine encounters between patients and physicians in remote locations, these barriers are slowly eroding. Tyler, *supra* note 87, at 278.

<sup>104</sup> Appendicitis is a medical term describing an inflammation of the appendix. *STEDMAN’S MEDICAL DICTIONARY* 118 (26th ed. 1995).

<sup>105</sup> In *Crum v. Health Alliance-Midwest, Inc.*, a triage nurse allegedly advised a heart attack victim to utilize self-help techniques at home, as the nurse believed the patient was suffering from “excess stomach fluids.” 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999).

<sup>106</sup> See, e.g., *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998) (holding that plaintiffs made a prima facie case against an HMO for vicarious liability and corporate liability for negligent rendering of triage services by its telephone triage nurses in failing to identify and recommend emergency care for a pregnant patient).

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* See also *Adams v. Kaiser Foundation Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995).



though with, the recommendation.<sup>109</sup> A recent survey of after-hours telephone triage services in pediatric settings concluded that approximately one-half of the patient groups surveyed who completed a triage encounter failed to take their ill child to the emergency room as directed by the triage nurse.<sup>110</sup> Medical Call Centers that follow proper protocols in a triage encounter will reduce their liability potential for negative outcomes due to a caller's negligence in failing to heed proper advice.<sup>111</sup> The question remains, however, as to what is the appropriate standard of care following a triage encounter.<sup>112</sup>

In determining the appropriate telephone triage standard of care, a determination must be made as to whether the responsibility should be placed upon the Medical Call Center to follow up on every call to confirm that the patient adhered to the recommended outcome. If the Medical Call Center bears such a responsibility, other issues arise, such as: what length of time may elapse after the patient's initial call before a follow-up call; must the Medical Call Center call several times before its responsibility is satisfied; and should the Medical Call Center contact a third party, such as the patient's primary care physician or local emergency department, immediately after concluding the triage call. The answers to these questions will have to be decided either by the courts or by state or federal legislation clarifying the operating parameters and standards of care for running a Medical Call Center.

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<sup>109</sup> See generally Baker, *supra* note 76.

<sup>110</sup> See generally Baker, *supra* note 76.

<sup>111</sup> See DIRECTORY, *supra* note 57, at 186. "By providing, enforcing, and monitoring strict compliance with written nursing guidelines, which are approved by the medical director in responding to calls, the nurse, medical director, and call center are less subject to liability." See DIRECTORY, *supra* note 57, at 186.

<sup>112</sup> See, e.g., *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998). Although this question has not yet been decided in the courts, the *Shannon* court has defined telephone triage as a "medical" service, requiring an appropriate duty of care. *Id.*

B. *Negligence and the Adams v. Kaiser*<sup>113</sup> *Decision*

When a call to a Medical Call Center is mishandled, ensuing legal action by the injured party typically is initiated in the form of a tort liability claim.<sup>114</sup> Due to the complex relationships between Medical Call Centers and their clients, especially those that contract their services with HMOs, affixing civil liability on the proper party may be complicated.<sup>115</sup> The first major case to be brought against a Medical Call Center, *Adams v. Kaiser Foundation Health Plan*, held Kaiser Permanente, a national HMO, directly liable for \$45 million dollars because of improper advice given by one of its telephone triage nurses that caused a delay in treatment.<sup>116</sup>

In *Adams*, the HMO operated its own Medical Call Center without the use of computers to aid the nurses in performing telephone triage or a written protocol for emergency procedures.<sup>117</sup> A Kaiser nurse recommended that a six-month old child with a high fever be driven to an emergency room within the Kaiser network that was forty-five minutes away.<sup>118</sup> The infant's parents took the nurse's advice and started driving to the recommended facility but then re-routed to a nearer emergency room when the child's condition deteriorated.<sup>119</sup> The infant suffered circulatory collapse<sup>120</sup> and lost both hands and most of his legs.<sup>121</sup> In a jury verdict for the plaintiff, the HMO was found liable, in part, because they had no written or taped documentation

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<sup>113</sup> *Adams v. Kaiser Found. Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995).

<sup>114</sup> *Id.*

<sup>115</sup> See Barbara Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 *MERCER L. REV.* 1219, 1230 (1997) (discussing the expansion of managed care tort liability for general medical malpractice by HMO physicians).

<sup>116</sup> Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995).

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> "Circulatory collapse" is a medical term describing failure of cardiac or peripheral circulation. *STEDMAN'S MEDICAL DICTIONARY* 364 (26th ed. 1995).

<sup>121</sup> *Adams*, Civ. Act. No. 93-VS79895.

to offer into evidence to dispute the plaintiff's negligence claim.<sup>122</sup> The *Adams* verdict focused on the nurse's administrative advice to go to a Kaiser facility, rather than to the nearest emergency room.<sup>123</sup> Although the *Adams* jury found that the nurse's instructions regarding the choice of hospital delayed the infant from receiving medical care, the issue of faulty "medical" advice was not litigated, as the nurse's underlying advice to seek immediate medical attention was not questioned.<sup>124</sup>

The *Adams* decision represents a straightforward tort claim against the primary party responsible for the alleged negligence.<sup>125</sup> In *Adams*, the HMO was the direct insurer of the plaintiffs and offered a telephone triage support line directly to them.<sup>126</sup> Thus, it was simple to ascertain who the responsible defendant was.<sup>127</sup> The claim represented a traditional negligence action for poor administrative advice because the nurse recommended a Kaiser facility that was further away than a local, non-Kaiser emergency department.<sup>128</sup> The *Adams* litigation did not, however, address many of the unique liability issues raised by the operation of a Medical Call Center, and thus, *Adams* failed to reflect the concerns of telephone triage from the industry's perspective. As the industry continues to expand, with more call centers handling greater volumes of calls, medical triage liability concerns may become more prevalent.

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<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.* See also Kearney, *supra* note 5, at A1; DIRECTORY, *supra* note 57, at 186 (suggesting that Medical Call Centers be clear in directing callers with emergencies to the nearest medical facility [regardless of cost] to avoid liability for delay in treatment).

<sup>125</sup> See DIRECTORY, *supra* note 57, at 196. The Adams family called Kaiser, their own health plan, for health information regarding their son's condition. See DIRECTORY, *supra* note 57, at 196. Kaiser operated its own Medical Call Center. See *Adams*, Civ. Act. No. 93-VS79895. Although the Court found Kaiser vicariously liable for the actions taken by its employee nurse, the issue of vicarious liability was not directly addressed. *Id.*

<sup>126</sup> *Adams*, Civ. Act. No. 93-VS79895.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

*C. Vicarious Liability and Shannon v. McNulty*<sup>129</sup>

Where two or more parties are involved in negligent conduct, the legal concept of vicarious liability for erroneous medical advice becomes an issue.<sup>130</sup> In *Shannon v. McNulty*, an action against a physician and an HMO for medical malpractice, the court was confronted with a claim of faulty medical advice.<sup>131</sup> In *Shannon*, the Pennsylvania Superior Court found that Health America Pennsylvania Inc., a regional HMO provider, could be held liable, both vicariously and directly, for negligent rendering of services by its triage nurse line.<sup>132</sup> The telephone triage nurse allegedly failed to refer the plaintiff, a pregnant woman exhibiting emergency symptoms, immediately to a physician or hospital for proper evaluation and testing.<sup>133</sup> Based on the nurse's alleged failure to properly refer the plaintiff, the court ruled that the HMO could be held liable for breaching its duty of care to oversee the dispensing of advice by nurses in its employ.<sup>134</sup> The court found that the nursing oversight should have been conducted in a "medically reasonable manner."<sup>135</sup> Although the lower court found that a standard of care could not be established for triage nurses as they are not permitted by state statute to render a medical diagnosis,<sup>136</sup> the Pennsylvania Superior Court reversed the lower court decision. The Pennsylvania Superior Court held that the plaintiff had

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<sup>129</sup> *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998).

<sup>130</sup> "Vicarious liability" refers to the liability that a supervisory party bears for the actionable conduct of a subordinate or associate because of the relationship between the two parties. BLACK'S LAW DICTIONARY 927 (7th ed. 1999).

<sup>131</sup> *Shannon*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998).

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* at 832. Those symptoms included severe back pains, back spasms, numbness in the legs, and abdominal pain indicating pre-term labor. *Id.*

<sup>134</sup> *Id.* at 836.

<sup>135</sup> *Id.*

<sup>136</sup> See *Shannon v. McNulty*, Civ. Act. No. G.D. 94-8506 (Ct. of Common Pleas, Alleg. C. 1996), *rev'd*, 718 A.2d 828 (Pa. Super. Ct. 1998). See also PA. PROF. NURSING LAW, 63 P.S. § 212 (defining the practice of nursing and licensing requirements).

established a prima facie claim<sup>137</sup> under both corporate and vicarious liability and that the issues of the adequacy of the HMO's service, and the reasonableness of the plaintiff's use thereof, were to be decided by a jury on remand to the lower court.<sup>138</sup>

*Shannon* involves a traditional relationship between the patient and the HMO sponsoring the telephone triage line.<sup>139</sup> HealthAmerica, the plaintiff's HMO which staffed the triage line, instructed the plaintiff to contact either her physician or HealthAmerica's triage nurses in the event she had any medical questions or emergent medical conditions.<sup>140</sup> On a few occasions, the plaintiff spoke with and was examined by her physician, a participating physician in the HealthAmerica network.<sup>141</sup> On other occasions, however, she called the triage line directly to report her deteriorating medical condition.<sup>142</sup>

The lower court, in ruling on the defendant's motion for a compulsory nonsuit after the completion of the plaintiff's case during the trial, held that no pre-existing duty arose between the triage nurse and the plaintiff because no physician-patient relation-

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<sup>137</sup> *Shannon*, 718 A.2d at 835.

<sup>138</sup> *Id.* at 836. Although the court did not discuss the issue of criminal unauthorized practice of medicine by the nurse rendering the medical advice, the nursing standard of care issue was raised by the Court of Common Pleas when the court found that the nurses could not make a medical diagnosis as they were expressly prohibited by state statute. See *Mario L. Shannon and Sheena Evan Shannon, Individually and Co-Administrators of the Estate of Evan Jon Shannon v. Larry P. McNulty, M.C. and HealthAmerica Pennsylvania, Inc.*, 146 PTT. LEGAL J. 22, 23 (1998) [hereinafter *Mario L. Shannon*]. See also *infra* Part III (discussing the impact of the *Shannon* decision).

<sup>139</sup> See *Mario L. Shannon*, *supra* note 138, at 23. The patient was offered the Medical Call Center services as a value added service of her health plan which was included at no charge as opposed to purchasing the service outright or some other method of obtaining these services. See *Mario L. Shannon*, *supra* note 138, at 23.

<sup>140</sup> See *Mario L. Shannon*, *supra* note 138, at 23. The lower court record on appeal describes how the plaintiff called the triage line on three occasions over the course of one week to report worsening conditions. See *Mario L. Shannon*, *supra* note 138, at 23.

<sup>141</sup> *Shannon*, 718 A.2d at 831. The physician, who was not an employee of the HMO, was also named as a defendant in the action. *Id.*

<sup>142</sup> *Id.*

ship existed.<sup>143</sup> Additionally, the lower court held that no previous nursing care had been provided by the triage nurse, as the nurse was not a member of the plaintiff's physician's staff, and no evidence existed that any triage nurses saw or even spoke to the plaintiff prior to the time she placed her calls to the triage line in October 1992.<sup>144</sup> The lower court also rejected the plaintiff's expert witness physician who testified that the triage nurses should have made a proper medical diagnosis that the plaintiff was in

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<sup>143</sup> See *Shannon v. McNulty*, Civ. Act. No. G.D. 94-8506 (Ct. of Common Pleas, Alleg. C. 1996), *rev'd*, 718 A.2d 828 (Pa. Super. Ct. 1998). See also *Mario L. Shannon*, *supra* note 138, at 27.

<sup>144</sup> See *Shannon*, Civ. Act. No. G.D. 94-8506. See also *Mario L. Shannon*, *supra* note 138, at 27. The lower court noted that during the first two calls to the triage line that week, the triage nurse referred the plaintiff to her doctor, Dr. McNulty. See *Mario L. Shannon*, *supra* note 138, at 27. After the last call, "an in-house orthopedic physician from HealthAmerica advised her to go to West Penn Hospital to have her back examined." *Mario L. Shannon*, *supra* note 138, at 23. It is unclear from the record how an orthopedic surgeon happened to get on the phone to speak with the plaintiff. See *Mario L. Shannon*, *supra* note 138, at 27. It is certainly not common practice for physicians to answer telephone triage lines at a Medical Call Center. See *Kearney*, *supra* note 5, at 20. Additionally, the question of liability became more pronounced because the new physician appeared to be diagnosing the plaintiff's condition over the phone without a proper examination. See *Mario L. Shannon*, *supra* note 138, at 27. The outcome of this case may very well have been different, had a nurse recommended an emergency room visit or even another urgent visit to Dr. McNulty as protocol dictated. This is borne out later in the opinion, when the court ruled that the nurses had no duty to provide obstetric care to the plaintiff because it would be illegal for nurses in Pennsylvania to render such a diagnosis. See *Mario L. Shannon*, *supra* note 138, at 28. Yet, the advice of a HealthAmerica physician certainly complicated the relationships in this case. The lower court also noted that the triage nurses merely referred the plaintiff to her own physician and to West Penn Hospital "at the suggestion of a HealthAmerica orthopedic specialist." *Mario L. Shannon*, *supra* note 138, at 27. This seems to have changed the triage call from one that started as a traditional non-diagnostic call, to a call involving a possible diagnosis by a physician who directed the triage nurse to suggest a treatment option. Contrary to the lower court's finding, this should have raised the duty of care standard to that of a traditional physician-patient relationship. It may be that the Superior Court recognized this distinction in its reversal of the lower court ruling, even though the court only referred to the phone service for emergent care having been staffed by triage nurses. See *Mario L. Shannon*, *supra* note 138, at 27.

premature labor<sup>145</sup> by stating that Pennsylvania law expressly prohibits nurses from rendering medical diagnoses.<sup>146</sup> The lower court ruled that a duty expressly prohibited by law cannot be the standard of care required of any professional and that no recognizable and legitimate standard of care existed for HealthAmerica's triage nurses.<sup>147</sup>

On appeal, the Pennsylvania Superior Court reversed, ruling that HealthAmerica did provide a "medical" service in the form of telephonic advice and that prima facie evidence existed that it failed to exercise reasonable care in rendering medical decisions affecting the plaintiff's medical care in a less than "medically reasonable" manner.<sup>148</sup> The ruling recognized that operating a triage line is equivalent to performing a medical service and, consequently, its operator may be held liable for medical malpractice if one of its nurses fails to give "medically reasonable" advice.<sup>149</sup> While the court did not directly address the lower court decision regarding the issue of the nurse's ability to make a medical diagnosis, the superior court's decision makes clear that as triage services are "medical" in nature, and as such, they must be performed in a medically reasonable manner.<sup>150</sup>

Both *Adams*<sup>151</sup> and *Shannon*<sup>152</sup> represent cases where vicarious liability is placed on the employer for the negligent actions of its employee under the doctrine of *respondeat superior*.<sup>153</sup> Vicar-

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<sup>145</sup> "Premature labor" is a medical term describing the onset of labor before the 37th completed week of pregnancy dated from the last normal menstrual period. *STEDMAN'S MEDICAL DICTIONARY* 927 (26th ed. 1995).

<sup>146</sup> See *Shannon v. McNulty*, Civ. Act. No. G.D. 94-8506 (Ct. of Common Pleas, Alleg. C. 1996), *rev'd*, 718 A.2d 828 (Pa. Super. Ct. 1998); See also *Mario L. Shannon*, *supra* note 138, at 28.

<sup>147</sup> See *Shannon*, Civ. Act. No. G.D. 94-8506. See also *Mario L. Shannon*, *supra* note 138, at 28.

<sup>148</sup> *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998).

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> *Adams v. Kaiser Foundation Health Plan*, Civ. Act. No. 93-VS79895 (E. Fulton Co. Ga. 1995).

<sup>152</sup> *Shannon*, 718 A.2d at 828.

<sup>153</sup> *Respondeat superior* is a Latin term meaning "let the superior make answer." *BLACK'S LAW DICTIONARY* 1313 (7th ed. 1999). The doctrine stands

ious liability issues become more complex when the triage nurse employee and Medical Call Center employer are contracted to provide telephone triage services for the HMO or hospital.<sup>154</sup> While such a scenario involving Medical Call Centers has not yet been decided in the courts, it is likely that such litigation will occur given the popularity of contracted telephone triage services with many HMOs today.<sup>155</sup>

Where an HMO or hospital hires a Medical Call Center and its employee triage nurses, the issue would arise as to whether the HMO, as the primary sponsor of the telephone triage service, would be primarily liable for negligent conduct of its contracted services or whether it would escape liability because the Medical Call Center was acting as an independent contractor.<sup>156</sup> The contracted Medical Call Center, however, could assert that such an arrangement constitutes a joint enterprise.<sup>157</sup> Thus, all parties are held vicariously liable for the torts of each other.<sup>158</sup> While

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for the premise that a principal (master or employer) is liable for injuries proximately resulting from the negligent acts of his agent (servant or employee) when the acts are committed within the scope of the agent's authority or apparent authority of employment. *Id.* The principal, who is deemed to act through his agents, maintains a duty to conduct his affairs so as not to injure others, and thus is liable for the negligent acts of his agents. *Id.*

<sup>154</sup> See Anders, *supra* note 11, at A1. This has become the more popular method for providing telephone triage services, as companies such as Access Health are contracted to provide such services for numerous HMOs nationally. See Anders, *supra* note 11, at A1.

<sup>155</sup> See DIRECTORY, *supra* note 57, at 257-370 (surveying the numerous hospitals, HMOs, and contracted Medical Call Centers operating nationwide).

<sup>156</sup> See *Hardy v. Brantley*, 471 So. 2d 358 (Miss. 1985) (relieving hospitals from liability for negligent conduct of independent physicians). Although the *Hardy* decision continues to gain ground around the country, there are courts that have taken a contrary view. See *Gilbert v. Sycamore Mun. Hosp.*, 622 N.E.2d 788, 794 (Ill. 1993) (holding that a hospital may be liable for negligent acts even of a physician who is an independent contractor if an apparent agency relationship exists between parties).

<sup>157</sup> A "joint enterprise" is an undertaking by two or more persons with an equal right to direct and benefit from the endeavor, as a result of which, one participant's negligence may be imputed to the other(s). BLACK'S LAW DICTIONARY 842 (7th ed. 1999).

<sup>158</sup> RICHARD A. EPSTEIN, CASES AND MATERIALS ON TORTS 465 (6th ed. 1995). There is also an important exception to the general rule that independent



factors, such as in whose name the center answers calls and whether the HMO has medical control over the algorithms and outcomes of the call, will help to determine this issue, even the most comprehensive contract may fail to prevent vicarious liability of the sponsoring HMO where patient health issues are involved. The clear signal sent by the *Shannon* court, that telephone triage services are “medical” in nature, may provide other courts with persuasive authority to find that HMOs utilizing Medical Call Centers with improper telephone triage techniques should be held directly liable for negligence.

*D. ERISA Preemption Issues and Crum v. Health Alliance*<sup>159</sup>

The distinction between HMOs providing administrative services<sup>160</sup> as opposed to actual medical services raises the issue of HMO protection from medical malpractice liability under ERISA.<sup>161</sup> ERISA protects an HMO from medical malpractice liability as the HMO is presumed to be rendering only administra-

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contractors exempt the employer from liability. *Id.* The exception applies to an independent contractor who does work involving a special danger to others which the employer knows or has reason to know to be inherent in the work. *Id.* See also RESTATEMENT (SECOND) OF TORTS § 427 (2000).

<sup>159</sup> 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999).

<sup>160</sup> See Noah, *supra* note 115, at 1242. ERISA “contains a broad preemption clause that provides that ERISA’s provisions supersede all state laws to the extent that they ‘relate to’ any employee benefit plan.” See Noah, *supra* note 115, at 1242. Most HMOs are covered under ERISA as employee benefit plans. See Noah, *supra* note 115, at 1243. Therefore any activities “related to” the plan, including financial, administrative, and even rationing decisions would be given ERISA preemption protection. See Noah, *supra* note 115, at 1243.

<sup>161</sup> 29 U.S.C. §§ 1001-1461 (1994 & Supp. II 1996) (regulating health plans and imposing certain requirements on employers). For an in depth look at the ERISA statute’s failure to provide consumers protection from negligent practices of HMOs, see Eric M. Eusanio, Note, *Control, Quality, and Cost: The Need for Federal Legislation Amending ERISA’s Failure to Protect Consumers from Liability-Free MCOs*, 7 J.L. & POL’Y 627 (1999) (discussing the current state of ERISA and proposed changes that would strengthen consumer protection from unscrupulous HMO practices).

tive services rather than making medical decisions.<sup>162</sup> In recent years, however, HMOs have seen some of their ERISA protection eroded by decisions holding that they are liable for “quality of care” decisions while remaining protected for administrative decisions.<sup>163</sup> Most of these “quality of care” issues specifically relate to claims regarding the quality of medical treatment provided by the HMO.<sup>164</sup> This ERISA erosion has continued into the area of medical telephone triage, adding further momentum to the notion that telephone triage services are “medical” in nature.<sup>165</sup>

Recently, a federal district court in Illinois found that an HMO may be held liable for the wrongful conduct of its advisory nurse and concluded that such conduct could be resolved without interpreting its ERISA plan, thus precluding ERISA preemption protection.<sup>166</sup> In *Crum v. Health Alliance-Midwest, Inc.*, the HMO had established a policy requiring mandatory calls to its Medical Call Center prior to seeking medical attention.<sup>167</sup> After calling the center and describing his chest pain symptoms to the triage nurse, the patient was instructed to perform some self-help techniques at home to relieve stomach acid discomfort.<sup>168</sup> He was further told that a trip to the emergency room was unnecessary.<sup>169</sup> The patient

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<sup>162</sup> See Noah, *supra* note 115, at 1242.

<sup>163</sup> See *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995) (holding that where a state law claim rests on the quality of treatment provided, and not on the quantity and administration of services or the decision by the HMO to deny coverage, the claim should not be preempted); *Corporate Health Ins. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 616-19 (S.D. Tex. 1998) (holding that HMOs are liable for negligence claims for lack of quality of services, but not merely for denying benefits).

<sup>164</sup> See Eusanio, *supra* note 161, at 653.

<sup>165</sup> *Shannon v. McNulty*, 718 A.2d 828, 836 (Pa. Super. Ct. 1998) (holding that triage services are “medical” in nature).

<sup>166</sup> *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999) (holding that an HMO plan can be held liable for negligence and for providing faulty medical advice from a medical triage nurse without interpreting ERISA).

<sup>167</sup> *Id.* It is unclear from the record whether the Medical Call Center was operated by the HMO or whether the services were contracted from an independent company. See *id.* at 1015.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

died of a heart attack within one hour of calling the Medical Call Center.<sup>170</sup> While the court did not rule on the substantive issues in the case, it determined that the HMO's alleged wrongful conduct did not rest upon the terms of the insurance plan and could be resolved without interpreting ERISA.<sup>171</sup> Decisions such as *Crum* may erode whatever ERISA protection HMOs had with respect to medical malpractice in the area of telephone triage.

Although HMOs currently maintain ERISA protection for decisions regarding whether to pay for a patient's treatment, even if such refusal to pay may harm the patient, the United States Department of Labor<sup>172</sup> has recently advocated a more narrow posture limiting ERISA protection in this area.<sup>173</sup> The courts, however, are still enforcing ERISA protection for HMO decisions regarding patient treatment coverage, as opposed to quality of care issues related to actual care by an HMO physician, which will not necessarily obtain preemption protection.<sup>174</sup> Recently, the United States Supreme Court granted *certiorari* in a case dealing with an HMO's right to ERISA preemption protection for alleged negligent

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<sup>170</sup> *Id.*

<sup>171</sup> *Id.* at 1020. The case was remanded back to the state court for trial, as the district court found federal jurisdiction lacking. *Id.* at 1021.

<sup>172</sup> The United States Department of Labor is charged with ensuring the adequacy of America's workplace. See U.S. Department of Labor, *Mission Statement* (visited March 15, 2000) <<http://www.dol.gov/dol/opa/public/aboutdol/-mission.htm>>. The agency is responsible for enforcing over 180 federal labor statutes and protecting workers' wages, health and safety, employment and pension rights, job training, unemployment insurance, and collective bargaining rights. *Id.*

<sup>173</sup> See Michael Higgins, *60 Second Opinions on HMOs*, A.B.A. J., April 1999, 60, 63 (discussing health plan negligence and the United States Department of Labor's position limiting ERISA in the area of HMO medical malpractice claims).

<sup>174</sup> See Higgins, *supra* note 173, at 63. See also *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995) (holding that where a state law claim rests on the quality of treatment provided, and not on the quantity and administration of services or the decision by the HMO to deny coverage, the claim should not be preempted); *Corporate Health Ins. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597, 616-19 (S.D. Tex. 1998) (holding that HMOs are liable for negligence claims stemming from the lack of quality of services, but not merely for denying benefits).

conduct by a plan physician who received an incentive payment for treatment.<sup>175</sup> The plaintiff's novel claim in *Herdich v. Pegram* alleges a breach of fiduciary duty on the part of the HMO.<sup>176</sup> Therefore, even if the Court finds the HMO protected for medical malpractice, the claim seeks to circumvent such protection by seeking damages for breach of a fiduciary duty to the plaintiff.<sup>177</sup> The remedy for such a breach is uncertain, however, as the plaintiff is seeking to force the health plan to disgorge profits made from an incentive system that led to unjustly limited care.<sup>178</sup> Because it would be difficult, if not impossible, to identify the amount of profit directly related to the savings generated by an incentive system, assessing actual damages for the plaintiff may be an insurmountable task for the court.

Irrespective of the outcome in the *Herdich* case, the trend limiting preemption protection for HMOs utilizing Medical Call Centers seems to have begun.<sup>179</sup> Managed care plans that favor profits over patient care may find disfavor in the courts, especially as the judiciary utilizes the very managed care services for which the HMOs are seeking liability protection.<sup>180</sup> Congress currently is debating the issue of eliminating ERISA protection for HMOs

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<sup>175</sup> *Herdich v. Pegram*, 154 F.3d 362 (7th Cir. 1998), *cert. granted*, 120 U.S. 10 (1999) (holding that a health insurance plan beneficiary who brought state court action against a physician, clinic association, and medical plan for medical negligence was not preempted by ERISA).

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> See Higgins, *supra* note 173, at 63.

<sup>179</sup> See *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999) (holding that an HMO can be liable for negligence and for providing faulty medical advice from a medical triage nurse without interpreting ERISA).

<sup>180</sup> See Higgins, *supra* note 173, at 63.

In the meantime, the HMOs should not expect any favors from judges on close cases, says Barry Furrow, director of the Health Law Institute at the Widener University School of Law in Wilmington, Delaware. 'They're older, and they have health care needs themselves,' Furrow says. Judges may have personal doubts about managed care, 'and I think it's showing up in the language' of their opinions, he says.

Higgins, *supra* note 173, at 63.

generally as part of the Patients' Bill of Rights of 1999.<sup>181</sup> There are, however, other concerns besides ERISA protection erosion that Medical Call Centers need to consider. As future cases continue to find that telephone triage is a "medical" service, ERISA erosion and civil liability issues may find themselves taking a back seat to concerns regarding potential criminal liability for the improper licensure of triage nurses and the unauthorized practice of medicine.

### III. LICENSURE ISSUES AND POTENTIAL CRIMINAL LIABILITY

Although civil liability for negligent triage advice warrants concern and is costly from the HMO's standpoint, it is not necessarily the only type of liability to which the industry may be susceptible. Specifically, the nurse rendering the triage advice must deal with two other issues arising from the triage encounter. First, nurses handling calls from states other than the state in which they are licensed are exposed to possible criminal prosecution from the unauthorized practice of nursing across state lines.<sup>182</sup> The Medical Call Center that knowingly hires and engages nurse employees to perform these possibly illegal acts may, likewise, be held criminally liable under an accomplice liability theory.<sup>183</sup> Second, recent rulings that have found Medical Call Centers civilly liable for operating medical services and requiring nurses to adhere to a standard of care which is "medically reasonable," implies that nurses may be rendering medical diagnoses as part of the process

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<sup>181</sup> S. 1256, 106th Cong. (1999). It is important that this debate include not only HMOs providing medical triage for their own members, but also services that are contracted by HMOs. *Id.*

<sup>182</sup> See, e.g., Glaneill, *supra* note 22, at 1 (describing Pennsylvania's struggle with telephone triage nursing licensure issues).

<sup>183</sup> JOSHUA DRESSLER, *CASES AND MATERIALS ON CRIMINAL LAW* 812 (1994). In most jurisdictions, the actual criminal act, or *actus reus*, component of accomplice liability includes having the second party soliciting the offense, furnishing an instrumentality used in the commission of the crime, or providing other significant aid in the perpetration of the offense. *Id.* In the telephone triage context, the Medical Call Center would be the second party soliciting the unauthorized practice of medicine by furnishing nurses who are not licensed to medically diagnose patients.

of giving medical advice, which may expose those nurses to potential criminal prosecution for the unauthorized practice of medicine.<sup>184</sup> Consequently, every civil liability claim for negligent medical advice may provide evidence for a possible criminal prosecution for the unauthorized practice of medicine.

#### A. *Unauthorized Practice of Medicine*

The licensure issues facing all Medical Call Centers arise from state statutes regulating the practice of nursing and medicine within each state's borders.<sup>185</sup> As a preliminary matter, the entire telephone triage encounter that occurs between a nurse and a caller raises the potential criminal liability issue of the unauthorized practice of medicine.<sup>186</sup> Although most centers have a standard disclaimer,<sup>187</sup> both in their contracts with members and contract vendees, and in the preamble to the telephone encounter as a recorded message, such disclaimer language may not necessarily

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<sup>184</sup> See *Mario L. Shannon*, *supra* note 138, at 27. The lower court in *Shannon* utilized circular reasoning to find that the nurses did not have a medical standard of care, as suggested by the plaintiff's expert witness physician. See *Mario L. Shannon*, *supra* note 138, at 27. The court held that because nurses are prohibited from diagnosing patients under Pennsylvania law, they may not have a duty of care imposed upon them. See *Mario L. Shannon*, *supra* note 138, at 27. The lower court may have failed to recognize, however, that there may be circumstances in which a duty of care should be imposed on an individual based on certain circumstances, including the fact that a certain level of care was initiated by the nurse when the call began.

<sup>185</sup> See, e.g., N.Y. EDUC. LAW § 6502 (McKinney 1999) (defining the practice of nursing in New York); PA. STAT. ANN. tit. 63 § 212 (West 2000) (defining the practice of professional nursing in Pennsylvania).

<sup>186</sup> See, e.g., Glaneill, *supra* note 22, at 1 (discussing how certain physicians in Pennsylvania fear that telephone triage may be crossing the line in terms of the unauthorized practice of medicine).

<sup>187</sup> See DIRECTORY, *supra* note 57, at 199 (discussing certain disclaimer language). Some disclaimers advise, for example, "if this is a medical emergency, hang up and call 911 immediately." DIRECTORY, *supra* note 57, at 199. Other language typically includes a disclaimer that the nurse's "advice" is not a medical diagnosis, but merely health information. See Goldberg, *supra* note 19.

shield the Medical Call Center from criminal liability for violating state licensure statutes.<sup>188</sup>

All states regulate the practice of medicine by statute.<sup>189</sup> As a general proposition, the practice of medicine includes the right of physicians to diagnose illnesses and treat patients with various ailments or conditions.<sup>190</sup> Non-physicians are prohibited from performing any medical procedures under penalty of criminal prosecution.<sup>191</sup> Nurses, however, are permitted to perform certain types of diagnosis under very strict statutory restrictions that vary by state.<sup>192</sup> The primary requirement in allowing nurses to perform certain diagnoses is the close supervision of a physician.<sup>193</sup> Presumably, many Medical Call Centers rely on the fact that they have a physician acting as a medical director who is responsible for the clinical supervision of the nurse triage staff.<sup>194</sup> A strict reading of many state statutes on nursing practices, however, raises many questions about the ability of the nurse to diagnose a

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<sup>188</sup> See Goldberg, *supra* note 19 (discussing possible criminal liability for Medical Call Centers).

<sup>189</sup> See, e.g., N.Y. EDUC. LAW § 6524 (McKinney 1999); CAL. BUS. & PROF. CODE § 2085 (West 2000); FLA. STAT. ANN. § 458.311 (West 1999). New York's statute is fairly typical of most states.

<sup>190</sup> *Id.*

<sup>191</sup> See, e.g., N.Y. EDUC. LAW § 6512(1) (McKinney 1999). In New York State, the unauthorized practice of medicine is a class E Felony. *Id.* See also *People v. Kleiner*, 664 N.Y.S.2d 704, 710 (Sup. Ct. 1997); *People v. Rubin*, 424 N.Y.S.2d 592, 597 (Crim. Ct. 1979) (applying the following factors: whether there was a diagnosis determining a disease infirmity or physical condition; whether a remedy or treatment was prescribed; whether the acts performed by the defendant were such to endanger the public health; and whether the defendant invaded the territory of the medical profession by specific actions solely within the province of a duly trained and knowledgeable medical practitioner).

<sup>192</sup> See, e.g., N.Y. EDUC. LAW § 6502 (McKinney 1999) (defining the practice of nursing in New York); PA. STAT. ANN. tit. 63 § 212 (West 2000) (defining the practice of professional nursing in Pennsylvania).

<sup>193</sup> See, e.g., N.Y. EDUC. LAW § 6502 (McKinney 1999) (requiring physician supervision for nurses in New York); PA. STAT. ANN. tit. 63 § 212 (West 2000) (requiring nursing supervision by physicians in Pennsylvania).

<sup>194</sup> See DIRECTORY, *supra* note 57, at 80 (discussing medical supervision of triage nurses). Most Medical Call Centers have medical leadership in place that closely directs medical care decisions and reviews the clinical guidelines being utilized by the triage nurses. DIRECTORY, *supra* note 57, at 80.

telephone patient with whom neither the nurse nor the medical director has had any previous contact.<sup>195</sup> The medical director certainly is not going to be familiar with most, if any, of the caller's conditions because the medical director does not speak with patients directly. It is inconceivable that a nurse will claim to be diagnosing a patient's symptoms, assuming they admit to diagnosing ailments under their nursing licenses during the triage encounter at all, under the direct supervision or collaboration of a physician, as the physician has had no contact with the patient.<sup>196</sup> The Medical Call Center, in order to avoid running afoul of the statute, may insist that the nurse is not performing any medical diagnosis at all, thereby eliminating the need for any license, including a nursing license.<sup>197</sup> This approach, however, is at odds with the recent court rulings on the issue of triage liability, which clearly indicate that some form of nursing medical standard is required.<sup>198</sup>

As evidenced by the rulings in *Shannon* and *Crum*, civil liability for negligent triage advice typically is predicated on the notion that the service is medical in nature and that nurses have a duty of care to provide medically reasonable advice.<sup>199</sup> While the lower court ruling in *Shannon* briefly addressed the apparent inconsistency in having a medical standard of care for medical

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<sup>195</sup> See, e.g., N.Y. EDUC. LAW § 6502 (McKinney 1999).

The practice of registered professional nursing by a nurse practitioner . . . may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures within a specialty area of practice, in collaboration with a licensed physician . . . provided such services are performed in accordance with a written practice agreement and written practice protocols.

*Id.* § 6502(3)(a). The term "collaboration" is key to analyzing whether a triage encounter satisfies this section of the statute.

<sup>196</sup> *Id.*

<sup>197</sup> See DIRECTORY, *supra* note 57, at 59. Indeed, there are Medical Call Centers that may choose not to utilize nurses at all for triage calls, instead relying on clerical staff members to save costs. See DIRECTORY, *supra* note 57, at 57.

<sup>198</sup> See *Crum v. Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999); *Shannon v. McNulty*, 718 A.2d 828, 836 (Pa. Super. Ct. 1998).

<sup>199</sup> See *Crum*, 47 F. Supp. 2d at 1020; *Shannon*, 718 A.2d at 836.



diagnosis apply to a triage nurse who is unlicensed to perform such a medical procedure,<sup>200</sup> the appeals court ruling implies that telephone triage services are performing medical functions and, by extension, that nurses performing these functions are performing medical services.<sup>201</sup> While no court has clearly stated that these nurses are performing medical diagnoses, the dicta in this ruling suggests that one who can be held liable for "medical malpractice" must be performing a medical procedure.<sup>202</sup> It is not unusual for a nurse to be held liable for medical malpractice in a traditional medical setting for negligent performance of nursing duties while under the supervision of a doctor.<sup>203</sup> In the telephone triage encounter, however, the only services that nurses perform are, presumably, the rendering of triage advice.<sup>204</sup> If this advice is deemed to constitute a medical procedure, then a Medical Call Center may be exposed to additional liability for the unauthorized practice of medicine.<sup>205</sup>

It is beyond the scope of a nurse's expertise to diagnose medical illnesses as a physician.<sup>206</sup> Yet, the *Shannon* court held that an HMO may be responsible for "medical malpractice" for performance of a medical procedure performed by telephone triage nurses.<sup>207</sup> This holding raises the issues of whether the triage nurse is actually practicing medicine without a license, and whether this encompasses every triage encounter where actual medical advice is rendered. It is difficult to believe that one can give competent advice about a medical question without performing some type of unsupervised diagnosis.<sup>208</sup> Potential criminal lia-

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<sup>200</sup> See *Mario L. Shannon*, *supra* note 138, at 27.

<sup>201</sup> *Shannon*, 718 A.2d at 836.

<sup>202</sup> *Id.*

<sup>203</sup> See, e.g., *Salter v. Deaconess Family Med. Ctr.*, 701 N.Y.S.2d 586 (App. Div. 1999) (holding a nurse and hospital liable for injuries to an infant's foot).

<sup>204</sup> See *Mario L. Shannon*, *supra* note 138, at 27.

<sup>205</sup> See *Goldberg*, *supra* note 19 (discussing the possible unauthorized practice of medicine by triage nurses).

<sup>206</sup> *Shannon*, 718 A.2d at 836.

<sup>207</sup> *Shannon*, 718 A.2d at 836.

<sup>208</sup> See *Goldberg*, *supra* note 19. One insurance industry executive is also uncomfortable with the current industry policies regarding medical triage, stating, "the fine line between suggesting a course of action and making a medical

bility is further supported by certain physicians who oppose the concept of nurse telephone triage.<sup>209</sup>

### B. Licensure Issues

Nurses require licenses in the states in which they practice.<sup>210</sup> Nursing licenses are issued to qualified nurses who have successfully completed the requisite education and clinical training by the department of education in the state in which they practice.<sup>211</sup> The privileges of the nursing license, however, are limited to the state in which it was issued.<sup>212</sup> When considering Medical Call Centers with a national reach, the question arises as to whether nurses handling out-of-state calls are violating interstate nursing licensure laws in telephone triage encounters.<sup>213</sup>

At least two states are investigating whether a nurse licensed in one state can perform telephone triage in another state without actually being licensed in the caller's state. For example, New York State has forced an HMO that contracted with an out of state Medical Call Center to cease its telephone triage hotline until the nurses at the center obtained New York State nursing licenses.<sup>214</sup> The New York State Department of Education has stated that any out-of-state nurse who provides "care, whether it is nursing

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diagnosis or recommendation is 'just playing with the English language'." Goldberg, *supra* note 19.

<sup>209</sup> See Gilbert, *supra* note 1, at 12A (quoting Dr. James Todd, Executive Vice President of the American Medical Association, who is uncertain about the legal effects of telephone triage by nurses).

<sup>210</sup> See, e.g., N.Y. EDUC. LAW § 6502 (McKinney 1999) (defining the practice of registered nursing in New York); PA. STAT. ANN. tit. 63 § 212 (West 2000) (defining the practice of professional registered nursing in Pennsylvania).

<sup>211</sup> See, e.g., N.Y. EDUC. LAW § 6502 (McKinney 1999).

<sup>212</sup> *Id.* See also *supra* notes 20-22 (discussing the New York nursing licensure statute).

<sup>213</sup> See Smith, *supra* note 29, at D9 (discussing New York State's insistence that out-of-state Medical Call Centers obtain proper nursing licenses for their triage nurses). See also Glaneill, *supra* note 22, at 1 (requiring similar licenses by the state of Pennsylvania).

<sup>214</sup> See Smith, *supra* note 29, at D9 (discussing New York State's insistence on requiring New York State nursing licenses for all of Physicians Health Plan's out-of-state triage nurses performing telephone triage in New York).

judgement, assessment, counseling or hands-on-care . . . over the telephone” without a New York state nursing license is committing a felony.<sup>215</sup> In Pennsylvania, the State Board of Medicine has recently begun investigating whether out-of-state nurses need a Pennsylvania nursing license before receiving calls from Pennsylvania residents.<sup>216</sup> This investigation was initiated by certain physicians in Pennsylvania who complained that the use of out-of-state nurses by a local HMO violated state licensure laws.<sup>217</sup>

Interstate nursing licensure is a subject that many states are grappling with and a consistent legal policy is lacking.<sup>218</sup> Without any uniform national policies in this area, state laws will pose challenges to the Medical Call Center industry, due to the lack of uniformity inherent in individual state licensing statutes. One solution to this problem is to have all nurses obtain licenses in all states in which calls are being initiated. Evidently, the Federal Board of State Medical Boards is struggling with the issue of interstate medical licensure with respect to physicians practicing telemedicine.<sup>219</sup> Nurses practicing under the supervision of a physician will likely be subject to the same proposed legislation as physicians, but whether triage nurses acting without a physician-client relationship also will be subject to such legislation is unclear.<sup>220</sup>

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<sup>215</sup> See Smith, *supra* note 29, at D9 (discussing possible criminal liability for out-of-state nurses who perform telephone triage without a New York State nursing license).

<sup>216</sup> See Glaneill, *supra* note 22, at A1 (discussing Pennsylvania’s investigation into in-state licensure for out-of-state triage nurses).

<sup>217</sup> See Glaneill, *supra* note 22, at A1 (discussing how certain Pennsylvania physicians disapprove of telephone triage).

<sup>218</sup> See *Worrisome State*, NURSING, Mar. 1, 1999, at 73 (discussing the concerns of nurses in the industry about interstate nursing licensure violations).

<sup>219</sup> See Lee S. Goldsmith, *Telemedicine and Changing Medical Law*, TRIAL, May 1998, at 49, 50. The Federal Board of State Medical Boards is considering a model telemedicine act that would provide for a national license permitting telemedicine contacts. *Id.*

<sup>220</sup> See *id.* at 50.

#### IV. CURRENT FEDERAL GOVERNMENT AND FDA REGULATIONS

Medical Call Centers thus far have escaped state or federal regulation, as many such proposed regulations have focused on telemedicine activities involving the practice of medicine.<sup>221</sup> The FDA, the federal agency empowered to regulate medical devices, has similarly exempted the computer triage software utilized by Medical Call Centers as it analogizes such software to self-help guides or medical encyclopedias.<sup>222</sup> These policies should be revisited, in light of the burgeoning telephone triage industry and the sheer number of triage encounters occurring annually.<sup>223</sup> Consequently, federal and state regulation and legislation should be enacted to ensure the safety of millions of Americans utilizing Medical Call Centers.

##### *A. Current Federal Government Legislation and Regulation*

The Federal government has not yet asserted a position on the industry practices of Medical Call Centers. Most traditional medical facilities are governed by some form of government and state regulation, which has been enacted from either the perspective of

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<sup>221</sup> Current telemedicine acts being proposed do not directly discuss telephone triage. *See, e.g.*, Telehealth Improvement Act of 1999, H.R. 3420, 106th Cong. (1999); Comprehensive Telehealth Act of 1999, S. 770, 106th Cong. (1999) (proposing to provide reimbursement under the medicare program for telehealth services); Promoting Health in Rural Areas Act of 1999, S. 980, 106th Cong. (1999) (promoting access to health care services in rural areas via development of telehealth networks); Triple-A Rural Health Improvement Act of 1999, H.R. 1344, 106th Cong. (1999) (promoting access to healthcare in rural areas via development of telehealth services).

<sup>222</sup> *See* FDA POLICY FOR THE REGULATION OF COMPUTER PRODUCTS, *supra* note 35, § III; Food, Drug, and Cosmetic Act, 21 U.S.C. § 201(h) (1994).

<sup>223</sup> *See* DIRECTORY, *supra* note 57, at 19. In 1997, Medical Call Centers responded to almost 100 million calls per year from about 35 million families. *See* DIRECTORY, *supra* note 57 at 19. This year, the industry estimates that over 100 million families will have access to a triage nurse. *See* DIRECTORY, *supra* note 57, at 19.

medical practice,<sup>224</sup> government insurance funding,<sup>225</sup> or medical equipment and supplies.<sup>226</sup> The FDA is the federal agency responsible for assuring the safety and effectiveness of medical devices under the Federal Food, Drug, and Cosmetic Act.<sup>227</sup> Computer products and software are also subject to regulation as medical devices when they meet certain statutory criteria.<sup>228</sup>

Although there is much legislation pending in the area of telemedicine,<sup>229</sup> Medical Call Centers have escaped scrutiny because they are usually privately funded, do not involve insurance reimbursement, do not use any medical drugs or equipment, and do not, presumably, involve the practice of medicine.<sup>230</sup> Therefore, anyone with sufficient capital may operate a Medical Call Center without any license, education, certificate, or training.<sup>231</sup> Considering the serious nature of the types of services offered and the direct effect that the industry has on the lives and health of

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<sup>224</sup> See, e.g., CAL. BUS. & PROF. CODE § 2085 (West 2000) (providing requirements for medical licensure in California); FLA. STAT. ANN. § 458.311 (West 1999) (providing requirements for medical licensure in Florida); N.Y. EDUC. LAW § 6524 (McKinney 1999) (providing requirements for medical licensure in New York).

<sup>225</sup> There are several federal and state agencies that regulate medical insurance and health care funding. These include: the federal Health Care Finance Administration ("HCFA"); state Medicaid agencies; and state insurance commissions. See *infra* note 266 and accompanying text (describing the Department of Health and Human Services and its agencies).

<sup>226</sup> See Food, Drug, and Cosmetic Act, 21 U.S.C. § 393 (Supp. IV 1998) (authorizing the Food and Drug Administration to regulate medical devices and pharmaceuticals).

<sup>227</sup> *Id.* The goal of the FDA is to interpret and enforce the Food, Drug, and Cosmetic Act and to issue guidelines to industry in connection with the Act. *Id.*

<sup>228</sup> See Food, Drug, and Cosmetic Act, 21 U.S.C. § 201(h) (1994) (defining the term medical device).

<sup>229</sup> See *supra* note 31 (discussing pending telemedicine legislation).

<sup>230</sup> Although the computer systems utilized by Medical Call Centers may be considered medical devices, they are currently exempted from FDA regulation. See *infra* note 240 (discussing medical triage software).

<sup>231</sup> See DIRECTORY, *supra* note 57, at 5 (discussing how regulatory bodies and professional organizations are establishing standards and a certification process for Medical Call Centers). Currently, however, no actual regulation or licensing requirements exist. DIRECTORY, *supra* note 57, at 5.

millions of Americans daily, it is hard to understand how such an environment of deregulation is tolerated.

### B. FDA Oversight of the Medical Call Center Industry

The FDA has exempted medical triage software from regulation as it has classified such software as an electronic encyclopedia that merely catalogs medical symptoms, and, therefore, is incapable of rendering a medical diagnosis.<sup>232</sup> Currently, the agency is reconsidering its policy regarding non-regulation of triage software as a result of the many misunderstood aspects of its 1989 draft policy, which exempted “previously unclassified information management products . . . such as expert or knowledge based systems, artificial intelligence, and other types of decision support systems intended to involve competent human intervention before any impact on human health occurs.”<sup>233</sup> A reevaluation is necessary as sophisticated medical triage software systems using complicated algorithmic features take some of the human decision making process away from the nurse. The less a system allows for human decision making skills, the more such software would fall under the regulation of the statute.<sup>234</sup>

Some of the difficulty that the FDA has with regulating the medical software utilized by the Medical Call Center industry is the definition of the term “medical device” which is specified in the Food, Drug, and Cosmetic Act.<sup>235</sup> This definition is extremely broad, but not necessarily all inclusive.<sup>236</sup> The FDA is the federal

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<sup>232</sup> See FDA POLICY FOR THE REGULATION OF COMPUTER PRODUCTS, *supra* note 35, § III.

<sup>233</sup> See FDA Software Policy Workshop, Center for Devices and Radiological Health, Natcher Auditorium, NIH (Sept. 3 & 4, 1996).

<sup>234</sup> See Telephone Interview, *infra* note 239 (discussing why the latest computer systems may not be exempt from the statute).

<sup>235</sup> Food, Drug, and Cosmetic Act, 21 U.S.C. § 201(h) (1994).

<sup>236</sup> *Id.* The definition of a medical device includes:

an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is . . . intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals . . . [or]

agency empowered by Congress to interpret the Act, define its terms, create exemptions, and promulgate guidelines for industry.<sup>237</sup> Until very recently, the FDA has chosen to draw a bright line to distinguish between devices or software that “diagnose,” as opposed to those that merely aid in diagnosis by serving a traditional “library” function, such as storage, retrieval, and dissemination of medical information, similar to an encyclopedia, textbook, or journal.<sup>238</sup> While this approach was sound given the state of software in the late 1980s and early 1990s that merely acted as a straightforward database of medical information, today’s versions of medical triage software with sophisticated algorithms<sup>239</sup> require the FDA to rethink its policy guidelines for such software.<sup>240</sup> Indeed, the FDA is planning a public forum in the spring of 2000 to hear comments and suggestions on proposed

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intended to affect the structure or any function of the body of man or other animals.

*Id.*

<sup>237</sup> See Food, Drug, and Cosmetic Act, 21 U.S.C. § 393 (Supp. IV 1998).

<sup>238</sup> FDA POLICY FOR THE REGULATION OF COMPUTER PRODUCTS, *supra* note 35, § III.

<sup>239</sup> See DIRECTORY, *supra* note 57, at 31. An algorithm uses a series of “yes” or “no” answers to arrive at appropriate advice. DIRECTORY, *supra* note 57, at 31.

<sup>240</sup> Telephone Interview with Stewart Crumpler, Software Compliance Officer, *Center for Devices and Radiological Health, a Division of the FDA* (Dec. 2, 1999) [hereinafter Telephone Interview]. According to the FDA policy published in 1989, stand-alone medical triage software is exempt from registration, listing, and pre-market notification. *Id.* This exemption applies to manufacturers of computer products that utilize decision support systems that are intended to involve “competent human intervention” before any impact on human health occurs. *Id.* Competent human intervention is defined by the FDA as when clinical judgment and experience can be used to check and interpret a system’s output, presumably by a physician or nurse who can override any computer recommendation. *Id.* Most older medical triage software systems would meet this definition and be eligible for exemption. *Id.* However, most recent versions of such software, especially those whose components include “neural networks” would not necessarily be exempt because they would fail to allow human intervention to have complete control over the process. *Id.* A neural network is a system where the computer essentially teaches itself with artificial intelligence based upon responses to the software. *Id.*

changes to its current policies regarding medical triage software.<sup>241</sup>

It would seem logical for the FDA to have oversight over today's sophisticated triage software in light of the sheer volume of patients being diagnosed daily by Medical Call Centers nationwide.<sup>242</sup> Moreover, it is hard to reconcile the fact that a product such as medical triage software, which in its sophistication recommends life and death decisions for millions of Americans, is not regulated by the FDA, while devices for the diagnosis of disease in animals are highly regulated.<sup>243</sup> Comprehensive legislative reforms are needed to protect the public and insure its safety when utilizing telephone triage services.

## V. STATUTORY AND LEGISLATIVE SOLUTIONS

The lack of current regulation in the Medical Call Center industry and recent court rulings ascribing civil liability for negligent telephone triage services requires legislative reforms in the nature of licensure and medical software regulation. Federal regulation should utilize a four pronged approach including: (1) drafting comprehensive industry guidelines; (2) amending ERISA to exclude telephone triage from preemption protection; (3) adopting proposed telemedicine legislation regarding licensure to Medical Call Centers; and (4) FDA regulation of telephone triage software. Additionally, states need to expand current nurse licensure statutes to include provisions for interstate telephone triage. Such comprehensive legislation will assure that Americans utilizing telephone triage services obtain the protection they require in a cost cutting healthcare environment.

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<sup>241</sup> See *Telephone Interview*, *supra* note 240.

<sup>242</sup> See *DIRECTORY*, *supra* note 57, at 19 (discussing how over 100 million Americans will have access to telephone triage this year).

<sup>243</sup> See Food, Drug, and Cosmetic Act, 21 U.S.C. § 201(h) (1994). The FDA has authority to regulate veterinary drugs for safety. *Id.*



A. *The Need for Legislative Reforms in the Medical Call Center Industry*

Historically, most government reforms have been developed only after some sort of tragedy or disaster shook the conscience of America.<sup>244</sup> For over a century, medicine and the treatment of human illness has been one of the most regulated industries in America.<sup>245</sup> For example, virtually every aspect of a patient's visit with a physician or hospital has some form of regulation that monitors the outcome.<sup>246</sup> Yet, medical triage has inexplicably been ignored by federal and state regulators and legislators since its inception. It is estimated that over fifty percent of the American population will have access to medical telephone triage in the coming decade.<sup>247</sup> Such a wide reaching medical service affecting the lives and health of so many Americans requires significant supervision and oversight to protect patients' well being.

As evidenced by recent court rulings attributing civil liability to Medical Call Centers whose nursing staffs perform telephone triage negligently,<sup>248</sup> the need to define the precise role of a

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<sup>244</sup> The airline industry and the Federal Aviation Administration's ("FAA") policies regarding airline safety in the wake of airliner crashes is a good example. Indeed, the FAA's web site emphasizes its safety programs and its unique monitoring of airline manufacturers and airlines in order to prevent future accidents. *FAA's Website: Aviation Support and Regulations* (visited Apr. 14, 1999) <<http://www.faa.gov/aviation.html>>.

<sup>245</sup> See Nissa M. Strottman, *Public Health and Private Medicine: Regulation in Colonial and Early National America*, 50 HASTINGS L. J. 383 (1999) (discussing the history of medical regulation in the United States).

<sup>246</sup> See *supra* note 225 (describing certain federal and state agencies charged with regulating medically related statutes). Such regulation includes oversight by: the FDA for drugs and laboratory testing; HCFA and various insurance commissions for insurance reimbursement; and state licensure boards for medical staff.

<sup>247</sup> See Anders, *supra* note 11, at A1.

<sup>248</sup> See, e.g., *Crum v Health Alliance-Midwest, Inc.*, 47 F. Supp. 2d 1013, 1020 (C.D. Ill. 1999); *Shannon v. McNulty*, 718 A.2d 828, 835 (Pa. Super. Ct. 1998).

triage nurse and proper standards of care for the industry is great.<sup>249</sup> Additionally, the anxiety that members of the medical, nursing, and insurance industry have about whether nurses are crossing the line into criminal liability for the unauthorized practice of medicine should give cause for concern to the Medical Call Center executives responsible for policy and staffing issues across the nation.<sup>250</sup> Consequently, self-regulation is not recommended for the Medical Call Center industry because of the increasingly important role it is playing in the delivery of healthcare to millions of American families.

### B. Proposed Federal Legislation, Regulatory Reform, and Oversight

A comprehensive proposal of federal regulatory reform for Medical Call Centers should utilize a four pronged approach. First, a detailed set of guidelines and standards should be drafted that encompass all aspects of the telephone triage encounter. The AAHCC/URAC, a non-profit accreditation commission,<sup>251</sup> has recently published standards for the Medical Call Center industry.<sup>252</sup> These standards should form the basis for federal legislation mandating certain acceptable requirements for the operation of a Medical Call Center.<sup>253</sup> Second, the federal government should

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<sup>249</sup> *Shannon*, 718 A.2d at 835. Although liability for the Medical Call Center was not decided conclusively, the issue of standards of care for telephone triage was discussed most clearly in the *Shannon* case. *Id.*

<sup>250</sup> See Glaneill, *supra* note 22, at 1. The current debate in the State of Pennsylvania over interstate nursing licensure and unauthorized practice of medicine is a good example of how these issues are affecting individual states' health care policies. Glaneill, *supra* note 22, at 1.

<sup>251</sup> See *URAC Standards*, *supra* note 36. The AAHCC/URAC establishes standards for the managed care industry. See *URAC Standards*, *supra* note 36.

<sup>252</sup> See *URAC Standards*, *supra* note 36. The telephone triage health standards provide benchmarks in the following areas: confidentiality; staff qualifications; program qualification; accessibility; information upon which clinical activity is conducted; documentation; and health information. See *DIRECTORY*, *supra* note 57, at 174.

<sup>253</sup> See *URAC Standards*, *supra* note 36.

amend ERISA<sup>254</sup> to specifically exclude telephone triage from preemption protection for HMOs.<sup>255</sup> Third, the proposed legislation regarding telemedicine currently being debated in Congress, should be expanded to include the Medical Call Center industry, including federal licensure of nurses performing medical triage.<sup>256</sup> Finally, there should be regulation of telephone triage software as a medical device.

The most critical component in the evolution of regulatory and legislative reforms for telephone triage is the development of standards by which the entire industry should be required to abide. A major breakthrough in this regard occurred last year when the AAHCC/URAC published its first set of comprehensive standards for twenty-four hour telephone triage and health information services.<sup>257</sup> Although these standards are voluntary in nature, with only a few HMOs and Medical Call Centers seeking and receiving accreditation, it is an important first step in the process.<sup>258</sup> These standards provide national benchmarks in all aspects of a Medical Call Center's operations and policies.<sup>259</sup> The AAHCC/URAC benchmarks include the following areas: health information; staff qualifications; clinical quality; access and on-site review procedures; information upon which clinical activity is conducted; and call documentation.<sup>260</sup> As these benchmarks seem to have been warmly received by the largest Medical Call Centers, it is suggested that the federal government look closely at ways in which to incorporate these guidelines into federal legislation that all industry participants must adhere to under penalty of fine or prosecution.

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<sup>254</sup> 29 U.S.C. §§ 1001-1461 (1994 & Supp. II 1996) (regulating health plans and imposing certain requirements on employers).

<sup>255</sup> *Id.*

<sup>256</sup> Comprehensive Telehealth Act of 1999, S. 770 (1999) (proposing to regulate the practice of telemedicine across state lines).

<sup>257</sup> See *URAC Standards*, *supra* note 36.

<sup>258</sup> It is significant to note that Access Health, one of the nation's largest Medical Call Centers, has received accreditation from the AAHCC/URAC for its telephone triage services. See Lori Harris Stevens, *New Telephone Triage Standards Added to URAC's Modular Accreditation Offerings*, ACCREDITWATCH, Fall 1998, at 1.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

An additional step in the legislative reform process should include an amendment to ERISA,<sup>261</sup> specifically excluding Medical Call Centers that are owned or contracted by HMOs from protection for negligent acts by its staff. Although legislation limiting ERISA preemption protection for HMOs is currently being debated in Congress as part of a proposed Patients' Bill of Rights attempting to reform the HMO industry in general, the specific issue of telephone triage is not being discussed.<sup>262</sup> Such positive legislative reform should include the Medical Call Center industry, thus protecting consumers from potentially harmful medical practices.

The third prong of a federal legislative reform policy should deal with the issue of federal certification of Medical Call Centers and interstate licensure of nurses performing medical triage. Similar types of issues are also currently being debated by Congress, but only in the context of telemedicine and physician interstate licensure.<sup>263</sup> It would be prudent to extend the debate in telemedicine to telephone triage and nurses, and include legislation that would set a national policy for both licensure of telephone triage nurses as well as for federal certification of Medical Call Centers whose operations cross state lines.<sup>264</sup>

Finally, the FDA should regulate medical triage software as a medical device and the Department of Health and Human Services ("HHS")<sup>265</sup> should regulate Medical Call Centers as ancillary medical facilities, similar to its regulation of laboratories and health clinics.<sup>266</sup> As these agencies are responsible for monitoring the health and safety of Americans, they are in the best position to

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<sup>261</sup> 29 U.S.C. §§ 1001-1461 (1994 & Supp. II 1996).

<sup>262</sup> See Patients' Bill of Rights of 1999, S. 1256, 106th Cong. (1999).

<sup>263</sup> See, e.g., Comprehensive Telehealth Act of 1999, S. 770 (1999) (proposing to regulate the practice of Telemedicine across state lines).

<sup>264</sup> See Anders, *supra* note 11, at A1. Since most currently operating Medical Call Centers operate regional or national phone lines, such federal certification would apply to most, if not all, of the currently operating centers.

<sup>265</sup> 3 U.S.C. § 301 (1994) The Department of Health and Human Services ("HHS") is the federal agency empowered to regulate federal health issues. *Id.*

<sup>266</sup> See *HHS: What We Do* (visited Mar. 16, 2000) <<http://www.hhs.gov/about/profile.html>> (describing the various departments and agencies under the umbrella of HHS and their functions).

expand their coverage to the Medical Call Center industry.<sup>267</sup> All issues relating to the operation and certification of a Medical Call Center should be established under the auspices of HHS.<sup>268</sup> There should be a formal application process that would require key information about the qualifications of all supervisory and management personnel similar to the requirements for insurance reimbursement by Medicare providers.<sup>269</sup> Centers would be monitored by HHS staff under a process similar to one monitoring laboratories.<sup>270</sup> This supervision would be coordinated on a state by state basis to ensure that employees of the center qualify under state licensing guidelines.<sup>271</sup> A comprehensive approach to federal legislative reforms for telephone triage services will benefit health care consumers immensely by standardizing the types of services, medical protocols, and staffing policies on a national level, thereby reducing overall liability issues and ensuring safe, effective health care advice.

### C. Proposed State Licensure and Regulatory Reform

States need to clearly define nurse licensure statutes to reflect the types of activities that nurses should be allowed to perform under their existing nursing licenses without raising any issues of unauthorized practice of medicine.<sup>272</sup> By including specific

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<sup>267</sup> *Id.*

<sup>268</sup> *Id.*

<sup>269</sup> *Id.*

<sup>270</sup> *Id.*

<sup>271</sup> See Glaneill, *supra* note 22 (discussing Pennsylvania's debate on these issues).

<sup>272</sup> See Edward J. Kabala, *Legalities of a Telephone Nurse Triage System*, PHYSICIAN'S NEWS DIG., Sept. 1998, at 1. For example, there are distinctions between the term "nursing diagnosis" and "medical diagnosis" in the Pennsylvania statute. *Id.* The main difference between the two types of diagnosis is that the nursing diagnosis does not make a final conclusion about the identity and cause of the underlying disease. *Id.* This distinction, while important, does not necessarily reflect the main difference in other state statutes, such as New York's, which requires that a nursing diagnosis can be made only under the direct supervision of a physician. See N.Y. EDUC. LAW § 6902 (McKinney 1999).

language in the nursing licensure statutes for telephone triage services, states will eliminate much of the ambiguity related to the questions of possible violations of interstate licensure as well as unauthorized practice of medicine by its licensed nurses.<sup>273</sup> The National Council of State Boards of Nursing has recently proposed an interstate compact for mutual recognition of telephone nurses that specifically deals with the issue of interstate licensure.<sup>274</sup> So far, this compact has been adopted only by the State of Utah, but many other states are reviewing it for possible enactment.<sup>275</sup> On the telemedicine front, the Federation of State Medical Boards of the United States has also proposed a model act that would apply to physicians practicing medicine across state lines.<sup>276</sup> By combining the best elements of both of these proposed acts into one cohesive policy statement, states would be able to enact uniform legislation dealing with these important medicolegal licensure issues.<sup>277</sup>

## CONCLUSION

Medical Call Centers have revolutionized the delivery of managed care services in America. While the concept of utilizing managed care to reduce healthcare costs is inherently sound, it is important to monitor certain disturbing aspects of its cost cutting methodology. A key component of this cost cutting initiative is the reduction of overall health care utilization, a goal that led to the creation of the Medical Call Center. However, the inherent tension involved in every telephone triage encounter between delivering premium health information and advice on the one hand, and being

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<sup>273</sup> See Kabala, *supra* note 272, at 1.

<sup>274</sup> See News Release, NATIONAL COUNCIL OF STATE BOARDS OF NURSING, Nov. 25, 1998.

<sup>275</sup> *Id.*

<sup>276</sup> See Report of the Ad Hoc Committee on Telemedicine, FEDERATION OF STATE MEDICAL BOARDS OF THE U.S., INC., Apr. 1996.

<sup>277</sup> See Emergency Nurses Association (visited March 2, 2000) <<http://www.-ena.org/services/posistate/data/teladv.htm>>. The Emergency Nurses Association has published a position paper on the industry, but has yet to formally adopt a specific set of protocols or standards by which to abide. *Id.*

pressured to reduce as many “unnecessary” healthcare facility visits by managed care on the other, increases the likelihood of inadvertent, improper health advice being dispensed by telephone triage nurses. The increase in popularity of these Medical Call Centers will cause only greater civil liability exposure to the current, unregulated industry. Additionally, vaguely worded state licensure statutes give little guidance to a call center operator seeking to avoid the dangers of having the nursing staff perform nursing services across state lines without proper licenses, or performing the unauthorized practice of medicine. The only solution to these problems is a cohesive, sound, and comprehensive policy of federal and state legislation and regulation of the Medical Call Center industry. Such policies will seek to reduce not only tort liability, but also criminal liability for improper licensure and practice issues, as well as establish a baseline standard that the health care community can rely on for safe and effective health information. This proposed legislation and regulation is not only good for America, it is vital for its continued health in the new millennium. For only with sound policies and fair legislation will consumers be protected from inappropriate services offered by the Medical Call Center industry.