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## Telemedicine in Illinois: Untangling the Complex Legal Threads, 50 J. Marshall L. Rev. 885 (2017)

Laura Wibberley

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# TELEMEDICINE IN ILLINOIS: UNTANGLING THE COMPLEX LEGAL THREADS

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## I. INTRODUCTION

A woman rushes her child to a small rural Illinois hospital to seek treatment for the child's schizophrenic episode only to discover a mental health physician is not available that day.<sup>1</sup> A non-English

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1. See STEDMAN'S MEDICAL DICTIONARY 1600 (2000) (defining "schizophrenia" as "a common type of psychosis, characterized by abnormalities in perception, content of thought, and thought processes [hallucinations and delusions] and by extensive withdrawal of interest from other people and the

speaking patient is unable to communicate to the limited medical staff to relay his symptoms. An elderly woman must wait over one month before she can seek treatment for her constant headaches from the rural town's overbooked primary care physician.<sup>2</sup>

Almost half of Illinois' hospitals are located within small rural areas of Illinois.<sup>3</sup> However, more than half of these rural hospitals are unequipped to provide proper care for patients.<sup>4</sup> Illinois' rural hospitals handle millions of patient visits each year, and this number is exponentially increasing.<sup>5</sup> The patients who frequent these hospitals tend to be older than patients in urban areas of Illinois and therefore require more care.<sup>6</sup> Yet, a substantial percentage of these small and rural Illinois hospitals are currently facing severe physician shortages.<sup>7</sup> Although Illinois medical schools provide training for new physicians each year, few transfer to practice in these rural areas primarily due to Illinois's medical

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outside world, with excessive focusing on one's own mental life.”).

2. See ASS'N OF AM. MED. COLL., RECENT STUDIES AND REPORTS ON PHYSICIAN SHORTAGES IN THE U.S. 6 (2012) (finding that physicians in Illinois are overburdened with heavy caseloads primarily due to physician shortages in Illinois). One reason for this physician shortage is the fact that one-half of Illinois's medical residents and fellows leave the state after completing his or her education. *Id.* The study noted that this was primarily due to Illinois's medical liability procedures and high malpractice insurance rates. *Id.*

3. ILL. HEALTH AND HOSP. ASS'N, ILLINOIS SMALL AND RURAL HOSPITALS: BACKBONES OF THEIR COMMUNITIES 2 (2016), [www.ihatoday.org/Member-Groups/Constituency-Sections/Small-and-Rural-Hospitals.aspx](http://www.ihatoday.org/Member-Groups/Constituency-Sections/Small-and-Rural-Hospitals.aspx). Currently, 87 of Illinois hospitals are located in rural areas of Illinois and comprise 42.1% of Illinois's total hospitals. *Id.*

4. ILL. HEALTH AND HOSP. ASS'N, FACTS ABOUT ILLINOIS'S CRITICAL ACCESS HOSPITALS 1 (2013), [www.ihatoday.org/Member-Groups/Constituency-Sections/Small-and-Rural-Hospitals/ResourcesBest-Practices.aspx](http://www.ihatoday.org/Member-Groups/Constituency-Sections/Small-and-Rural-Hospitals/ResourcesBest-Practices.aspx). The report further indicates that 51 of these small and rural hospitals are designated as “Critical Access Hospitals” and have under 26 beds for patient care. *Id.*

5. *Id.* Despite the extremely low capacity to provide patient care, these small and rural Illinois hospitals served 40,246 inpatient visits, 2,076,397 outpatient visits, and 368,484 emergency room visits in 2011 alone. *Id.*; see also U.S. CENSUS BUREAU, ILLINOIS 2010 POPULATION AND HOUSING UNIT COUNTS 5 (2010) (specifying Illinois's rural population totaled 1,477,079 in the 2010 United States Census).

6. See FACTS ABOUT ILLINOIS'S CRITICAL ACCESS HOSPITALS, *supra* note 4, at 1 (explaining that within these critical access hospitals in Illinois, nearly 59.6% of patients are over the age of 65, while 22.4% of patients are over the age of 85).

7. ILLINOIS SMALL AND RURAL HOSPITALS: BACKBONES OF THEIR COMMUNITIES, *supra* note 3, at 13. Within small and rural Illinois hospitals, 92% are currently facing mental health professional shortages while over 37.8% of these hospitals are suffering from primary care physician shortages. *Id.*

liability risks and high malpractice insurance rates.<sup>8</sup> Healthcare within rural Illinois is silently but rapidly deteriorating.<sup>9</sup>

Telemedicine is the answer.<sup>10</sup> Telemedicine has the potential to expand the access and quality of healthcare to rural areas of Illinois.<sup>11</sup> Telemedicine allows medical professionals in out-of-state areas to treat patients remotely using real-time telecommunication technologies.<sup>12</sup> Telemedicine technology provides audio, visual, and other data sharing communications to enable out-of-state physicians to provide treatment to rural patients in Illinois.<sup>13</sup> For example, in a hospital with limited physicians, a digital stethoscope can transmit lung sounds of a child to an available distant treating physician for an evaluation.<sup>14</sup> A non-English speaking patient could “see” a licensed medical professional who is able communicate in the patient’s native language and provide treatment.<sup>15</sup> Nurse practitioners can assist busy primary care physicians by conducting virtual visits with patients in need of immediate assistance while also eliminating a patient’s travel time and expenses.<sup>16</sup> Research

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8. ASS’N OF AM. MED. COLL., *supra* note 2, at 6. Only 1.5% of recent Northwestern University School of Medicine graduates in 2010 planned to practice medicine in a rural setting within Illinois. *Id.* The study noted that the physician shortage was primarily due to medical liability procedures and high malpractice insurance rates in Illinois. *Id.*

9. See ASS’N OF AM. MED. COLL., *supra* note 2 and accompanying text; see also ILLINOIS SMALL AND RURAL HOSPITALS: BACKBONES OF THEIR COMMUNITIES, *supra* note 3 and accompanying text.

10. See also Regina A. Bailey, *Cybermedicine: What you Need To Know*, 21 HEALTH LAWYER 13, 13-14 (2011) (recognizing that telemedicine services may also be known as “cybermedicine”). Although telemedicine and cybermedicine technically differ, commonly the terms are interchangeable in their use. *Id.*

11. NAT’L CONFERENCES OF STATE LEGISLATURES, TELEHEALTH POLICY TRENDS AND CONSIDERATIONS 6 (2015).

12. *Id.*

13. *Id.*

14. Janet Grady, *Telehealth: A Case Study in Disruptive Innovation*, 114 AM. J. NURSING 39, 39 (Apr. 2014). Additional data that can be collected from a patient via telemedicine equipment include, pulse, weight, blood pressure, blood glucose levels, and medication-tracking. *Id.* at 40. This data can then be transmitted in real time or through a “store and forward” option. *Id.* For example, to transmit in real time, a patient may simply stand on a scale and press a “send” button on the device. *Id.* The “store and forward” option, transmits and stores patient data to be reviewed by a medical professional at a later time. *Id.*

15. David D. Luxton, Larry D. Pruitt, & Janyce E. Osenbach, *Best Practices for Remote Psychological Assessment via Telehealth Technologies*, 45 PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 27, 32 (2014). Typically, psychological assessment interviews are conducted using webcams connected to computer monitors. *Id.* at 27. In addition, even smart phone device applications can assist with psychological assessments. *Id.*

16. *Id.* Nurses are essential in the telemedicine context. *Id.* at 40–43. Nurses can utilize the telemedicine equipment with patients and subsequently transmit the data to the distant treating physician to render treatment. *Id.*; see also E. Ray Dorsey & Eric J. Topol, *State of Telehealth*, 375 N. ENGL. J. MED.

has shown that telemedicine technology reduces healthcare costs while increasing patient access to primary and specialty care.<sup>17</sup> This allows doctors to maximize his or her busy schedules to be able to treat more patients.<sup>18</sup> Thus, telemedicine services can provide a cost effective way to provide greater access of care to Illinois patients, especially those located in severely under equipped rural areas.<sup>19</sup>

Although technology is able to provide a solution to Illinois's dire healthcare system, legal uncertainties nationwide are suffocating the growth of telemedicine.<sup>20</sup> These threads of legal uncertainties include whether a physician licensed in Wisconsin should be required to obtain Illinois licensure prior to providing medical care via telemedicine to Illinois patients.<sup>21</sup> Additionally, in the event of a lawsuit involving the interstate use of telemedicine, there is a question of whether the proper jurisdiction should be the location of the patient or of the physician.<sup>22</sup> Other issues include the

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154, 154 (2016) (noting that by allowing patients to be treated in their own homes, patients are able to save time and travel expenses).

17. Hilary Daniel & Lois S. Sulmasy, *Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper*, 163 ANN. INTERN. MED. 787 (Nov. 17, 2015), <http://annals.org/article.aspx?articleid=2434625#r34-1>; see also NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 10 (describing a private nursing home study that was conducted wherein nursing homes regularly received telemedicine physician care). Not only did the study reveal that there was a significant decline in hospitalizations for the patients, but also the average saving to Medicare would be \$151,000 per nursing home facility per year. *Id.*

18. Dorsey & Topol, *supra* note 16, at 154.

19. *Id.*

20. ROBERT J. KANE & LAWRENCE E. SINGER, ILL. PRACTICE SERIES, THE LAW OF MEDICAL PRACTICE IN ILLINOIS: TELEMEDICINE § 1.10 (3d ed. 2016). Additionally, notes the use of telemedicine raises "significant legal and ethical concerns, including those related to the technological standards for delivering care, confidentiality, informed consent, malpractice and licensure and discipline." *Id.*; see also Kathleen M. Vyborny, *Legal and Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 66 (1996) (affirming other issues surrounding telemedicine use include concerns about patient privacy, which includes the confidentiality of medical records transmitted via electronic networks).

21. See MATTHIAS I. OKOYE & S. SANDY SANDBAR, TELEMEDICINE: FORENSIC AND MEDICOLEGAL ASPECTS, 2-27E FORENSIC SCIENCES § 27E.03[c] (2016) (stating several states require full medical licensure in the state where the physician is practicing telemedicine). Some states require a special purpose license in order to practice telemedicine, while others have implemented an expedited licensure process to enable a physician to practice within the state. *Id.*

22. See LYNN D. FLEISHER & JAMES C. DECHENE, TELEMEDICINE AND E-HEALTH LAW § 1.04[1][a][i] (2015) (opining that jurisdictional issues are especially complicated when using online medical practices and treatments). Theoretically, a medical practitioner may be practicing medicine in both the state where she or he resides, as well as the state where the patient resides. *Id.* For a physician to be subject to personal jurisdiction in another state, the physician must have sufficient minimum contacts with the state. *Id.*

manner in which insurance companies reimburse telemedicine services.<sup>23</sup> Finally, malpractice liability risks and concerns surrounding telemedicine use are escalating nationwide.<sup>24</sup>

Without a uniform national system to regulate the use of telemedicine, each state has implemented varying answers to these threads of legal uncertainties.<sup>25</sup> Incongruent state laws force physicians to navigate through law and regulation minefields should they desire to provide care to a patient in a different state. For this reason, Illinois must provide answers to untangle these threads of legal uncertainties to maximize patient safety and minimize malpractice fears to encourage physicians to utilize telemedicine services within Illinois.

This Comment begins in Section II with an overview of the current telemedicine practices in healthcare, as well as the current law within Illinois regarding telemedicine use. Section III of this Comment discusses the flaws under the current Illinois law that act to impede licensed medical professionals from providing telemedicine services in patient care. Section III specifically focuses on the area of medical negligence to include the establishment of the physician-patient relationship, the applicable standard of care, and the scope of the requisite informed consent. This Section also examines and compares various legislation enacted in other states that provide a solution to these liability issues in telemedicine. Section IV proposes legislation for the Illinois Legislature to adopt in order to address these medical negligence and liability concerns, maximizing the protection and safety of patients through the use of telemedicine. Section V concludes by urging the Illinois Legislature to adopt legislation utilized by other States to protect against the deteriorating quality of healthcare by expanding for the utilization of telemedicine services.

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23. See KANE & SINGER, *supra* note 20 and accompanying text.

24. *Id.*

25. *E.g.* Bill Marino, Roshen Prasad, & Amar Gupta, *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 304-6 (2015) (arguing that federal control over telemedicine should occur to quash barriers imposed by States). Yet, health regulation remains primarily with the police powers of the states under the Tenth Amendment. *Id.* To resolve this dichotomy, first, Congress may decide to implement telemedicine measures under the Commerce Clause, Necessary and Proper Clause, and Spending Clause of the Constitution of the United State of America. *Id.* Second, Congress may regulate telemedicine under the Commerce Clause as a channel, instrumentality, or activity that substantially affects interstate commerce. *Id.* The Necessary and Proper Clause may be coupled with the Commerce Clause to “extend” Congressional powers. *Id.* Lastly, since telemedicine licensure measures would “provide for the general welfare” of United States citizens, the Congressional Spending powers could further support a federal spending program implementing licensure of telemedicine. *Id.*

## II. BACKGROUND

This Section will first examine the developments of the use of telemedicine within healthcare. This Section will then discuss the current legislation enacted within Illinois regulating telemedicine use within the state, and further explain the malpractice liability concerns that remain unaddressed under the current Illinois law.

### A. Current Telemedicine Practices in Illinois

Telemedicine was first utilized in the early twentieth century using telegraph wires to transmit electrocardiograph or heart rhythm data.<sup>26</sup> The modern form of telemedicine began in the 1960s, which included the use of a television to facilitate patient consultations, as well as to provide physician training and teaching.<sup>27</sup> Currently, telemedicine services within Illinois treat a variety of illnesses, including gastroenterology disorders, infectious disease, and wound and tissue repair.<sup>28</sup> Some Illinois hospitals even offer telemedicine “robot” services to monitor and provide care to potential stroke patients.<sup>29</sup>

Within Illinois, medical professionals may provide treatment through telemedicine encounters in several ways. The first allows a patient to consult simultaneously with a licensed clinical staff located at a distant site through a two-way audio and visual communication system.<sup>30</sup> The “store and forward” method allows a licensed medical professional to collect data from a patient, such as blood glucose levels or heart beat rhythms, to then forward the data to another licensed professional for an evaluation.<sup>31</sup> Additional telemedicine uses include “remote patient monitoring” wherein a

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26. WORLD HEALTH ORG., TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES 9 (2010).

27. *Id.* The report additionally notes that military and space technology divisions primarily advanced the modern form of telemedicine. *Id.*

28. *Telemedicine Clinical Physician Services*, UNIV. OF ILL. COLL. OF MED., [www.medicine.uic.edu/telehealth-and-telemedicine/clinical\\_services/](http://www.medicine.uic.edu/telehealth-and-telemedicine/clinical_services/) (last visited Sept. 19, 2017). The University Of Illinois College Of Medicine utilizes telemedicine services to treat patients suffering from these and other disorders. *Id.*

29. *Loyola Medicine and Palos Community Hospital Offering Telestroke Care to Southwest Suburbs*, LOYOLA MED. (Nov. 3, 2015), [www.loyolamedicine.org/news/loyola-medicine-and-palos-community-hospital-offer-telestroke-care-southwest-suburbs-11032015](http://www.loyolamedicine.org/news/loyola-medicine-and-palos-community-hospital-offer-telestroke-care-southwest-suburbs-11032015). Telemedicine provides care 24 hours a day to patients by instantly transmitting data to a specialist physician who can respond and provide treatment. *Id.* This rapid care is essential given that a stroke can kill 32,000 brain cells each second. *Id.*

30. ILLINOIS SMALL AND RURAL HOSPITALS: BACKBONES OF THEIR COMMUNITIES, *supra* note 3, at 9.

31. *Id.*

device is able to collect data from the patient while at home or within a clinic.<sup>32</sup> The device then transmits the collected data for review by a medical professional.<sup>33</sup>

Additional telemedicine uses within Illinois include physician education and training programs. The University of Chicago launched its “ECHO” program to host live video conferences with medical specialist physicians to provide medical guidance and training to rural primary care physicians.<sup>34</sup> As of 2014, the ECHO program allowed medical specialists to train more than 250 medical providers on subjects; including, resistant hypertension, pediatric ADHD, and hepatitis C.<sup>35</sup>

Telehealth and telemedicine services are not only expanding within Illinois, but these services are also expanding exponentially both nationwide and globally.<sup>36</sup> By the year 2021, telemedicine is expected to reach \$66 billion in the global market.<sup>37</sup> The number of patients treated through telemedicine nationwide is expected to grow from 250,000 patients per year in 2013 to 3.2 million patients per year by 2018.<sup>38</sup> Recently, CVS collaborated with three leading telemedicine technology providers to begin implementing the use of telehealth services within the hundreds of CVS Minute Clinics nationwide.<sup>39</sup> APPLE and IBM both initiated smart phone applications that can collect data such as blood glucose levels and deliver personalized medical advice.<sup>40</sup> Because of these recent

32. NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 8. For example, such technology can be used to monitor glucose levels for a diabetic patient. *Id.*; see also Grady, *supra* note 14 and accompanying text.

33. *Id.*

34. Sara Serritella, *ECHO Chicago Expands its Geographic Reach and Training Offerings*, SCIENCE LIFE (Nov. 3, 2014), <https://sciencelife.uchospitals.edu/2014/11/03/echo-chicago-expands-its-geographic-reach-and-training-offerings/>. “ECHO stands for Extension of Community Healthcare Outcomes, and its goal is to provide innovative medical training using videoconferencing technology to break down the divisions between primary and specialty care.” *Id.*

35. *Id.*

36. MORDOR INTELLIGENCE, GLOBAL TELEMEDICINE MARKET – GROWTH, TRENDS, AND FORECASTS (2016-2021) (2016), [www.mordorintelligence.com/industry-reports/global-telemedicine-market-industry](http://www.mordorintelligence.com/industry-reports/global-telemedicine-market-industry).

37. *Id.*

38. Kate Blackman, *Covering and Reimbursing Telehealth Services*, LEGISBRIEF (Jan. 2016), [www.ncsl.org/documents/health/lb\\_2404.pdf](http://www.ncsl.org/documents/health/lb_2404.pdf).

39. *CVS Health to Partner with Direct-to-Consumer Telehealth Providers to Increase Access to Physician Care*, CVS HEALTH (Aug. 26, 2015), <http://cvshhealth.com/newsroom/press-releases/cvs-health-partner-direct-consumer-telehealth-providers-increase-access>. CVS conducted customer surveys which indicated that patients were overall pleased with the use and implementation of telemedicine services. *Id.*

40. Tom Simonite, *Apple and IBM's Plan to Make Smarter Health-Tracking iPhone Apps*, MIT TECHNOLOGY REVIEW (Apr. 22, 2015), [www.technologyreview.com/s/536846/apple-and-ibms-plan-to-make-smarter-health-tracking-iphone-apps/](http://www.technologyreview.com/s/536846/apple-and-ibms-plan-to-make-smarter-health-tracking-iphone-apps/). Patients use a smartphone application to collect data, such as blood glucose levels. *Id.* This application can then automatically upload this data into

developments, telemedicine services are expected to continue to grow exponentially as medical technology continues to improve.<sup>41</sup>

### B. Current Telemedicine Legislation in Illinois

In an effort to embrace these rapid nationwide technological advances, more than 200 telemedicine related bills were introduced in various States' Legislature in 2015 alone.<sup>42</sup> Within Illinois, telemedicine is statutorily defined as "the use of a telecommunication system to provide medical services for the purpose of evaluation and treatment when the patient is at one medical provider location and the rendering provider is at another location."<sup>43</sup> Telemedicine falls under the umbrella of telehealth or e-health services. Illinois does not statutorily define telehealth or e-health, but it generally includes a much broader scope of health related services conducted through electronic means to include consultations, training, and health care marketing.<sup>44</sup> Another related term is "cybermedicine," which is generally narrower in scope than telemedicine.<sup>45</sup> Although not statutorily defined in Illinois, cybermedicine concerns the practice of medicine through communication and treatment over the internet.<sup>46</sup> Though the

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that individual's medical file for review and monitoring by a physician. *Id.* A physician can then render personalized medical advice based on this reading. *Id.*

41. See MORDOR INTELLIGENCE, *supra* note 36 and accompanying text.

42. Blackman, *supra* note 38, at 1.

43. ILL. ADMIN. CODE tit. 89, § 140.403. The Act defines "telemedicine" in the realm of Illinois Medicaid programs. *Id.*; see also The Medical Practice Act of 1987, 225 ILL. COMP. STAT. ANN. 60/49.5(c) (2012) (defining telemedicine as "rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State."). The Act specifically excludes:

- (1) periodic consultations between a person licensed under this Act and a person outside the State of Illinois;
- (2) a second opinion provided to a person licensed under this Act; and
- (3) diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine.

*Id.* However, it should be noted that this telemedicine provision, located within The Medical Practice Act of 1987, is set to be repealed December 31, 2017. See 5 ILL. COMP. STAT. 80/4.27a (West Supp. 2017) (providing for the repeal of the Medical Practice Act of 1987, effective December 31, 2017).

44. NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 4; see FLEISHER & DECHENE, *supra* note 22, at § 1.04 (noting that "E-Health" or "Telehealth" is the broadest term used to define telemedicine related medical services).

45. FLEISHER & DECHENE, *supra* note 22, at § 1.04.

46. *Id.*; see also Bailey, *supra* note 10, at 13 (recognizing that "cybermedicine" is also a term that has grown out of telehealth services).

distinctions in some jurisdictions may be essential, this comment will refer to these services collectively as “telemedicine” as statutorily defined within Illinois.

The Illinois Legislature has adopted several laws to expand and improve the quality of healthcare to Illinois citizens by eliminating the legal uncertainty of telemedicine use.<sup>47</sup> Illinois successfully defeated the medical licensing impediment to the growth of telemedicine services when the state adopted the Interstate Medical Licensure Compact in June of 2016.<sup>48</sup> The Interstate Medical Licensure Compact creates an expedited licensure process for eligible out of state physicians that wish to obtain a license to practice medicine in Illinois.<sup>49</sup> Although the expedited licensure process created under the Compact is not specific to the practice of telemedicine, one of the goals of the Compact was to increase patient access to care through telemedicine.<sup>50</sup> By eliminating this licensure barrier, Illinois became one of seventeen states that passed Medical Compact Licensure requirements to advance the practice of telemedicine services.<sup>51</sup>

Additionally, Illinois recently passed legislation regarding payment and reimbursement of telemedicine services. The Illinois Medicaid program now provides reimbursement for telemedicine services.<sup>52</sup> Coverage includes live video telemedicine services, store and forward uses, as well as patient home monitoring.<sup>53</sup> Presently,

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Cybermedicine is known as “the communication between a physician and patient by email or online chat services to obtain healthcare information and/or receive medical services.” *Id.*

47. See 225 ILL. COMP. STAT. ANN. 60/49.5(c); see also 45 ILL. COMP. STAT. ANN. 180/5 (West 2017).

48. 45 ILL. COMP. STAT. ANN. 180/5 (2015).

49. *Id.* This Act also clarifies jurisdictional questions surrounding the use of telemedicine, stating, “[t]his Compact...affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.” *Id.* at 180/5.1.

50. NAT’L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 16.

51. Blackman, *supra* note 38, at 1. Also notes that the other states that adopted the Interstate Medical Licensure Compact include, Alabama, Arizona, Colorado, Idaho, Iowa, Kansas, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, West Virginia, Wisconsin, and Wyoming. *Id.*; see also NAT’L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 16–17 (asserting that the Interstate Commission met for the first time in October 2015 and will develop and enforce rules).

52. 89 ILL. ADM. CODE 140.403 (2012).

53. *Id.* For reimbursement for telemedicine services to occur, several requirements must be satisfied, such as “a physician or other licensed health care professional must be present at all times with the patient at the originating site.” *Id.* Additionally, “the distant site provider must be a physician, physician assistant, podiatrist or advanced practice nurse who is licensed by the State of Illinois or by the state where the patient is located.” *Id.*

Illinois has not yet formally adopted legislation that would require private insurance companies to provide coverage for telemedicine services.<sup>54</sup> However, if insurance groups and policies do provide coverage for telemedicine services, Illinois law requires deductibles or copayments to be equal to that as an in-person consultation.<sup>55</sup>

Yet, unlike most other states, Illinois law does not provide guidance for the actual practice of telemedicine within the state.<sup>56</sup> This silence places a chilling effect on the growth of these services, as the absence of legislation raises medical liability and malpractice concerns.<sup>57</sup>

### C. Illinois Medical Liability Concerns Involving Telemedicine

The uncertain medical malpractice liability risks involved with telemedicine use is a cascading fear that hinders the growth of telemedicine services.<sup>58</sup> The fear of liability can influence a medical professional's decision on where and whether to practice in a certain medical specialty.<sup>59</sup> These medical negligence liability concerns can

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54. See generally 2013 Bill Text IL S.B. 1422 (proposing to amend various Codes to provide that accident and health insurance policies and managed care plans must provide coverage for telemedicine services."). The Bill additionally provided "that the required coverage for telemedicine services shall be subject to the same deductible, coinsurance, and copayment as if the telemedicine services were provided through face-to-face interactions between patients and their providers." *Id.* The Bill was introduced on February 6, 2013; however, the bill was not adopted by the Illinois Legislature. *Id.*

55. 215 ILL. COMP. STAT. ANN. 5/356z.22 (West Supp. 2016). Additionally, this statute states that insurance policies cannot "require that in-person contact occur between a health care provider and a patient; require the health care provider to document a barrier to an in-person consultation for coverage of services to be provided through telehealth; require the use of telehealth when the health care provider has determined that it is not appropriate; or require the use of telehealth when a patient chooses an in-person consultation." *Id.*

56. *E.g.*, MISS. CODE ANN. § 73-25-34:5.4 (West 2017); but see 225 ILL. COMP. STAT. ANN. 60/49.5(c) (providing little guidance regarding the legal ramifications of telemedicine use).

57. See NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 16 (noticing that some state legislatures merely wish to stay informed about the unresolved issues in the use of telemedicine that directly relate to liability; while, a handful of cases states are taking action in these unresolved areas).

58. OKOYE & SANBAR, *supra* note 21, at § 27E.03[f][1][i].

59. *Id.*; see also *Lebron v. Gottlieb Mem. Hosp.*, 237 Ill. 2d 217, 232–34, 930 N.E.2d 895 (2010) (reviewing statutory limitations on non-economic damages, the Illinois Supreme Court ruled such damages limitations as unconstitutional in the realm of medical malpractice claims). Thus, a physician's fear of malpractice may be especially heightened since there are no limits on the amount a patient can recover in a medical liability cause of action. *Id.*; see also EDWARD J. KIONKA, TORTS IN A NUTSHELL 372 (6th ed. West Publishing 2015) (defining "malpractice" as the common term for negligent conduct of individuals practicing within a profession or skilled trade, such as medicine).

also affect a patient's ability to recover in the event of an injury.<sup>60</sup> Physicians, patients, and medical negligence attorneys remain unaware of the complicated legal uncertainties surrounding telemedicine use, especially since telemedicine involves advanced technology and transforms the manner in which a physician provides treatment.<sup>61</sup>

However, some states have enacted laws and regulations that implement standards to the practice of telemedicine that provide answers to this liability fear. Inevitably, these standards vary from state to state.<sup>62</sup> Since Illinois recently passed legislation allowing out-of-state physicians an expedited ability to practice medicine within the state, implementing clear legislation providing guidance to the actual practice of telemedicine is of the utmost importance in order to protect Illinois patients.<sup>63</sup>

Since Illinois law is silent on the issue of medical negligence claims surrounding the use of telemedicine, the current Illinois law governing common medical negligence issues for traditional in-person care is a critical issue. The vast majority of causes of action against medical professionals are based in negligence.<sup>64</sup> In a cause of action for medical negligence, a patient has the burden to prove

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60. Kenneth C. Chessick & Matthew D. Robinson, *Symposium: Medical Malpractice: Emerging Issues & the Effect on Tort Reform: Article: Medical Negligence Litigation is Not the Problem*, 26 N. ILL. U. L. REV. 563, 567–8 (2006). Article argues for medical malpractice liability reform in Illinois. *Id.* Plaintiffs' attorneys only accept those medical malpractice cases with clear and strong liability and high damages due to the high litigation costs and the difficulty in winning compensation for the injured patient. *Id.* Ordinarily, litigation can cost an average of \$ 35,000 to \$ 50,000. Yet, only half of patients actually receive any compensation in Illinois. *Id.*

61. *Id.*

62. FED'N OF STATE MED. BD., MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MED. 1 (2014); *see also* Pierron Tackes, *Going Online with Telemedicine: What Barriers Exist and How Might They Be Resolved?*, 11 OKLA. J. L. & TECH. 80–85 (2015) (noting that state legislatures delegate broad authority to state medical boards to implement rules for the regulation of telemedicine). This article highlights the consequences, as this broad discretion is often "politics based, not science based." *Id.* The article states that the problem arises from state medical boards losing sight of their primary objective in protecting the public welfare. *Id.* Most state medical boards are currently resisting the use of interstate telemedicine, because such use threatens each state medical board's authority to regulate the practice of medicine and serves to allow others to encroach upon its patient population. *Id.*

63. *See* Illinois Interstate Medical Licensure Compact, 45 ILL. COMP. STAT. 180/5 (West Supp. 2016); *see also* NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 16 (remarking that the group composed of state legislators, legislative staff, and private industry representatives focused attention on telemedicine barriers and implemented options for state policymakers to encourage state legislatures to produce telemedicine legislation to provide guidance).

64. BRUCE L. OTTLEY, ROGELIO A. LASSO, & MICHAEL J. POLELLE, ILLINOIS TORT LAW § 15.02 (Matthew Bender ed. 4th ed) (2015).

that a medical professional owed a duty, the medical professional then failed to exercise the skill and care of a reasonable medical professional, and finally that this failure was a proximate cause of the patient's damages.<sup>65</sup> Within the telemedicine context, the greatest liability concerns relate primarily to the formation of the physician-patient relationship, the appropriate standard of care, and the requisite informed consent.<sup>66</sup>

Under current Illinois law, it is uncertain whether medical treatment through telemedicine services can establish a sufficient physician-patient relationship.<sup>67</sup> In order for a patient to recover damages in the event of an injury, a patient must first establish that the physician owed the patient a duty.<sup>68</sup> Illinois law holds that a physician owes a duty of care upon the establishment of a valid physician-patient relationship.<sup>69</sup> The physician-patient relationship is established when a patient "knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient."<sup>70</sup> The court determines whether a valid relationship exists as a matter of law.<sup>71</sup> Nevertheless, in the context of telemedicine, it is debatable whether the establishment of such a relationship is possible.<sup>72</sup> Other states have enacted legislation that provides clarity to this uncertainty by requiring the formation of the

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65. *Purtill v. Hess*, 111 Ill. 2d 229, 241-42 (1986).

66. NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 20-22.

67. *Id.* Also notes that the issue of whether and how a patient-physician relationship can be established via telemedicine is the "crux" of patient safety. *Id.*

68. *Reynolds v. Decatur Mem'l Hosp.*, 277 Ill. App. 3d 80, 85 (1996).

69. *Id.*

70. *Id.*; *see also Gillespie v. Univ. of Chi. Hosp.*, 387 Ill. App. 3d 540 (1st Dist. 2008) (finding the physician-patient relationship must be a "consensual relationship").

71. *Reynolds*, 277 Ill. App. 3d at 85.

72. *See FLEISHER & DECHENE*, *supra* note 22, at § 1.04[3][a] (arguing that although the establishment of the physician-patient relationship may seem relatively simple, the telemedicine context raises several unique issues). Since telemedicine devices are becoming more high-tech, a physician could consult with another physician in another state while the patient is able to see and view the consultant in the patient's own room. *Id.* This may pose a significant difference compared to the typical situation wherein a consultant is merely contacted over the phone and has no contact with the patient. *Id.* Thus, there is much greater potential for a consulting telemedicine physician to establish a physician-patient relationship. *Id.*

physician-patient relationship prior to the use of telemedicine.<sup>73</sup> It is unsettled if Illinois should follow this line of reasoning.<sup>74</sup>

Furthermore, the standard of care applied to telemedicine services remains in doubt.<sup>75</sup> Under Illinois common law, in a medical negligence case, a patient must establish the standard of care expected of the medical professional and further that the professional's deviation from this standard caused the injury.<sup>76</sup> The standard of care is also within the element of duty in a medical negligence claim.<sup>77</sup> It is unclear whether a standard of care that mirrors and is equivalent to an in-person consultation is appropriate within the telemedicine context, especially given the use of this advanced technology.<sup>78</sup> Since telemedicine services drastically change the traditional in-person consultation, a new standard of care may be more accommodating to both physicians and patients.<sup>79</sup>

Recently, the Illinois legislature successfully managed to statutorily define the standard of care applied to telemedicine services within the realm of occupation and physical therapy under

73. See MISS. CODE ANN. § 73-25-34:5.4 (West 2017) (requiring the formation of a valid physician-patient relationship in order to utilize telemedicine services in patient care. Mississippi law states, “[i]n order to practice telemedicine a valid ‘physician patient relationship’ must be established”). The Act further delineates the elements required to form this relationship, including verifying the identity of the patient. *Id.*; see also FLA. ADMIN. CODE ANN. r. 64B8-9.0141 (West Supp. 2017) (allowing flexibility in the formation of the physician-patient relationship). Florida law does not require a formed relationship, as it merely clarifies that such a relationship is possible via telemedicine. Florida law states, “[a] physician-patient relationship may be established through telemedicine.” *Id.*; see also MO. ANN. STAT. § 191.1146 (West Supp. 2017) (requiring under Montana law that “[t]he physician-patient relationship may be established by . . . a telemedicine encounter . . .”).

74. *Id.*

75. OKOYE & SANBAR, *supra* note 21, at § 27E.03[f][iv][A]–[C]. Additionally, comments that there remains very little case law in any jurisdiction to provide an analysis for the applicable standard of care in the context of telemedicine. *Id.* The majority of telehealth cases involve medical professionals that prescribed medication using only online questionnaires. *Id.* This falls into the realm of cybermedicine, not telemedicine. *Id.*

76. *Purtill v. Hess*, 111 Ill. 2d 229, 241-42 (1986).

77. *Jones v. Chi. HMO Ltd.*, 191 Ill. 2d 278, 294 (2000)

78. Wayne Willoughby, *Medicine in a Virtual World*, 51 TRIAL 38 (2015); see also OKOYE & SANBAR, *supra* note 21 at § 27E.03[f][1][vii][C] (asserting that the standard of care for telemedicine is a “moving target” due to increasing advances in technology).

79. Willoughby, *supra* note 78, at 38; see NAT'L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 20 (noting that there remains an unease about creating higher standards for the use of telemedicine services, because it may create a barrier to its access and use to provide patient care); see also Bailey, *supra* note 10, at 14-15 (noting that within context of cybermedicine, either a national standard should be applied or cybermedicine physicians should be its own specialty of practice).

the Illinois Occupational Therapy Practice Act.<sup>80</sup> The Act provides, “occupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however the standard of care shall be the same whether a patient is seen in-person, through telemedicine, or other method of electronically enabled health care.”<sup>81</sup> Yet, the Illinois Legislature still not clarified whether physicians, nurses, physician assistants, and other medical personnel are also held to this standard.

Finally, other common liability issues surrounding telemedicine use involve the requirement of an informed consent from the patient prior to rendering treatment and care.<sup>82</sup> Liability surrounding the issue of informed consent is also unsettled in Illinois. Informed consent is a process wherein the patient is made aware of the benefits and risk of undergoing a medical service, treatment, or procedure.<sup>83</sup> Yet, the necessary scope and substance of the risk and benefits that must be conveyed to each patient is uncertain. It is debatable whether informed consent for telemedicine services should be specific to encompass the new technological equipment and advances or if merely general informed consent is satisfactory.<sup>84</sup> Additionally, the scope of information that must be relayed to an Illinois patient is also open to debate, such as whether the physician should include potential privacy concerns prior to utilizing telemedicine.<sup>85</sup>

Thus, these legal uncertainties surrounding the use of telemedicine preclude an efficient and effective means of healthcare to Illinois patients. Physicians are hesitant to utilize telemedicine when the law is unsettled and patient safety is at risk since new technology is employed.

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80. The Illinois Occupational Therapy Practice Act, 225 ILL. COMP. STAT. ANN. 75/2 (West Supp. 2016).

81. *Id.*; see also Christine Calouro, Mei W. Kwong, and Mario Gutierrez, *An Analysis of State Telehealth Laws and Regulations for Occupational Therapy and Physical Therapy*, 6 INT’L J. TELEREHABILITATION 7-8 (2014) (finding that laws and regulations that clearly allow for telemedicine use for occupational and physical therapists, while still mandating the same standard of care expected for in person service, have the greatest potential to expand use while still maintaining patient protection).

82. FLEISHER & DECHENE, *supra* note 22, at § 1.04[3][c].

83. *Taylor v. Cnty. of Cook*, 2011 IL App (1st) 093085, ¶ 52 (citing *Coryell v. Smith*, 274 Ill. App. 3d 543, 546, 653 N.E.2d 1317 (1995)).

84. See NAT’L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 22 (stating some states are creating statutes specifically indicating the information that must be conveyed in order to obtain proper consent). Some states also specify whether written or oral consent is necessary. *Id.*

85. OKOYE & SANBAR, *supra* note 21, at § 27E.03[f][1][vii][C] (arguing that an additional question includes whether the standard of care of an urban specialist should be imparted to the rural primary care physician who consults with the specialist relating to patient treatment).

### III. ANALYSIS

The legal uncertainties under Illinois statutory and common law impede the proliferation of telemedicine as a means to improve the access and quality of healthcare to rural Illinois patients. This Section analyzes the current liability risks and uncertainties for medical professionals utilizing telemedicine in patient care within Illinois. Specifically, this comment focuses on issues involving the establishment of the physician-patient relationship, the applicable standard of care, and the requisite scope of informed consent. This Section first examines the current Illinois statutory and common law. This Section then compares legislation enacted in other states that provide solutions to these uncertainties.

#### A. *Physician-Patient Relationship in Illinois*

The physician-patient relationship is an essential aspect of a medical negligence claim.<sup>86</sup> To recover in a medical negligence cause of action, a patient must prove that the medical professional owed the patient a duty of care.<sup>87</sup> The duty of care primarily arises from the creation of the physician-patient relationship.<sup>88</sup> Therefore, a cause of action for medical negligence requires a valid physician-patient relationship. Although multiple states have enacted legislation regarding the establishment of the physician-patient relationship in the context of telemedicine, Illinois law is silent on the issue.

##### 1. *Establishing the Physician-Patient Relationship*

Generally, the physician-patient relationship is established in Illinois based on a contractual agreement when the physician agrees to provide medical services to a patient in exchange for payment.<sup>89</sup> The relationship is a consensual relationship in which

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86. *See Siwa v. Koch*, 38 Ill. App. 3d 444, 447 (1st Dist. 2009) (stating, “a physician’s duty only arises when a clear and direct physician-patient relationship has been established.”).

87. *Reynolds v. Decatur Mem’l Hosp.*, 277 Ill. App. 3d 80, 85 (1996).

88. *Id.*

89. *See Siwa*, 388 Ill. App. 3d at 447 (holding that a physician-patient relationship was not established when plaintiff did not seek out physician for medical advice but merely volunteered to assist the physician in testing new laboratory equipment); *see also Gathings v. Muscadin*, 318 Ill. App. 3d 1091, 1094 (1st Dist. 2001) (ruling that no physician patient relationship was established when physician expressly denied to treat the patient); *see also OTTLEY, LASSO & POLELLE, supra* note 64, at § 15.02 (noting that a duty is created when an individual who is not a licensed medical professional holds him or herself out to a patient as a licensed healthcare professional); *see also McNevens v. Lowe*, 40 Ill. 209, 210 (1866), quoting:

“the patient knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient.”<sup>90</sup> The creation of this relationship is unequivocal in most medical cases. The relationship is typically created when a patient attends an appointment with a physician who agrees to provide treatment to the patient.<sup>91</sup> The physician then owes the patient a duty of care.<sup>92</sup>

Additionally, a physician can voluntarily assume a duty to provide adequate care to a patient.<sup>93</sup> This “special physician-patient relationship” is typically established when a doctor is consulted by another physician to provide a service to a patient and the consulting doctor agrees.<sup>94</sup> In this situation, in order for a court to impose liability on behalf of a consulting physician, the consulting physician must take some affirmative action to participate in the current care of a patient.<sup>95</sup> Illinois courts often look to the extent to which the consulting physician “participate[d] in the care,

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[I]f a person holds himself out to the public as a physician he must be held to ordinary care and skill in every case of which he assumes the charge, whether in the particular case he has received fees or not. But if he does not profess to be a physician nor to practice as such, and is merely asked his advice as a friend or neighbor, he does not incur any professional responsibility.

*Id.*

90. *Reynolds*, 277 Ill. App. 3d at 85.

91. See also OTTLEY, LASSO, & POLELLE, *supra* note 64, at § 15.02(1) (postulating that the typical relationship between a medical professional and a patient is based on contract principles). However, other causes of actions surrounding the relationship are also recognized in Illinois, including a breach of fiduciary duty, strict liability, and intentional infliction of emotional distress. *Id.*

92. *Id.*

93. *Reynolds*, 277 Ill. App. 3d at 85. Illinois courts occasionally refer to this relationship as a “special relationship.” *Id.*

94. See *Bovara v. St. Francis Hosp.*, 298 Ill. App. 3d 1025, 1030–32 (1st Dist. 1998) (concluding a valid relationship was created when consulting physicians agreed to review a patient’s test results and rendered an opinion that was relied upon by the primary treating physician); *c.f.* OTTLEY, LASSO, & POLELLE, *supra* note 64, at § 15.02 (justifying that when a physician merely refers the patient to another medical professional, the first physician will not be liable for the negligence arising within treatment from the second professional unless the first physician retains some control over the treatment).

95. *Gathings v. Muscadin*, 318 Ill. App. 3d 1091, 1093-94 (1st Dist. 2001) (reasoning that no relationship existed when physician did not take any affirmative action to provide for patient by stating he was out of town, refused to take any information about the patient, and did not charge a fee); *but see Gillespie v. Univ. of Chi. Hosp.*, 387 Ill. App. 3d 540, 545-46 (1st Dist. 2008) (ruling that no relationship even though physician did receive and review patient’s medical records, drafted report, and charged fee because court found that the physician’s affirmative actions were not applied to the current care of the patient.) The physician rendered the services only after the patient was discharged. *Id.*

evaluation, diagnosis or treatment of a specific patient.”<sup>96</sup> This will include factors such as whether the consulting physician conducted tests, reviewed medical records, or charged a fee for such services to the specific patient.<sup>97</sup> Illinois courts distinguish that when a consulting physician merely provides an “informal opinion” to another primary treating physician regarding the care of a patient, a physician-patient relationship is not established.<sup>98</sup>

The court ultimately determines as a matter of law whether a valid physician-patient relationship was formed under the particular circumstances.<sup>99</sup> In these cases, the court will make a policy determination on whether a duty should be owed based on consideration of “the likelihood of injury, the magnitude of the burden of guarding against it, and the consequences of placing that burden on the defendant.”<sup>100</sup> The court will look to the facts of each case to determine if a physician-patient relationship was formed.<sup>101</sup>

## 2. *Issues Surrounding the Development of the Physician-Patient Relationship in the Context of Telemedicine*

Within the context of telemedicine, several legal uncertainties exist regarding the creation of the physician-patient relationship. Although telemedicine encounters often eliminate a patient’s face-to-face encounter with a physician, certain circumstances may still allow a valid physician-patient relationship to be created.<sup>102</sup> If a

96. *Gathings*, 318 Ill. App. 3d at 1093–94.

97. *Id.* (finding no relationship existed when physician declined to consult with the primary treating physician, refused to take any information about the patient, and did not charge a fee); *see Bovara*, 298 Ill. App. 3d at 1031 (weighing the fact that the physician’s medical opinions were not offered voluntarily but rather the physician’s medical opinion was required within regular course of duties); *see also Mackey v. Sarroca*, 2015 IL App (3d) 130219, ¶ 26 (examining hospital’s protocols and procedures, which included assigning the consulting physician the task of providing consulting services).

98. *Gathings*, 318 Ill. App. 3d at 1094.

99. *Id.* at 1093.

100. *Reynolds v. Decatur Mem’l Hosp.*, 277 Ill. App. 3d 80, 85 (1996); *see also Bovara*, 298 Ill. App. 3d at 1030 (stating an additional factor in determining whether a duty exists is the “reasonable foreseeability of injury”).

101. *See Mackey*, 2015 IL App (3d) at ¶ 26 (comparing facts of present case to the facts of similar cases to determine whether a physician-patient relationship or special relationship was created).

102. *See Smith v. Pavlovich*, 394 Ill. App. 3d 458,466, 914 N.E. 2d 1258, 1266 (5th Dist.) (asserting that “a physician-patient relationship may exist in the absence of any meetings between the physician and patient, where the physician performs services for the patient. Thus, it is not necessary that the patient and physician have actual contact with each other in order for a physician-patient relationship to exist.”); *see also FLEISHER & DECHENE, supra* note 22, at § 1.04[3][a][i] (opining that several jurisdictions have held that in-person contact with a physician is not needed to create a physician-patient relationship).

physician only utilizes telemedicine after the physician has conducted traditional face-to-face communication and examination, Illinois courts will likely find that a valid relationship existed.<sup>103</sup> In this case, the physician's use of telemedicine will likely be seen as a continuation of care based under the established relationship. However, if a physician only virtually "sees" a patient to enable the physician to examine and treat the patient in exchange for payment, Illinois courts may or may not find that a valid physician-patient relationship existed in the absence of face-to-face contact.<sup>104</sup> Illinois courts, in some cases, have found that a duty existed on behalf of a physician even in the absence of an in-person encounter with the patient.<sup>105</sup> Yet, there is no law existing in Illinois that provides the answer in the context of telemedicine.

Even though Illinois law is unsettled as to whether a valid physician-patient relationship may be established via telemedicine devices, current case law provides guidance. In *Estate of Kundert*,<sup>106</sup> a physician-patient relationship did not exist even though a medical professional rendered specialized medical advice to a mother over the telephone regarding her sick infant.<sup>107</sup> The Illinois court found that the physician-patient relationship was not established through this phone conversation.<sup>108</sup> Since personalized medical advice rendered via audio over the telephone was not enough to create a valid physician-patient relationship, audio equipment coupled with visual equipment still may not be enough to form a physician-patient relationship under Illinois law.<sup>109</sup> It remains debatable what

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103. FLEISHER & DECHENE, *supra* note 22, at § 1.04[3][a].

104. See OKOYE & SANBAR, *supra* note 21, at § 27E.03[f][1][vii] (stating that where telemedicine consultations reflect the traditional medical examinations and situations, various courts may be more likely to acknowledge the existence of a valid physician-patient relationship); see also FLEISHER & DECHENE, *supra* note 22, at § 1.04[3][a][i] (stating courts may be more likely to find a valid relationship within a telemedicine consultation when the physician is able to conduct a physical examination of the patient, review medical records, provide a diagnosis, and accept a fee).

105. See *Smith*, 394 Ill. App. 3d at 466.

106. *Estate of Kundert v. Ill. Valley Cmty. Hosp.*, 2012 IL App (3d) 110007, ¶ 11.

107. *Id.* The court found that no valid physician-patient relationship existed when an emergency room personnel rendered medical advice to a mother via telephone leading to the delayed treatment and eventual death of the infant. *Id.* at ¶ 1. The court focused on the fact that the emergency room personnel on the telephone relayed to the mother that the hospital lacked equipment to treat infants. *Id.* at ¶ 26. The court viewed this evidence of a clear refusal of service to the mother, which did not create a physician-patient relationship. *Id.* However, the infant was later rushed and treated at the same hospital. *Id.* at ¶ 7. Additionally, the emergency room personnel did render medical advice to the mother suggesting giving the infant Tylenol and tepid baths. *Id.* at ¶ 27. The court characterized the advice as an informal opinion. *Id.* at ¶ 30.

108. *Id.* at ¶ 30.

109. Ultimately, the *Kundert* court focused on the fact that the emergency

effect the use of advanced technology would have on the formation of a physician-patient relationship.<sup>110</sup>

Another area of uncertainty is the establishment of the physician-patient relationship involving a physician utilizing telemedicine for consulting purposes.<sup>111</sup> In *Reynolds*,<sup>112</sup> the Illinois court found that a physician-patient relationship was not formed between a consulting physician and the patient, even though the consulting physician rendered the final diagnosis.<sup>113</sup> The consulting physician discussed over the telephone with the primary treating physician the patient's test results and even guided the primary physician through the physical examination of the patient.<sup>114</sup> However, the court concluded that the consulting physician rendered only an "informal opinion."<sup>115</sup> The court reasoned that imparting liability to the consulting physician would have a "chilling effect upon the practice of medicine."<sup>116</sup> The court feared that this would stifle education, communication, and common medical practices, which would ultimately cause harm to patients.<sup>117</sup>

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room personnel on the telephone relayed to the mother that the hospital lacked equipment to treat infants. *Id.* at ¶ 26. The court viewed this evidence of a clear refusal of service to the mother, which did not create a physician-patient relationship. *Id.*

110. See OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(1)(vii)(B)).

111. FLEISHER & DECHENE, *supra* note 22, at § 1.04(a)(3)(ii).

112. *Reynolds v. Decatur Mem'l Hosp.*, 277 Ill. App. 3d 80, 85, 660 N.E.2d 235, 239 (1996). A minor suffered severe injury after falling when jumping on couches. *Id.* at 82. The minor was taken to the emergency room. *Id.* at 81. Doctor Bonds performed an examination. *Id.* In order to gain a second opinion, Bonds consulted another doctor, Doctor Fulbright, via telephone. *Id.* Fulbright asked Bonds to verify test results and check to find whether the minor had a stiff neck. *Id.* Bonds performed the physical examination and relayed the findings to Fulbright. *Id.* At the end of the conversation, Fulbright suggested a treatment. *Id.* Bonds rendered treatment and arranged for Fulbright to consult with the minor the following morning. *Id.* at 83. Fulbright did not consult with the minor instead the minor was emergency transported to another hospital where the minor was diagnosed with a severe spinal cord injury. *Id.* Even though Fulbright guided Bonds and ultimately rendered the improper diagnosis, the court held that a valid physician-patient relationship did not exist. *Id.* at 87. Fulbright's guidance to Bonds was characterized as an "informal opinion." *Id.* at 85.

113. *Id.* at 85. The court stated the consulting physician "did nothing more than answer an inquiry from a colleague." *Id.* Court additionally considered that "[t]he consequence of such a rule would be significant. *Id.* It would have a chilling effect upon practice of medicine and would stifle communication, education and professional association, all to the detriment of the patient." *Id.* at 86.

114. *Id.* at 85–86.

115. *Id.*

116. *Id.*

117. *Id.*

Nonetheless, this shield against liability for consulting physicians in Illinois raises uncertainties in the context of telemedicine. Medical professionals often use telemedicine to provide educational services to other physicians practicing at a distance.<sup>118</sup> Telemedicine is heavily expanding upon these services.<sup>119</sup> A consultation can regularly occur via telemedicine through audio and visual devices to enable a consulting physician to guide another physician through the treatment of a patient.<sup>120</sup> It remains uncertain whether such case law provides a basis to shield consultants from liability when utilizing telemedicine.<sup>121</sup> It also remains ambiguous whether liability should continue to be precluded when telemedicine services may dramatically increase the utilization of consulting physicians in medical care.

3. *Approaches by Other States Regarding the Formation of the Physician-Patient Relationship in the Context of Telemedicine*

To provide clarity to these uncertainties regarding the formation of the physician-patient relationship, other states have enacted legislation that provides answers. Several state legislatures have enacted laws that require the formation of an established physician-patient relationship prior to the use of telemedicine services to maximize the patient's safety.<sup>122</sup> For example, Mississippi law states, "[i]n order to practice telemedicine a valid 'physician patient relationship' must be established."<sup>123</sup> The American Medical Association also has supported legislation that requires the formation of the relationship prior to the use of telemedicine services.<sup>124</sup> In addition, the Federation of State Medical Boards also acknowledges the importance of establishing the physician-patient relationship prior to telemedicine treatment.<sup>125</sup> It argues that a "physician must take appropriate

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118. See Serritella, *supra* note 34 and accompanying text.

119. See Luxton, Pruitt, & Osenbach, *supra* note 15, at 27 and accompanying text.

120. *Id.*

121. See FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(a)(ii) (noting that there may be significant differences between consulting over the phone versus consulting via telemedicine equipment).

122. See MISS. CODE ANN. § 73-25-34:5.4 (stating that "in order to practice telemedicine a valid 'physician patient relationship' must be established.").

123. *Id.*

124. See AMERICAN MEDICAL ASSOCIATION, MODEL STATE LEGISLATION: TELEMEDICINE 2 (2015) (advocating for states to adopt legislation that requires the formation of the physician-patient relationship and outlines the steps necessary for the physician to take in order to ensure that a valid physician-patient relationship is formed).

125. See FED'N OF STATE MED. BDS., *supra* note 62, at 3-4 (noting, "the physician-patient relationship is fundamental to the provision of acceptable

steps to establish a physician-patient relationship” and further that “such physician-patient relationships may be established using telemedicine technologies...”<sup>126</sup>

By requiring the creation of this relationship, this legislation affords patients maximum safety, which some argue is necessary given the inherent risks with technology use.<sup>127</sup> Telemedicine use runs the risk of diminishing the overall quality of care received by a patient, since a physician will not be able to examine the patient in-person.<sup>128</sup> Additionally, the technology may not be as reliable as an in-person evaluation if the images produced via telemedicine are of low quality.<sup>129</sup> However, it is possible that strict requirements will discourage the use of telemedicine, especially for consulting physicians. Under Illinois law, consulting physicians are not required to form a physician-patient relationship when the medical professional merely relays an “informal opinion.”<sup>130</sup> The concern is that consulting physicians will not readily offer medical opinions and assistance to other physicians for fear of potential liability.<sup>131</sup>

Recognizing these concerns, other states have adopted laws that create a flexible standard on the creation of the physician-patient relationship to encourage physicians to utilize telemedicine.<sup>132</sup> These states enacted laws that merely provide clarification that the physician-patient relationship may be created using telemedicine technology.<sup>133</sup> For example, Missouri law states, “[t]he physician-patient relationship may be established by . . . a telemedicine encounter . . .”<sup>134</sup> This legislation arguably provides

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medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship.”).

126. *Id.*

127. *Id.* In order to support the future innovation of telemedicine use in healthcare, standards and safeguards are needed. *Id.* Such standards additionally ensure patient safety and the privacy of patient information. *Id.* Standards will also ensure the quality of healthcare by protecting the patient-physician relationship, while promoting improved care coordination and communication with medical facilities. *Id.*

128. BARRY R. FURROW ET AL., *HEALTH LAW: HORNBOOK SERIES* 86 (3d ed. 2015).

129. *Id.*

130. See *Reynolds v. Decatur Mem'l Hosp.*, 277 Ill. App. 3d 80, 85, 660 N.E.2d 235, 239 (1996) (holding that a consulting physician that merely provides an informal opinion is shielded from liability because a physician-patient relationship is not formed).

131. FURROW ET AL., *supra* note 128, at 86.

132. See MO. ANN. STAT. § 191.1146 (West 2017); see also FLA. ADMIN. CODE ANN. r. 64B8-9.0141 (West 2017) (allowing flexibility on the creation of the physician-patient relationship).

133. See MO. ANN. STAT. § 191.1146; see also FLA. ADMIN. CODE ANN. r. 64B8-9.0141 (stating, “[a] physician-patient relationship may be established through telemedicine.”).

134. MO. ANN. STAT. § 191.1146.

greater flexibility to physicians. This would allow medical professionals to provide care to patients without fear of liability in the event a step was not properly taken to adequately ensure the formation of the relationship. This legislation also acts to instruct the courts that the establishment of the physician-patient relationship is possible in the context of telemedicine use.

Other states created laws that provide detail regarding the formation of the relationship in the context of telemedicine.<sup>135</sup> These states specify the conduct that does not form a physician-patient relationship via telemedicine.<sup>136</sup> For example, West Virginia law prevents the relationship to be established via “[a]udio-only communication; text-based communications such as e-mail, internet questionnaires, text-based messaging or other written forms of communication; or any combination thereof.”<sup>137</sup> Proponents of this legislation argue that this protection is necessary given the abuses that have historically occurred in the context of telemedicine, wherein physicians prescribed narcotic medications to patients using only an online questionnaire.<sup>138</sup>

Conversely, other state legislation specifies the requirements that a physician must follow to properly establish the physician-

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135. See W. VA. CODE ANN. § 30-3-13a (West 2017) (West Virginia law requires, “[a] physician-patient or podiatrist-patient relationship may not be established through: Audio-only communication; Text-based communications such as e-mail, internet questionnaires, text-based messaging or other written forms of communication; or Any combination thereof.”). West Virginia law further clarifies that if the physician-patient relationship does not exist prior to the utilization of telemedicine, the relationship may only be established “through the use of telemedicine technologies which incorporate interactive audio using store and forward technology, real-time videoconferencing or similar secure video services during the initial physician-patient or podiatrist-patient encounter...” *Id.*

136. *Id.*

137. W. VA. CODE ANN. § 30-3-13a.

138. See *United States v. Quinones*, 536 F. Supp. 2d 267, 268–69 (E.D.N.Y. 2008) (finding that physicians were abusing the physician-patient relationship in the context of telemedicine or specifically cybermedicine). The facts of this case indicated that medical providers in Puerto Rico were criminally charged for creating and operating various websites to disburse controlled substances. *Id.* Customers completed online questionnaires. *Id.* Doctors then allegedly reviewed these questionnaires and wrote prescriptions for the drugs. *Id.* The doctor had no contact with the patients, no examinations were conducted or history gathered. *Id.* The medications were ordered and shipped to the customers. *Id.*; see also *Golob v. Arizona Med. Bd. of State*, 217 Ariz. 505, 512 (Ct. App. 2008) (finding that physicians again were abusing the physician-patient relationship). Patients received medication online via telemedicine after merely filing out an online questionnaire. *Id.* at 508. The doctor did not conduct an examination though the standard of care required a physical examination prior to prescription. *Id.* The court affirmed that the doctor deviated from Arizona state regulated standard of care when she prescribed medication to patient via the internet without establishing the proper patient-physician relationship. *Id.* at 512.

patient relationship.<sup>139</sup> For example, South Carolina law requires, “a licensee who establishes a physician-patient relationship solely via telemedicine. . . shall verify the identity and location of the patient and be prepared to inform the patient of the licensee’s name, location, and professional credentials.”<sup>140</sup> Under Hawaii law, a relationship can be established if the “patient is referred to the telehealth provider by another health care provider who has conducted an in-person consultation. . . .”<sup>141</sup> Additionally, Texas law states that all medical professionals must “require a face-to-face consultation between a patient and a physician providing a telemedicine medical service within a certain number of days following an initial telemedicine medical service only if the physician has never seen the patient.”<sup>142</sup>

Such detailed legislation further ensures patient safety and care, which many argue is essential in the proliferation of potentially unreliable technology.<sup>143</sup> Nevertheless, others argue that such specific requirements act to impede physicians from utilizing telemedicine.<sup>144</sup> Such legislation may arguably recreate the barriers to accessible healthcare that legislation should seek to avoid.<sup>145</sup> Critics of strict practice guidelines fear that physician flexibility will be undermined, which would ultimately diminish the quality of patient care.<sup>146</sup> Physicians may lose the incentive to try new approaches and expand upon current practices.<sup>147</sup> Some fear

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139. See S.C. CODE ANN. § 40-47-37(C)(3) (West 2017) (requiring a physician utilizing telemedicine to also “maintain a complete record of the patient’s care according to prevailing medical record standards...”). The Act further requires medical professionals utilizing telemedicine to “maintain the patient’s records’ confidentiality and disclose the records to the patient consistent with state and federal law.” *Id.* at § 40-47-37(C)(7), (8).

140. *Id.*

141. See HAW. REV. STAT. ANN. § 453-1.3(e)–(f) (West 2017) (requiring physicians to obtain a license to practice medicine within the state prior to establishing physician-patient relationships with patients via telemedicine).

142. See TEX. OCC. CODE ANN. § 111.004(5) (West 2017) (requiring all medical professionals to “require a face-to-face consultation between a patient and a physician providing a telemedicine medical service within a certain number of days following an initial telemedicine medical service only if the physician has never seen the patient.”).

143. FURROW ET AL., *supra* note 128, at 86.

144. See FED. OF STATE MED. BDS., *supra* note 62, at 3 (insinuating that legislation that mandates an in person encounter prior to the formation of a physician-patient relationship should be avoided). The Federation of State Medical Board stresses the relationship should be established “whether or not there has been an encounter in person between the physician or other appropriately supervised health practitioner and patient.” *Id.*

145. See NAT’L CONFERENCES OF STATE LEGISLATURES, *supra* note 11, at 21 (noting that “many stakeholders are wary of requiring in-person visits because of the additional burden placed on a patient to see in-person care, which would help create some of the barriers telehealth seeks to remove.”).

146. FURROW ET AL., *supra* note 128, at 80–1.

147. *Id.*

strict guidelines may prevent individuals from the field of medicine, as a whole may become less attractive to individuals.<sup>148</sup>

Although multiple other states have enacted legislation that guide the practice of telemedicine, Illinois law is silent on this issue. Several states have enacted legislation providing solutions to these issues, but it is unclear which solution best complies with the current Illinois law and medical practices.

### B. *The Standard of Care in Illinois*

Illinois law is also unsettled as to the proper standard of care that applies when medical professionals utilize telemedicine services for a patient's care.<sup>149</sup> After a patient proves the physician owed the patient a duty of care within an established physician-patient relationship, the patient then must establish that the physician breached or fell below the required standard of care required of the physician.<sup>150</sup> As such, it is necessary for a patient to prove the applicable standard of care.<sup>151</sup> Within the context of telemedicine, not only is the standard of care that should be applied uncertain, but the manner in which a patient is required to prove that standard of care is also unclear under Illinois law.

#### 1. *Determining the Appropriate Standard of Care*

The standard of care that applies to medical professionals licensed and practicing in Illinois is "the same degree of knowledge, skill, and ability as an ordinary careful professional would exercise

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148. *Id.* Also indicates that strict guidelines may lack sufficient evidence to create the standard. *Id.* Additionally notes that authors of the drafted guidelines could have been motivated by bias due to financial conflicts and disagreements regarding the guidelines may be concealed. *Id.*

149. See Illinois Occupational Therapy Practice Act, 225 ILL. COMP. STAT. 75/2 (2012) (reasoning that the standard of care that must apply to occupational and physical therapists when utilizing telemedicine is the equivalent to in-person standard of care); see also *Smith v. Bhattacharya*, 2014 IL App (2d) 130891, ¶ 45, 11 N.E.3d 20, 23 (noting that in order to recover, a plaintiff must prove "(1) the applicable standard of care against which defendant's actions may be measured; (2) defendant's deviation from the standard of care; and (3) that the defendant's deviation from the standard proximately caused the plaintiff's injury." *Id.* (citing *Rohe v. Shivde*, 203 Ill. App. 3d 181, 192, 560 N.E.2d 1113, 1121 (1st Dist. 1990)).

150. *Wilbourn v. Cavalenes*, 398 Ill. App. 3d 837, 847; 923 N.E.937, 949 (1st Dist. 2010). See also *Smith v. Silver Cross Hosp.*, 339 Ill. App. 3d 67, 75, 790 N.E.2d 77, 84 (1st Dist. 2003) (ruling that the standard of care separately needs to be determined when a patient sues a hospital or clinic separately from the physician). The court also clarifies that a clinic's internal policies and procedures can be used as evidence. *Id.* The failure of a clinic to follow its policies can even be used as evidence of a breach of the clinic's duty to a patient. *Id.*

151. *Id.*

under similar circumstances.”<sup>152</sup> Essentially, the patient must prove the requisite standard of care in order to establish that an ordinary careful medical professional would not have acted in the same manner as that as the defendant medical professional.<sup>153</sup> The purpose of the standard of care is to serve as a guide to the jury.<sup>154</sup> Unlike the element of duty that is determined as a matter of law by a court, whether a physician breached that duty by falling below the applicable standard of care is a matter reserved for the jury.<sup>155</sup> The jury is required to measure or compare the medical professional’s conduct against the established standard of care to determine whether a deviation or breach occurred.<sup>156</sup> As such, the standard of care must be sufficiently understandable to a jury.<sup>157</sup>

The standard of care required of professionals incorporates subjective factors.<sup>158</sup> Illinois law does not recognize medicine as an exact science.<sup>159</sup> An acceptable standard of care provides for the independent judgment of a physician, granted it is within the bounds of established procedures.<sup>160</sup> The standard allows “under similar circumstances” to provide flexibility for independent discretion given the particular situation.<sup>161</sup>

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152. Illinois Patterned Jury Instruction, 150.00 Professional Negligence (2016) (noting that this same standard applies to all professionals, including architects, lawyers, etc); *see* *Thompson v. Webb*, 138 Ill. App. 3d 629, 632, 486 N.E.2d 326, 328 (4th Dist.1985) (applying the jury instruction to the standard of care of a licensed doctor); *see generally* JOHN L. DIAMOND ET AL., UNDERSTANDING TORTS 95 (4th ed. 2010) (clarifying that the professional standard of care is not a higher standard of care, merely a different standard of care that applies to professionals when he or she is engaged in conduct that requires the specialized skills).

153. *See* OTTLEY, LASSO & POLELLE, *supra* note 64, at § 15.02(4) (noting that the physician’s conduct must be more than that the medical professional merely failed to secure a good result). The patient is required to show that the defendant medical professional failed to possess the knowledge and competence to conduct his or her manner in a way that an ordinary reasonable prudent medical professional in the field would have acted under the circumstances. *Id.*

154. *Kemnitz v. Semrad*, 206 Ill. App. 3d 668, 673 (1st Dist. 1990); *see also* *Advincula v. United Blood Services*, 176 Ill. 2d 1, 23 (1996) (noting that the standard of care recognizes that lay jurors are not capable of effectively determining what constitutes reasonable care unless the conduct in question is measured against that of other professionals).

155. *Kemnitz*, 206 Ill. App. 3d at 673.

156. *Id.*; *see also* MARSHALL S. SHAPO, PRINCIPLES OF TORT LAW: CONCISE HORNBOOK SERIES (3d Ed 2010) at 152 (noting that courts take proper caution for concern that jurors may be too empathetic to injured patients, because most jurors have been patients but few jurors are medical professionals).

157. *Kemnitz*, 206 Ill. App. 3d at 673.

158. *Advincula*, 176 Ill. 2d at 22.

159. *Kemnitz*, 206 Ill. App. 3d at 673.

160. *Id.*

161. *See* DIAMOND, *supra* note 152, at 50–1 (commenting that flexibility in the standard of care is added through the “circumstances” part of the analysis). This allows a jury to consider the defendant’s conduct in light of the surrounding

Additionally, the standard of care incorporates external and objective factors.<sup>162</sup> Medical professionals, such as physicians, nurses, and therapists are expected to possess a specialized skillset, knowledge, and training more so than the average individual.<sup>163</sup> Thus, not only must medical professionals act in an ordinary and careful manner, but they must also possess the requisite knowledge and ability.<sup>164</sup> Medical professionals are not expected to manifest the highest skill or insure a particular result, rather practitioners are held only to the standard of reasonable skill.<sup>165</sup>

Therefore, the standard of care is essential in all medical negligence causes of action. However, in the context of telemedicine, the standard of care poses a unique challenge. Since telemedicine use is rapidly growing and evolving, a flexible standard of care is required. However, due to the unreliability of telemedicine, a standard of care must be developed that maximizes patient safety.

## 2. *Approaches by Other States to the Standard of Care for Telemedicine*

Multiple states have enacted legislation that provides varying and even conflicting resolutions to the standard of care that should apply to telemedicine. Additionally, some states have enacted legislation and regulations detailing the standard of care in various contexts while other states merely provide a general standard of care.

Illinois has implemented legislation regarding the required standard of care for occupational therapists in the context of telemedicine.<sup>166</sup> Illinois law states that “the standard of care shall be the same whether a patient is seen in person, through telehealth, or other method of electronically enabled health care” for licensed occupational therapists in Illinois.<sup>167</sup> Additional states have implemented this standard of care for telemedicine.<sup>168</sup> For example,

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circumstances, including an emergency situation. *Id.*

162. *Advincula*, 176 Ill. 2d at 22.

163. *Id.*

164. *Id.*

165. *Thompson v. Webb*, 138 Ill. App. 3d 629, 631–32 (4th Dist. 1985).

166. *See* 225 ILL. COMP. STAT. ANN. 75/2 (stating, “[o]ccupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however *the standard of care shall be the same* whether a patient is seen in person, through telehealth, or other method of electronically enabled health care.”) (emphasis added).

167. *Id.*

168. *See also* DEL. CODE ANN. tit. 24, § 1769D(c) (West 2017) (providing the standard of care in the context of cyber medicine, “[t]reatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional [encounter in person] settings.”).

Tennessee,<sup>169</sup> New Hampshire,<sup>170</sup> South Carolina,<sup>171</sup> and Colorado<sup>172</sup> all have enacted legislation that require the standard of care for telemedicine services to mirror that of the standard of care applied to the traditional in-person visit. Most argue that this standard is necessary in order to ensure patient safety.<sup>173</sup> Patient safety is viewed as essential because technology may be potentially unreliable or abused. Some argue that the use of telemedicine technology may limit the ability of a physician to properly examine a patient and lead to a misdiagnosis, which may be avoided with an in-person encounter.<sup>174</sup> With an in-person examination, a medical professional can use sight, touch, and smell to examine a patient.<sup>175</sup>

On the other hand, others argue that such a high standard should not be utilized in order to encourage telemedicine use.<sup>176</sup> A physician could simply choose not to utilize telemedicine services in order to avoid potentially high liability risks.<sup>177</sup> A high standard also arguably burdens physicians to constantly remain current with respect to rapidly changing telemedicine advances.<sup>178</sup> Recognizing

169. TENN. CODE ANN. § 63-1-155(c)(1)(A) (West 2017) (stating that “[a] healthcare provider who delivers services through the use of telehealth shall be held to the same standard of professional practice as a similar licensee of the same practice area or specialty that is providing the same healthcare services through in-person encounters, and nothing in this section is intended to create any new standards of care.”).

170. N.H. REV. STAT. ANN. § 329:1-d (West 2017) (creating the standard of care for physicians and surgeons: “[a] physician providing services by means of telemedicine directly to a patient shall: (a) Use the same standard of care as used in an in-person encounter; (b) Maintain a medical record; and (c) Subject to the patient’s consent, forward the medical record to the patient’s primary care or treating provider, if appropriate.”).

171. See S.C. CODE ANN. § 40-47-37 (stating, “A licensee who establishes a physician-patient relationship solely via telemedicine as defined in Section 40-47-20(52) shall adhere to the same standard of care as a licensee employing more traditional in-person medical care and be evaluated according to the standard of care applicable to the licensee’s area of specialty.”).

172. See COLO. REV. STAT. § 10-16-123(2) (West 2017) (requiring that “Any health benefits provided through telemedicine is the same standard of care as for in-person care.”).

173. See FED. OF STATE MED. BDS., *supra* note 62, at 3-4 (2014) (noting that standards and safeguards are need in order to support future innovation in the use of telemedicine and ensure patient safety).

174. *Id.* Telemedicine may severely limit the ability of a medical professional to fully and accurately examine a patient. *Id.* “During an in-person examination, a physician can use sight, touch, hearing, and smell to take a patient’s vital signs; examine the skin; palpate the neck, abdomen, and extremities; test reflexes; assess the patient’s mental state; and listen to the heart, lungs, and abdomen.” *Id.* Although technology is improving, there are risks that a medical professional will gather incomplete information and lead to mistreatments. *Id.*

175. Willoughby, *supra* note 78, at 42–43.

176. NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 20.

177. *Id.*

178. OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(1)(vii)(F); see also Amy J. Sokol & Christopher J. Molzen, *The Changing Standard of Care in Medicine:*

these concerns, other states have implemented a standard of care for telemedicine services to be equivalent to the standard of care for non in-person examinations and consultations. For example, Hawaii requires the standard of care for telemedicine services to be equivalent to that of a non-in-person consultation.<sup>179</sup> Hawaii created this standard to accommodate the fact that a physician may not be able to fully and properly examine a patient using telemedicine.<sup>180</sup>

Some state legislatures enacted detailed legislation regarding the standard of care for telemedicine services.<sup>181</sup> These states have enacted legislation that provides clarity that the standard of care is not satisfied through the sole use of an online questionnaire.<sup>182</sup> For example, Hawaii legislation states, “issuing a prescription based solely on an online questionnaire is not treatment for the purposes of this section and does not constitute an acceptable standard of care.”<sup>183</sup> Again, this legislation was likely in response to abuses within the realm of telemedicine wherein patients were ordering prescription medication from licensed physicians solely through an online questionnaire.<sup>184</sup> This detailed legislation may be essential to maximize patient care and prevent abuse.

Conversely, others argue that detailed legislation has little effect in changing a physician’s behavior.<sup>185</sup> Moreover, medical professionals will be hindered if the regulations are detailed and difficult to use.<sup>186</sup> Detailed legislation may pose threats to the use

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*E-Health, Medical Errors, and Technology Add New Obstacles*, 23 J. OF LEGAL MEDICINE 449, 478 (2002) (criticizing the serious problem of medical professionals being unable to keep abreast on the multitude of new case studies, medical journals, newsletters, and vast electronic repositories of changing new medical information). However, this article also notes that technology advances have allowed this information to be readily available to medical professionals. *Id.*

179. HAW. REV. STAT. ANN. § 453-1.3(c) (stating “[t]reatment recommendations made via telehealth, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit...”).

180. *Id.*; see also OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(1)(vii)(E).

181. See e.g., HAW. REV. STAT. ANN. § 453-1.3(c) (detailing the standard of care for telemedicine encounters).

182. See HAW. REV. STAT. ANN. § 453-1.3(c) (stating “Issuing a prescription based solely on an online questionnaire is not treatment for the purposes of this section and does not constitute an acceptable standard of care.”); see also W. VA. CODE § 30-3-13a (West Supp. 2016) (noting “Treatment, including issuing a prescription, based solely on an online questionnaire, does not constitute an acceptable standard of care.”).

183. *Id.* at § 453-1.3.

184. See *United States v. Quinones*, 536 F. Supp. 2d 267, 268–69 (E.D.N.Y. 2008); *Golob v. Arizona Med. Bd. of State*, 217 Ariz. 505, 710 (Ct. App. 2008)

185. FURROW ET AL., *supra* note 128, at 81.

186. *Id.*

of telemedicine if the legislation is created arbitrarily.<sup>187</sup> Specified standard of care requirements may inhibit a patient's ability to access medical treatment via telemedicine.<sup>188</sup> For example, in Iowa, a detailed regulation in Iowa required a physician to be physically present with a patient prior to the administration of abortion inducing medication.<sup>189</sup> This regulation precluded an abortion facility of the ability to use telemedicine services to connect the patient and the physician via audio and visual equipment to administer the medication.<sup>190</sup> Additionally, technology is rapidly increasing and legislatures would be forced to implement modified legislation to stay current with these changes.<sup>191</sup> Scholars refer to the standard of care in telemedicine as a "moving target."<sup>192</sup> As technology continues to develop, a standard of care could even be created that imputes liability to a physician who fails to utilize telemedicine technology in the care of a patient.<sup>193</sup>

Various solutions have been enacted by the states in the context of telemedicine. Illinois must determine which approach best aligns with Illinois law while maximizing patient safety and encouraging telemedicine use.

### 3. *Proving the Requisite Standard of Care in Illinois*

Within Illinois, expert testimony is required to establish and demonstrate to the jury the appropriate standard of care, as well as the deviation thereof.<sup>194</sup> The expert must be able to communicate

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187. Sokol & Mozen, *supra* note 178, at 484. Problems can also be created in medical malpractice cases wherein guidelines exist that favor both the plaintiff and defendant. *Id.*

188. *See e.g.*, Planned Parent Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med., 865 N.W. 2d 252, 260 (IA 2015).

189. *See Planned Parenthood of the Heartland, Inc.*, 865 N.W. 2d at 260. The Iowa State Medical Board adopted a new regulation that required physician to be present in room when abortion medication was given to patient. *Id.* However, Planned Parenthood, an abortion facility, used telemedicine to communicate with an offsite doctor. *Id.* at 255. This new regulation would force women to travel to distant site in order to receive the abortion inducing medication. *Id.* The court reasoned that this placed an undue burden on the right to have abortion. *Id.* at 269. The guidelines established by American College of Obstetricians and Gynecology stated that a physical examination was not necessary prior to the administration of abortion inducing medications. *Id.* at 266. For this reason, the regulation should not have been implemented. *Id.* at 269.

190. *Id.*

191. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 20.

192. FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(b)(iii); *see also* OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(1)(vii)(E) (noting the standard of care in telemedicine to be a "moving target" due to the rapid increases in technology).

193. OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(1)(vii)(E).

194. *Taylor*, 2011 IL App (1st) 093085, ¶ 32, 957 N.E.2d 413, 426. An expert may not be necessary when the physician's negligence is extreme and grossly

and explain to the jury as to the generally accepted medical standard of care relating to the procedure, diagnosis, or treatment rendered.<sup>195</sup> In order to qualify as a witness, the Illinois Supreme Court established a three-step analysis.<sup>196</sup> First, the expert must be a “licensed member of the school of medicine about which he proposes to testify.”<sup>197</sup> Second, “the expert must show that he is familiar with the methods, procedures, and treatments ordinarily observed by other physicians, in either the physician’s community or a similar community.”<sup>198</sup> Finally, a trial court has the discretion to determine whether the expert is overall qualified to state an opinion as to the standard of care.<sup>199</sup> The expert must base the opinion on “recognized standards of competency in the profession.”<sup>200</sup> Plaintiff’s expert must then testify that the physician’s conduct at issue deviated or fell short of this established standard of care.

The first prong of the analysis is commonly referred to as the “school of medicine” rule.<sup>201</sup> The rule acknowledges that the Illinois Legislature separately regulates various areas of medicine and issues separate licenses to each of these schools of medicine.<sup>202</sup> Each

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apparent to that of a layperson. *Id.*; see *Bryant v. LaGrange Mem. Hosp.*, 345 Ill. App. 3d 565, 577, 803 N.E.2d 76, 84 (1st Dist. 2003) (providing an example of extreme and gross conduct wherein expert testimony would not be necessary would be when sponge or an instrument was left in a patient’s body after surgery).

195. *Walski v. Tiesenga*, 72 Ill. 2d 249, 259 (1978).

196. *Sullivan v. Edward Hosp.*, 209 Ill. 2d 100, 112 (2000) (citing *Jones v. O’Young*, 154 Ill. 2d 39, 43 (1992)); see also 735 ILL. COMP. STAT. ANN. 5/8-2501 (West 2012) (establishing four standards for a court to apply in its determination of whether an individual is competent to testify as an expert, including, “(a) Relationship of the medical specialties of the witness to the medical problem or problems and the type of treatment administered in the case; (b) Whether the witness has devoted a substantial portion of his or her time to the practice of medicine, teaching or University based research in relation to the medical care and type of treatment at issue which gave rise to the medical problem of which the plaintiff complains; (c) Whether the witness is licensed in the same profession as the defendant; and (d) Whether, in the case against a nonspecialist, the witness can demonstrate a sufficient familiarity with the standard of care practiced in this State.”).

197. *Sullivan*, 209 Ill. 2d at 112.

198. *Id.*

199. *Id.*

200. *Advincula v. United Blood Services*, 176 Ill. 2d 1, 23 (1996); see Illinois Patterned Jury Instructions, 150.00 Professional Negligence (stating that “the applicable standard of care may also be proven by explicit manufacturer’s instructions for proper use of a medication (*Ohligschlager v. Proctor Community Hosp.*, 55 Ill.2d 411 (1973)), by cross-examination of the defendant (*Metz v. Fairbury Hosp.*, 118 Ill.App.3d 1093 (4th Dist.1983)), or by hospital licensing regulations or accreditation standards (*Smith v. South Shore Hosp.*, 187 Ill.App.3d 847 (1st Dist.1989))”).

201. *Dolan v. Galluzzo*, 77 Ill. 2d 279, 283 (1979).

202. *Id.*; see generally The Medical Practice Act of 1987, 225 ILL. COMP. STAT.

school of medicine relates to a separate system of training, diagnosis, and treatment that a patient adopts when he or she selects a physician within the school of medicine.<sup>203</sup> A medical professional is entitled to have his or her conduct assessed by only those within the same school of medicine.<sup>204</sup> For example, the Illinois Supreme Court held that a physician could not establish the appropriate standard of care for a nurse even though a physician supervises the work of a nurse.<sup>205</sup> The court reasoned that, unlike physicians, nurses are held to the unique licensing and regulatory schemes of the Nursing and Advanced Practice Nursing Act.<sup>206</sup> Thus, in order to testify, the expert must be licensed and familiar with the defendant's particular school of medicine.

The second prong of the analysis also limits the applicable standard of care. Illinois law employs the "similar locality rule," which requires a medical professional "to possess and to apply that degree of knowledge, skill, and care which a reasonably well-qualified physician in the same or similar community would bring to a similar case under similar circumstances."<sup>207</sup> The Illinois Supreme Court clarified that a party may only invoke the similar locality rule in limited circumstances.<sup>208</sup> The similar locality rule

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ANN. 60/1, *et seq.* (2012) (regulating physician licensing); The Illinois Occupational Therapy Act, 225 ILL. COMP. STAT. ANN. 75/1, *et seq.* (standardizing occupational therapist licensing); Nursing Practice Act, 225 ILL. COMP. STAT. ANN. 65/50, *et seq.* (regulating nursing licensing).

203. *Dolan*, 77 Ill. 2d at 283.

204. *Id.* Court additionally noted that the school of medicine rule prevents a medical professional from being held to a higher standard of care than required. *Id.* at 284-85.

205. *Sullivan v. Edward Hosp.*, 209 Ill. 2d 100, 119 (2000). The court noted that a physician does not have direct knowledge of nursing standards of care. *Id.* at 121. A physician does not teach nurses and is not familiar with the protocols and procedures that a nurse must abide by. *Id.*

206. *Id.* at 122; *but see Gill v. Foster*, 157 Ill. 2d 304, 316-17 (1993) (finding a surgeon could be an expert witness against a radiologist because it is not necessary for a medical expert to specialize in the same area of medicine). The surgeon was proper because he was a licensed physician and testified he was familiar with the practices and procedures of radiologists. *Id.*

207. *Purtill v. Hess*, 111 Ill. 2d 229, 246-47 (1986) (affirming the validity of the similar locality rule despite plaintiff's accusations that the similar locality rule was as "outmoded as the horse and buggy in the in the modern medical world"); *see Sokol & Molzen, supra* 178, at 473-77 (noting that the "locality rule" has been abandoned by several jurisdictions and replaced by a national standard of care). The article clarifies that this is primarily due to technological advancements wherein medical professionals have access to the latest and current medical information. *Id.*

208. *Id.* at 248-49; *see also Jackson v. Graham*, 323 Ill. App. 3d 766, 776 (4th Dist. 2001) (noting "[a] party may invoke the 'similar locality' rule *only* when a question exists regarding the inequality of medical facilities and conditions, such as the availability of facilities for examination and treatment of the patient or the presence of a specialist, which would make it unfair to hold a physician practicing in a small, rural community to the same standard of care as a

protects rural physicians from being held to the same standard of care as that of a physician practicing in an urban environment with more resources and specialized facilities available.<sup>209</sup> However, because of the relatively uniform standards required for physicians in terms of licensing and education, the similar locality rule is interpreted broadly.<sup>210</sup> In addition, when nationally recognized standards exist, an individual cannot employ the locality rule.<sup>211</sup>

Telemedicine renders significant proof problems for the standard of care. For example, if the standard of care is equivalent to that of a traditional in-person setting, it may be difficult for the fact finder to be able to determine whether a proper diagnosis would have actually occurred had the physician decided not to utilize telemedicine equipment.<sup>212</sup> The standard of care could be inherently difficult for a jury to be able to determine.

It additionally remains unclear whether telemedicine should be considered its own “school of medicine” under the first prong of the analysis. The fate of the similar locality rule under the second prong of the analysis also remains unknown, given that telemedicine services act to enable rural hospitals and physicians with urban resources. Thus, within Illinois, the proof required for the standard of care for the use of telemedicine must also be determined.

### C. *Informed Consent Requirements in Illinois*

Finally, another area of liability concern surrounding telemedicine use is the requirement of informed consent. Under Illinois common law, physicians are required to inform the patient of all the foreseeable risks and benefits of a particular medical procedure, along with any alternative treatments.<sup>213</sup> As of 2015,

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physician practicing in an urban environment where specialized care facilities are readily available.”)(no emphasis added).

209. *Id.*; see *Purtill*, 111 Ill. 2d at 245 (quoting “[t]he physician’s professional conduct must be judged in light of the conditions and facilities with which he must work.”). The similar locality rule takes into account the availability of medical equipment, specialists, and medical personnel. *Id.* at 246.

210. *Purtill*, 111 Ill. 2d at 249.

211. *Jackson*, 323 Ill. App. 3d at 775-76.

212. Bradley J. Kaspar, Comment, *Note: Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 856 (2014).

213. *Davis v. Kraff*, 405 Ill. App. 3d 20, 28–29 (1st Dist. 2010) (citing *Coryell v. Smith*, 274 Ill. App. 3d 543, 546 (1995)); see also *Lenahan v. Univ. of Chi.*, 348 Ill. App. 3d 155, 161 (1st Dist. 2004) (quoting, “The general rule that physicians, not hospitals, have the duty to obtain informed consent from their patients. The rationale for this rule is that the physician has the knowledge and training necessary to advise each patient of the risks, whereas the hospital does not know the patient’s medical history or the details of the particular surgery to be performed.”).

twenty-nine states have enacted legislation requiring a physician to obtain oral or even written consent prior to the administration of telemedicine services.<sup>214</sup> Illinois law is yet again silent on these issues.

### 1. *Ensuring an Informed Decision by the Patient*

Prior to a procedure performed by health care professionals, express or implied consent of the patient is required.<sup>215</sup> The underlying theory to this requirement recognizes patient autonomy wherein a patient must be given the ultimate decision regarding medical care of his or her own body.<sup>216</sup> The doctrine of informed consent acts as a boundary line for the physician-patient relationship.<sup>217</sup> If a physician fails to obtain any consent at all prior to a procedure, a patient may be able to bring a claim of battery against a medical professional.<sup>218</sup> However, commonly the cause of action lies in medical negligence.<sup>219</sup> A cause of action in negligence for lack of informed consent arises if a medical professional fails to fully inform a patient of the relevant factors necessary to allow the patient to make an informed decision.<sup>220</sup> If a patient's consent is not informed, a medical practitioner may be held liable in a medical negligence cause of action of a failure to acquire informed consent.<sup>221</sup>

Under Illinois law in a cause of action based on the doctrine of informed consent, the plaintiff must prove four essential elements.<sup>222</sup> These elements are that, "(1) the physician had a duty to disclose material risks; (2) she failed to disclose or inadequately disclosed those risks; (3) as a direct and proximate result of the failure to disclose, the patient consented to treatment he otherwise would not have consented to; and (4) plaintiff was injured by the

214. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 22.

215. OTTLEY, LASSO & POLELLE, *supra* note 64, at § 15.02(8).

216. *Id.*; *see also* FURROW ET AL., *supra* note 128, at 121 (stating that the doctrine of informed consent developed out of the prevalent belief that an individual has a right to be free of interference with his or her own person). The doctrine also developed from moral principles that it is wrong to force an individual to act against his or her will. *Id.*

217. FURROW ET AL., *supra* note 128, at 121.

218. *See* Pratt v. Davis, 224 Ill. 300, 309–310 (1906) (reasoning that consent must be obtained prior to a surgical operation when the patient is mentally competent and no emergency exists).

219. *See* OTTLEY, LASSO & POLELLE, *supra* note 64, at § 15.02(8) (warning that a cause of action may also be brought against a medical professional for intentional infliction of emotional distress when a medical professional fails to acquire the patient's consent prior to a procedure).

220. Guebard v. Jabaay, 117 Ill. App. 3d 1, 9 (2d Dist. 1983)

221. Illinois Patterned Jury Instruction, 105.07.01 Informed Consent – Professional Negligence (2016).

222. Coryell v. Smith, 274 Ill. App. 3d 543, 546 (1995).

proposed treatment.”<sup>223</sup> The scope of information required for disclosure by the physician is essential. Illinois requires disclosure of the nature of the procedure, risks and outcomes of the procedure, available alternatives to the procedure, and the anticipated benefits of the procedure.<sup>224</sup>

Illinois law embraces the majority rule of the reasonable physician or national standard, which “measures the standard of physician disclosure by what a reasonable physician would disclose under the same or similar circumstances.”<sup>225</sup> Thus, a medical professional must disclose the risks that a reasonable medical professional would have disclosed under similar circumstances.<sup>226</sup> This majority standard is justified because this standard best protects the practice of medicine.<sup>227</sup> This standard grants flexibility to physicians in order to determine the information that must be relayed to a patient under the particular circumstances.<sup>228</sup> Additionally, this standard precludes a physician from communicating each and every possible risk and side effect of a procedure and interfere with the best interests of the patient.<sup>229</sup>

Under the causation requirement, Illinois also employs the majority rule of the objective standard.<sup>230</sup> The objective standard requires a determination of whether “after proper disclosure, a prudent person would have nonetheless proceeded with the proposed treatment.”<sup>231</sup> This requirement recognizes that the

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223. *Id.*

224. *Id.*

225. *Guebard*, 117 Ill. App. 3d at 9, 452 N.E.2d at 756; *see also* Ingrid Dreezen, *Telemedicine and Informed Consent*, 23 MED. & THE LAW 541, 543 (2004) (noting that another standard is the reasonable patient standard, wherein the patient should be informed based on what an average patient under the same or similar circumstance would need to know to make an informed decisions). A third possibility is known as the subjective standard, wherein the specific needs of the particular patient control as the basis for the necessary information that must be divulged. *Id.*

226. *Guebard*, 117 Ill. App. 3d at 6.

227. FURROW ET AL., *supra* note 128, at 123.

228. *Id.*

229. *Id.* Further notes that the physician-based standard under the doctrine of informed consent is also justified by the fact that physicians should be able to act in the best interests of the patient without fear that a lay juror may subsequently decide the information relayed by the physician was improper. *Id.* Finally, physicians are in the best standing to accurately evaluate the psychological and other conditions of the patient that may impact the scope of information that should be relayed. *Id.*

230. *Guebard*, 117 Ill. App. 3d at 10.

231. *Taylor v. Cnty. of Cook*, 2011 IL App (1st) 093085, ¶ 53; *see also* DIAMOND ET AL., *supra* note 152, at 102 (noting that others employ the subjective causation standard, wherein the individual patient would not have consented to the treatment but for the proper adequate disclosure by the medical professional). Most argue that this standard is should be employed or else a “patient’s right of self-determination is irrevocably lost.” *Id.*

acceptable physician standard of information that must be relayed to a patient may in reality conflict with a patient's true informational needs.<sup>232</sup>

As with the requisite standard of care, an expert is typically needed to establish that the physicians did not conform to the professional standard of disclosure.<sup>233</sup> Unlike the requisite standard of care, a national standard is employed and the "locality rule" does not apply to lack of informed consent causes of action.<sup>234</sup>

## 2. *Safeguards Implemented by Other States*

Illinois has not enacted standards regarding informed consent in the realm of telemedicine. The majority of scholars and legal commentators, including the Federation of State Medical Boards, agree that a medical professional should obtain the patient's informed consent prior to telemedicine use.<sup>235</sup> However, since most patients will be unfamiliar with telemedicine services, some argue a treating physician should render greater detailed information to patients to discuss the specific benefits and risks of telemedicine use, the technology equipment used, and privacy concerns.<sup>236</sup>

Several states have enacted legislation that requires either oral or written consent of the patient prior to the administration of telemedicine services.<sup>237</sup> For example, California and Arizona

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232. FURROW ET AL., *supra* note 128, at 124. Additionally, notes that the subjective patient standard, though arguably best aligns with the underlying policy goals of informed consent, has not been adopted by courts. *Id.* This is primarily due to the fear that a patient would almost always simply testify that the withheld information was essential such that the patient would have declined treatment. *Id.*

233. Xeniotis v. Satko., 2014 IL App (1st) 131068, ¶¶ 50–51.

234. *Guebard*, 117 Ill. App. 3d at 6.

235. See FED'N OF STATE MED. BDS., *supra* note 62, at 4 (acknowledging the need to obtain documented informed consent from a patient prior to administering telemedicine technology). The Board further recommends at a minimum that doctors should inform the patient as to the type of telemedicine technology, details of the security measures in place for privacy concerns, and the physician's credentials. *Id.*; see also OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(iii) (arguing health care practitioner that has primary physical contact with patient must obtain informed consent from the patient).

236. FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(c)(ii)(A) (noting that the privacy concerns should be relayed to discuss the fact that non-medical personnel may be involved with operating the technology). Additionally, technology may be vulnerable for failure and unauthorized access. *Id.*

237. See TEX. OCC. CODE ANN. § 111.002 (West 2017) (requiring "A treating physician or health professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided."); see also MO. REV. STAT. § 208.670(3) (West 2017) (stating "[t]elehealth providers shall be required to obtain participant consent before telehealth services are initiated

enacted legislation requiring a medical professional to obtain a patient's consent for the use of telemedicine services in the patient's care, and further requiring that oral consent obtained must be documented in the patient's record.<sup>238</sup> Other states, such as Oklahoma, have stricter requirements mandating that the patient must receive both oral and written information regarding telemedicine prior to the use of telemedicine services.<sup>239</sup> Scholars argue that a prudent medical professional should obtain both oral and written consent from patients regardless of the level of risk involved, because telemedicine raises unique informed consent concerns.<sup>240</sup>

Other states have enacted detailed legislation that specifically addresses the information that a medical professional must discuss with a patient in order to enact greater protection for patient safety. For example, Colorado requires that a medical practitioner must provide the patient with written information regarding the use of telemedicine, including confidentiality concerns and the ability of the patient to refuse the services at any time.<sup>241</sup> Delaware also

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and to ensure confidentiality of medical information).

238. CAL. BUS. & PROF. CODE § 2290.5(b) (West 2017) (requiring that “[p]rior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health.”). The Act further requires the consent to be documented and also clarifies that “telehealth” shall include “telemedicine” *Id.* at § 2290.5(h)(3); *see also* ARIZ. REV. STAT. § 36-3602(A) (West 2017) (requiring, “before a health care provider delivers health care through telemedicine, the treating health care provider shall obtain verbal or written informed consent from the patient or the patient’s health care decision maker.” The Act further states that “[i]f the informed consent is obtained verbally, the health care provider shall document the consent on the patient’s medical record.” *Id.*

239. *See* OK. STAT. tit. 36, § 6804(B) (West 2017) (noting “[t]he patient shall sign a written statement prior to the delivery of health care via telemedicine indicating that the patient understands the written information provided pursuant to subsection A of this section and that this information has been discussed with the health care practitioner or the practitioner’s designee.”).

240. FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(c)(ii)(A).

241. COLO. REV. STAT. ANN. § 25.5-5-320(4) (West 2017), asserting:

[a] health care or mental health care provider who delivers health care or mental health care services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements: (a) That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled; (b) That all applicable confidentiality protections shall apply to the services; and (c) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

enacted a statute regarding the disclosure of the delivery models and treatment methods, as well as their limitations.<sup>242</sup> Several argue that medical professionals should take great care to explain the risks and benefits of telemedicine, because the use of telemedicine will be a completely new experience for most patients.<sup>243</sup>

Thus, the Illinois Legislature should enact a law that provides a clear requirement for physicians and other medical professionals to adhere to when providing care to patients via telemedicine. It is unclear whether a medical professional must obtain written consent from a patient within Illinois, or whether only verbal consent would suffice. Additionally, the scope of information that medical professionals must divulge is also unknown.

#### IV. PROPOSAL

Illinois should enact legislation that will expand the use of telemedicine in order to increase the access and quality of healthcare for Illinois patients in rural areas.<sup>244</sup> This Section provides a legislative solution regarding telemedicine use that maximizes patient safety while also quashing liability concerns for medical professionals. The proposed legislation addresses the establishment of the physician-patient relationship, the applicable standard of care, and the requisite scope of informed consent. The proposed legislation also conforms to existing Illinois law in the realm of malpractice liability in healthcare.

##### *A. Illinois Legislation and Court Action Regarding the Physician-Patient Relationship in Telemedicine*

Illinois must enact legislation regarding the formation of the physician-patient relationship in the context of telemedicine. Illinois should adopt legislation similar to the legislation adopted in Florida and Missouri wherein the legislation clarifies that “a physician-patient relationship may be established via

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*Id.*

242. DEL. CODE ANN. tit. 24, § 1769D(b)(3) (West 2017) (stating that “[o]btaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including informed consents regarding the use of telemedicine technologies.”). The statute further requires, “[d]iscussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options.” *Id.* at § 1769D(b)(5).

243. FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(c)(ii)(A).

244. *See* NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 20 (noting that “[m]any policymakers are balancing the rapid acceleration of technology and telehealth and its potential benefits with the responsibility to ensure safe, quality care for their constituents.”).

telemedicine.”<sup>245</sup> Illinois should also consider adding language that states, “a physician must take appropriate steps to establish a physician-patient relationship,” similar to the language adopted by the Federation of State Medical Boards.<sup>246</sup> This standard aligns with principles in Illinois law that a valid relationship is created when “the patient knowingly seeks the physician's assistance and the physician knowingly accepts the person as a patient.”<sup>247</sup> Since telemedicine is merely a means through which a physician can provide care, the requirements necessary to establish a physician-patient relationship should apply equally within telemedicine. Yet, since the technology will be unfamiliar to the patient, legislation should require a physician to take the appropriate steps to ensure that the relationship is formed while utilizing telemedicine equipment. This clear legislation would also provide notice to medical professionals desiring to practice in Illinois and quash uncertain liability risks and concerns.

The Illinois Legislature may choose to enact a more detailed law that delineates the specific steps necessary that a medical professional must take in order to establish the physician-patient relationship. However, such detailed legislation would act as a barrier and fail to effectuate the wide spread use of telemedicine to increase access of healthcare.<sup>248</sup> Legislation enacting high standards would act to discourage medical professionals from utilizing such services.<sup>249</sup> Physicians may regularly opt for in-person treatment and choose not to utilize telemedicine with his or her patients. Other high standards, such as Texas, which requires an in-person consultation after telemedicine use, undermines the very essence of telemedicine services in providing patient care.<sup>250</sup>

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245. *Id.*; see also FLA. ADMIN. CODE ANN. r. 64B8-9.0141 (2016) (legislating, “[a] physician-patient relationship may be established through telemedicine.”); see also MO. ANN. STAT. § 191.1146 (2016) (noting “[t]he physician-patient relationship may be established by... a telemedicine encounter...”).

246. See FED’N OF STATE OF MED. BD., *supra* note 62, at 4 (stating, “[w]here an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship...and while, each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies, provided the standard of care is met.”). The policy also states, “[i]t is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship.” *Id.* at 3.

247. *Reynolds v. Decatur Mem'l Hosp.*, 277 Ill. App. 3d 80, 85 (1996).

248. See NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 21 (noting that several argue mandating in-person visits prior to telemedicine use in order to ensure the establishment of a valid physician-patient relationship may act to simply recreate the barriers most are attempting to remove).

249. See *id.* at 21 (noting that there is an unease for creating higher standards in the realm of patient-provider relationships because these high standards could inhibit a patient’s access to care).

250. See TEX. OCC. CODE ANN. § 111.004(5) (requiring all medical professionals to “require a face-to-face consultation between a patient and a

These strict requirements act to recreate the barriers that the new legislation is acting to destroy.<sup>251</sup> Moreover, detailed legislation would impose a substantial burden on the Illinois Legislature to continue to modify the Act periodically to incorporate the advancements of telemedicine technology.<sup>252</sup> An adaptable and clear standard is essential in the context of telemedicine use.

Importantly, Illinois should not adopt legislation similar to Mississippi, the Federation of State Medical Boards, and the American Medical Association, which strictly requires that the physician-patient relationship “must” be formed prior to the use of telemedicine in patient care.<sup>253</sup> A flexible and non-detailed standard that a physician-patient relationship merely “may” be established will still allow the courts to review the specific facts of each case to determine whether a physician took appropriate steps to form a valid relationship. Each telemedicine encounter within a case could vary significantly depending on the equipment used, the conduct of the physician, and other surrounding circumstances. The court must continue to have a prominent role in the determination of the physician-patient relationship, because whether the relationship is formed is heavily dependent upon the facts in each case. Even though recent cases, such as *Estate of Kundert*, cast doubt on how the court would view the formation of physician-patient relationship via telemedicine encounters, Illinois courts are unlikely to allow all physicians to be shielded from liability while utilizing telemedicine services.<sup>254</sup> This is especially true given that Illinois courts have previously found a valid physician-patient

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physician providing a telemedicine medical service within a certain number of days following an initial telemedicine medical service only if the physician has never seen the patient.”); *but see* FED’N OF STATE MED. BDS., *supra* note 62, at 3 (insinuating that legislation that mandates an in person encounter prior to the formation of a physician-patient relationship should be avoided. The Federation of State Medical Board stresses the relationship should be established “whether or not there has been an encounter in person between the physician or other appropriately supervised health practitioner and patient.” *Id.*).

251. See NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 21 (justifying that enacting high standards in order to ensure the establishment of a valid physician-patient relationship may act to simply recreate the barriers most are attempting to remove).

252. FURROW ET AL., *supra* note 128, at 80–1.

253. See CODE MISS. R. 30-17-2635:5.4; AMERICAN MEDICAL ASSOCIATION, *supra* note 124, at 2; *see also* FED’N OF STATE MED. BDS., *supra* note 62, at 3–4.

254. See *Estate of Kundert v. Ill. Valley Cmty. Hosp.*, 2012 IL App (3d) 110007, ¶ 30 (wherein Illinois Appellate Court held that a valid physician-patient relationship did not exist even though emergency room personnel rendered inaccurate medical advice to a mother via telephone leading to the infant’s death); *see* FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(a)(i) (noting that courts in general would unlikely allow a physician to avoid liability when using telemedicine services simply because the physician never direct examined the patient).

relationship existed absent a face-to-face encounter.<sup>255</sup> Thus, legislation that does not require the formation would clarify that the a physician-patient relationship is possible in a telemedicine setting.

Additionally, this flexible legislation is essential in the context of consulting physicians when utilizing telemedicine. Legislation must conform with current Illinois law that precludes liability to consulting physicians that merely render an “informal opinion.”<sup>256</sup> Imposing strict requirements on physicians to form the relationship prior to telemedicine use will wreak havoc on the current practices and long-standing guidelines of medical practice in Illinois. Consulting physicians must continue to remain shielded from liability to encourage education and communication via telemedicine, which will ultimately continue to benefit the patient.<sup>257</sup>

However, under the current Illinois law, telemedicine use will likely pose more liability risks to consulting physicians, because telemedicine equipment may provide a greater opportunity for the consulting physician to become involved with the patient’s care.<sup>258</sup> Telemedicine equipment would allow a consulting physician to examine and communicate with a patient, even in the absence of in-person contact. This could possibly render a consulting physician’s opinion to the primary physician to be an informed medical opinion rather than a mere “informal opinion.”<sup>259</sup> Therefore, consulting physicians should be aware that utilizing telemedicine to provide patient care may result in potential liability risks.

In order to ease the liability concerns of physicians wishing to provide consultation services, Illinois should adopt legislation similar to the legislation enacted within Delaware. Delaware law states, “[t]elemedicine may be practiced without a physician-patient relationship during [i]nformal consultation performed by a

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255. See *Smith v. Pavlovich*, 394 Ill. App. 3d 458, 466 (5th Dist.) (finding that “[a] physician-patient relationship may exist in the absence of any meetings between the physician and patient, where the physician performs services for the patient. Thus, it is not necessary that the patient and physician have actual contact with each other in order for a physician-patient relationship to exist.”); see also FLEISHER & DECHENE, *supra* note 22, at § 1.04 (noting that several jurisdictions have held that in person contact with a physician is not needed to create a physician-patient relationship).

256. See *Reynolds v. Decatur Mem’l Hosp.*, 277 Ill. App. 3d 80, 85 (1996) (finding that consulting physicians are not liable when he or she merely renders an “informal opinion” regarding the care of the patient)

257. FURROW ET AL., *supra* note 128, at 86.

258. FLEISHER & DECHENE, *supra* note 22, at § 1.04.

259. See *Reynolds*, 277 Ill. App. 3d at 85 (reasoning that even though a consulting physician guided the physician through the physical examination of the patient, verified test results, and rendered a diagnosis, a physician-patient relationship was not created. *Id.* The consulting physician merely relayed an “informal opinion.”).

physician outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation.”<sup>260</sup> This legislation allows consulting physicians to have flexibility when utilizing telemedicine. Not only does this legislation mirror Illinois law regarding consulting physicians, this legislation also acts to encourage the educational consultation use of telemedicine by clarifying the liability risks.

Thus, Illinois law should continue to further the growth of telemedicine services by enacting a flexible approach to the formation of the physician-patient relationship. This flexible approach accommodates for the regular medical practices while still providing protection to Illinois patients.

### *B. Legislation Implementing a Standard of Care for Telemedicine Services*

Illinois should also enact legislation establishing a clear standard of care required of all medical professionals when utilizing telemedicine. This is especially important, because the standard of care is the crux of patient protection and safety. Illinois has implemented legislation regarding the required standard of care for occupational therapists in the context of telemedicine.<sup>261</sup> Under Illinois law, a licensed occupational therapist is required to exercise the same standard of care as that of a traditional in-person standard of care.<sup>262</sup> The Illinois Legislature should adopt similar legislation for all medical professionals.

The standard of care in the context of telemedicine must mirror that of the traditional in-person consultation setting. The proliferation of technology is not an excuse to threaten the welfare of a patient. Several scholars agree that the standard of care in telemedicine use must be the same as the traditional in-person standard of care.<sup>263</sup> Since telemedicine technology merely acts as a

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260. DEL. CODE ANN. tit. 24, § 1769D. Additionally provides exceptions for “furnishing of medical assistance by a physician in case of an emergency or disaster if no charge is made for the medical assistance” or “episodic consultation by a medical specialist located in another jurisdiction who provides such consultation services on request to a licensed health-care professional.” *Id.*

261. See 225 ILL. COMP. STAT. ANN. 75/2 (2012) (stating “[o]ccupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however the standard of care shall be the same whether a patient is seen in person, through telehealth, or other method of electronically enabled health care.”).

262. *Id.*

263. See AMERICAN MEDICAL ASSOCIATION, *supra* note 124, at 2 (advocating for states to adopt legislation that requires the standard of care for telemedicine services to be identical to the standard of care for traditional in-person services); see also FED’N OF STATE MED. BDS., *supra* note 62, at 4 (noting “[t]reatment and

means in which to deliver care, the standard of care for each service should still be the same.<sup>264</sup> If the standard of care required for a particular treatment or consultation cannot be properly established with the telemedicine equipment available, then the physician should decide not to utilize telemedicine in the treatment of a patient. For example, if the standard of care requires a medical professional to palpate the patient's abdominal area in order to render a diagnosis for kidney failure, then telemedicine cannot be utilized if the equipment cannot adequately gather the data from palpating the abdominal area.<sup>265</sup> The discretion of telemedicine use must ultimately remain up to the practicing medical professional. As such, Illinois cannot adopt legislation similar to Hawaii wherein the standard of care mirrors that of non-in-person consultations.<sup>266</sup> Not only is this standard difficult to apply, this legislation undermines patient safety.

This legislation providing for an equivalent standard of care would also ease a medical practitioner's liability concerns when deciding whether to practice telemedicine in Illinois. Some medical professionals misbelieve that the standard for in-person care is the "highest" care and would result in a high risk for liability.<sup>267</sup> However, the in-person standard of care merely acts to ensure that professional standard of care does not change simply because new modalities are introduced to aid physicians in the treatment of patients. In fact, this legislation would protect medical professionals by providing assurance that a "higher" standard of care will not be utilized simply because technology is involved.<sup>268</sup> Since Illinois courts have not yet determined the standard of care that must apply, physicians will have knowledge of the standards required in a given medical situation.

The proof required for the standard of care involving telemedicine services must also be resolved. To prove the standard of care for telemedicine services, expert testimony will be essential. An expert should still be able to communicate the standard of care to the jury as to the generally accepted medical standard of care

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consultation recommendations made in an online setting...will be held to the same standards of appropriate practice as those in traditional encounter in person settings.”).

264. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 11, at 20.

265. See MISS. CODE. ANN. § 73-25-34:5.5 (stating, “this exam need not be in person if the technology is sufficient to provide the same information to the physician as if the exam had been performed face to face.”).

266. See HAW. REV. STAT. ANN. § 453-1.3(c) (postulating “[t]reatment recommendations made via telehealth, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit...”).

267. *Id.* at 20-21.

268. *Id.*

relating to the diagnosis or treatment rendered via telemedicine.<sup>269</sup> In order to align with current principles of Illinois law, the expert must be able to satisfy the three-step analysis.<sup>270</sup>

Since telemedicine is merely a means with which a medical professional can provide care, telemedicine does not need to be considered its own school of medicine under Illinois law under the first prong of the analysis.<sup>271</sup> The school of medicine rule acknowledges that the Illinois Legislature separately regulates various areas of medicine and issues separate licenses to each of these schools of medicine.<sup>272</sup> Since there is no need to issue separate licenses for telemedicine use, telemedicine cannot be considered its own school of medicine. Thus, the testifying expert need only be licensed and familiar with the traditional school of medicine as that of the defendant physician.

Under the second prong of the analysis, the locality rule will likely become eradicated upon the proliferation of telemedicine use in small rural communities. The locality rule requires a medical professional “to possess and to apply that degree of knowledge, skill, and care which a reasonably well-qualified physician in the same or similar community would bring to a similar case under similar circumstances.”<sup>273</sup> As telemedicine continues to grow, the specialized knowledge of urban facilities will become readily accessible to small rural facilities. The blanket of liability protection to these smaller hospitals will no longer be justified. In fact, the Illinois Pattern Jury Instructions already caution, “the locality rule has largely faded from current practice. If there is no issue of an applicable local standard of care, the locality language should be deleted.”<sup>274</sup> Telemedicine will be the finishing touch to the eradication of the locality rule.<sup>275</sup>

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269. *Walski v. Tiesenga*, 72 Ill. 2d 249, 259 (1978).

270. *Sullivan v. Edward Hosp.*, 209 Ill. 2d 100, 112 (2000) (citing *Jones v. O’Young*, 154 Ill. 2d 39, 43 (1992)); *see also* 735 ILL. COMP. STAT. ANN. 5/8-2501 (2013) (establishing four standards for a court to apply in its determination of whether an individual is competent to testify as an expert).

271. *Id.*

272. *See Dolan v. Galluzzo*, 77 Ill. 2d 279, 283 (1979); *see also* note 202, and accompanying text.

273. *Purtill v. Hess*, 111 Ill. 2d 229, 246-47 (1986) (affirming the validity of the similar locality rule despite plaintiff’s accusations that the similar locality rule was as “outmoded as the horse and buggy in the in the modern medical world.”); *see Sokol & Molzen, supra* note 178, at 473-77 (2002) (asseverating that the “locality rule” has been abandoned by several jurisdictions and replaced by a national standard of care primarily due to technological advancements wherein medical professionals have access to the latest and current medical information).

274. *See* Illinois Patterned Jury Instruction, 105.01 Professional Duty – Negligence, Notes on Use (2016).

275. *Jackson v. Graham*, 323 Ill. App. 3d 766, 775-76 (4th Dist. 2001).

Finally, under the third prong of the analysis, a trial court should retain the discretion to determine whether the expert is overall qualified to state an opinion as to the standard of care.<sup>276</sup> Ultimately, the court will determine whether the expert witness is qualified to aid the jury in their determination.<sup>277</sup> Since an expert can rely on her own knowledge, experience, and education, this will require the expert to possess information regarding the telemedicine equipment utilized. The expert must base the opinion on “recognized standards of competency in the profession,” which may transform overtime as telemedicine technology continues to expand.<sup>278</sup> In some instances, a plaintiff may find it necessary to retain two experts in order to prove the standard of care and the breach thereof if the telemedicine technology is complicated.<sup>279</sup> The jury must retain the ability to determine under the totality of the circumstances whether the medical professional failed to conform with the established standard of care.

Therefore, the Illinois Legislature should adopt legislation that establishes a standard of care required of all medical professionals when utilizing telemedicine.

### *C. Legislating for the Proper Requirements of Obtaining a Patient’s Informed Consent*

The scope of the informed consent given for telemedicine services is uncertain within Illinois. Additionally, it is not clear whether the consent must be oral or written. The Illinois Legislature should enact a statute clarifying the requirements and scope of informed consent when utilizing telemedicine services.

The Illinois Legislature must adopt legislation that requires a medical professional to obtain the patient’s informed consent prior to telemedicine use.<sup>280</sup> At a minimum, new legislation should require a patient’s oral consent prior to the treatment via

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276. *Id.*

277. See FURROW ET AL., *supra* note 128, at 87 (reporting that the “test is whether the witness will aid the trier of fact.”). Also, notes that “the trial judge is the gatekeeper to decide whether experts are allowed to testify” *Id.* at 89-90.

278. *Advincula v. United Blood Services*, 176 Ill. 2d 1, 23 (1996)

279. See FURROW ET AL., *supra* note 128, at 87 (articulating that “more than one expert may testify as to an issue of breach of the standard of care of causation”).

280. See FED’N OF STATE MED. BDS., *supra* note 62, at 4 (acknowledging the need to obtain documented informed consent from a patient prior to administering telemedicine technology). The Board recommends at a minimum of informing the patient as to the type of telemedicine technology, details of the security measures in place for privacy concerns, and the physician’s credentials. *Id.*; see also OKOYE & SANBAR, *supra* note 21, at § 27E.03(f)(iii) (arguing health care practitioner that has primary physical contact with patient must obtain informed consent from the patient).

telemedicine. Illinois should enact a statute using similar language adopted within California stating:

[P]rior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health.<sup>281</sup>

Legislation that requires either written or oral consent from the patient is important because such legislation furthers the purpose of informed consent under Illinois law by ensuring patient autonomy. This would ensure that patients understand the risks and benefits of telemedicine use, because telemedicine services will be a new and unfamiliar experience for most patients.<sup>282</sup>

By allowing either oral or written consent, a physician will have flexibility to provide treatment through telemedicine use. This flexibility also aligns with Illinois law since Illinois law adopted the reasonable physician standard under the doctrine of informed consent that provides flexibility to the physician.<sup>283</sup>

Importantly, to remove the barriers to telemedicine use, Illinois law should not require physicians to document the consent obtained by the patient similar to California law on informed consent.<sup>284</sup> Although such conduct may be considered good medical practice, strict legislation requiring medical professionals to document each patient's consent to telemedicine is simply adding another brick to the barrier wall of telemedicine use. Other barriers include legislation detailing strict requirements for a physician to receive both oral and written consent from a patient prior to telemedicine use similar to Oklahoma law.<sup>285</sup> The Illinois Legislature should aim to remove these barriers to encourage physicians to utilize telemedicine services to provide superior and specialized quality care to patients residing in rural areas without fear of liability.

281. CAL. BUS. & PROF. CODE § 2290.5(b).

282. See FLEISHER & DECHENE, *supra* note 22, at § 1.04(3)(c)(ii)(A) (explaining that a physician should take care to greatly explain telemedicine, because a patient is likely to be unfamiliar with telemedicine technology and use).

283. See FURROW ET AL., *supra* note 128, at 123 (specifying that the physician-based standard adopted by the majority of jurisdictions provides flexibility to physicians in his or her decision as to what material risks must be disclosed to a patient in order to receive adequate consent).

284. See CAL. BUS. & PROF. CODE § 2290.5(b) (requiring that a patient's consent must be documented).

285. See OK. STAT. tit. 36, § 6804(B) (noting "The patient shall sign a written statement prior to the delivery of health care via telemedicine indicating that the patient understands the written information provided pursuant to subsection A of this section and that this information has been discussed with the health care practitioner or the practitioner's designee.").

Furthermore, the scope of the required informed consent for telemedicine should mirror the scope of required information currently required under Illinois law. The Illinois Legislature should adopt legislation that requires physicians utilizing telemedicine to inform the patient of all the foreseeable risks of a particular medical procedure, along with any alternative routes available for treatment similar to the current Illinois law.<sup>286</sup> However, legislation would ensure clear notice to out of state physicians desiring to render medical care to Illinois patients.

In the context of telemedicine, the foreseeable risks would depend on the circumstances, including the specific technology involved. If the technology is new, a physician may need to disclose any possible malfunctions. A malfunction may also lead to privacy concerns regarding a patient's medical information that may be inadvertently hacked, lost, or even destroyed. Other privacy concerns may need to be addressed such as whether other individuals may be present in the room with the physician who may be able to overhear a patient's medical information.<sup>287</sup> To eliminate these privacy concerns, the Illinois Legislature should also consider requiring the suggestions of the Federation of State Medical Boards that include verifying the identity and location of the client, while also disclosing and validating the physician's credentials to the patient.<sup>288</sup>

Other states have enacted more detailed legislation that specifically addresses the information that a medical professional must discuss with a patient in order to enact greater protection for patient safety. However, Illinois should refrain from adopting legislation that delineates the specific information that must be relayed for a patient's consent to be considered informed similar to Colorado and other state laws.<sup>289</sup> Such specificity within the

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286. *Davis v. Kraff*, 405 Ill. App. 3d 20, 28–29 (1st Dist. 2010) (citing *Coryell v. Smith*, 274 Ill. App. 3d 543, 546 (1995)).

287. *FLEISHER & DECHENE*, *supra* note 22, at § 1.04(3)(c)(ii)(A) (articulating that the privacy concerns should be relayed to discuss the fact that non-medical personnel may be involved with operating the technology. Additionally, technology may be vulnerable for failure and unauthorized access).

288. *See* FED'N OF STATE OF MED. BD., *supra* note 62, at 3, postulating that:

[a] physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment or limitations . . .

*Id.*

289. *See* COLO. REV. STAT. ANN. § 25.5-5-320(4) enumerating that:

[A] health care or mental health care provider who delivers health care or mental health care services through telemedicine shall provide to each

legislation will only raise the fear of malpractice for physicians. A patient could then theoretically bring a lawsuit against a physician for the absence of trivial information that a physician failed to relay to the patient. This legislation would not act to encourage telemedicine use, as it would only present additional liability concerns.

Thus, the Illinois Legislature should enact a law that requires either oral or written informed consent requirements to maintain patient autonomy in the advanced technological landscape of healthcare. The scope of this consent should continue to mirror current Illinois law.

## V. CONCLUSION

The complex legal threads surrounding telemedicine use have become severely tangled within Illinois. In order to provide a solution, Illinois should enact legislation to provide clarity to the medical negligence concerns of licensed professionals, including the establishment of the physician-patient relationship, the applicable standard of care, and the requisite informed consent. The rural hospitals within Illinois are severely under equipped and lack medical professionals. Telemedicine is the solution. Telemedicine can provide these rural Illinois patients with greater access to quality healthcare. However, in order to encourage medical professionals to utilize telemedicine services, while still ensuring patient safety, the Illinois Legislature must adopt legislation that delineates the standards of telemedicine practice in order to quench liability concerns. Only clear legislation can untangle these complex legal threads.

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patient, before treating that patient through telemedicine for the first time, the following written statements: (a) That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled; (b) That all applicable confidentiality protections shall apply to the services; and (c) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

*Id.*

