**Telehealth on Trial Case 1 – Could the Failure to Provide Telemedicine Breach the Standard of Care?**

HYPOTHETICAL

The trial we are putting on alleges medical malpractice by an urgent care center and its employed nurse practitioner in the care of a patient suspected of stroke. It is very loosely based on a real case, but in the main is entirely imaginary.

In a real trial, facts are developed by the testimony of witnesses, a time-consuming process. To save time here, we are dispensing with the great majority of the testimony that would normally be required. On the facts of this hypothetical, for example, the plaintiff would almost certainly testify to her damages. In the mock trial, she will not. As another example, we have provided a glossary of terms that may be unfamiliar to non-clinicians; in real life, that information would similarly be provided by testimony. Testimony is not the only aspect of trial that we have curtailed. We are also omitting opening statements. Rarely if ever in real life would a party relinquish its right to address the jury as the start of the proceedings. Staging a real trial, however, would not be feasible in the context of the MATRC meeting. We are presenting the testimony of only two witnesses: an expert for the defense, and an expert for the plaintiff. This arrangement is of course highly artificial, but geared to keeping the exercise manageable under the circumstances of the MATRC meeting.

Even more artificial is the agreement by both sides to the qualifications of the experts on both standard of care and causation, two key elements of the tort of medical malpractice. To prevail, plaintiff must prove each by a preponderance of the evidence. The qualifications of experts are frequently challenged, and only occasionally could one expert qualify on both issues. Please assume that the court has ruled that both experts are qualified to testify to both the standard of care and to causation. To see the real bios of our experts, refer to the mobile app, which provides them under each speaker's profile.

Please note that for purposes of this mock trial our experts may express views at variance with those they truly embrace. A trial is nothing, after all, if not a disagreement, and the nature of an expert's role inherently entails disagreement with the other expert. Those presenting here are doing so as actors playing roles. We need them to disagree. Do not assume, then, in this hypothetical case invented solely for purposes of the MATRC meeting, that the testimony of an expert, or for that matter the questioning or argument of counsel, necessarily reflects the views of the speakers, of MATRC, or of anyone else. Also, for the sake of brevity and simplicity, we are not considering thrombectomy as a potential therapy for the plaintiff. Instead, we will focus on anticoagulant therapy only. All parties agree that, to be effective, such therapy, where indicated, must be administered quickly.

Normally, a foundation must be laid to admit exhibits into evidence. The admissibility of exhibits is often hotly contested. We are going to assume that, by the time the experts testify, the exhibits are already in evidence.

At the close of cross-examination, the lawyer who called the witness initially may wish to re-direct—to ask questions to balance testimony elicited on cross. It is also customary for the defense to move to

strike the plaintiff's evidence at the close of plaintiff's case-in-chief. The plaintiff often does the same at the close of the defense case. To save time we will dispense with re-direct and with motions.

Please accept the "STIPULATED FACTS," below, as established, non-controverted facts, even facts that in an actual trial would likely be disputed, and even facts that you believe you know to be untrue. Please assume, perhaps through the testimony of witnesses we are not calling in this mock trial, that the jurors know what telemedicine is, and at least in general terms how it works; and that Bell's palsy is an acute peripheral facial nerve palsy of unknown etiology, causing rapid onset of facial weakness. Assume further that, through suitable evidence, the jurors have learned that Bell's is the most common cause of facial nerve palsy. Deficits accumulate over hours to days, and reach maximum severity within three weeks. The symptoms may also develop at night while the patient is sleeping, making them seem more acute. Facial weakness typically recovers-partially or fully-within six months. Although Bell's palsy can affect patients of any age, the medium age of onset is 40 years, and it is more common in patients in their 3rd to 5th decades.

Since Bell's palsy affects the facial nerve, it causes facial weakness in a peripheral pattern-that is, weakness involving the mouth, eye and forehead. Specific clinical features include: weakness raising the eyebrow and furrowing the brow; difficulty or inability to close the eye; weakness in grimacing and smiling; and flattening of the nasolabial fold. Although the exact cause of Bell's palsy is unknown, infectious causes are thought to contribute in the majority of cases. It is widely believed that the most common cause is reactivation of herpes simplex virus one. Bell's palsy is treated with a 10-day course of steroids. In some cases antiviral therapy may also be prescribed. While some patients are left with permanent facial paralysis, the majority of patients with Bell's palsy experience complete, or near complete, recovery.

**STIPULATED FACTS**

Please assume the following to be established:

E. Warren, a 64 year-old uninsured, impoverished American Indian woman with severe aviophobia (fear of flying), presents to the St. Charles Urgent Care Center in St. Charles, Kentucky, a small town with a high proportion of seniors in a remote part of the state. Ms. Warren's chief complaint is headache. She had been in her usual state of good health until the morning of presentation, when upon awakening she noticed a tingling sensation in the right side of her forehead and scalp, as well as a right-sided facial droop and slurred speech. Mary Jones, NP, NP, MSN, CNRN, a Certified Neuroscience Registered nurse practitioner who for twenty years before joining the UCC staff had collaborated with a neurosurgical practice in Louisville, was on duty when the patient presented that evening.

This was actually the patient's second such episode. One month earlier Ms. Warren had offered a similar complaint at the center; at that time, a CT of the head without contrast was negative for any acute abnormalities. At discharge from the facility on that occasion, the patient was advised to get an MRI, and to follow up with her PCP, but she failed to do so. The patient denied any other medical problems.

On exam, Mary Jones, MSN, the NP on duty, confirmed the facial droop and the slurred speech. On further exam, Ms. Jones did not observe abnormalities in the extremities. The NP arranged for the

patient to get a non-contrast CT of her head and neck. To the NP's evaluation, the CT resembled the one done a month earlier; in particular, she saw neither hemorrhage nor occlusion. The NP nevertheless was unwilling to rely upon her own interpretation alone. Fearing a stroke, Ms. Jones arranged for helicopter transport to a Level II trauma center in Louisville at a cost of $40,000. Five minutes before the air ambulance arrived, the NP persuaded the fearful patient to accept air ambulance transport because, otherwise, the patient "was risking her life." When the patient arrived at the receiving facility, Joe Black, M.D., the emergency physician, performed a full neurological evaluation, noting the right-sided facial droop, including both the upper and lower face, but no other deficits. On re-evaluating a copy of the CT, he confirmed the NP's initial impression: it was a normal study. The patient was diagnosed with Bell's palsy. She was discharged home on acyclovir and prednisone and, from a neurologic standpoint, did well. She claims, however, to experience ongoing nightmares and flashback related to the air transport.

The patient has brought a claim for medical malpractice personal injury against Mary Jones and the St. Charles Urgent Care Center. She seeks to recover the cost of the transport, the anxiety caused by the fear of stroke, and the emotional trauma of riding in a helicopter. Unlike many other states under traditional common law, Kentucky permits recovery for serious emotional distress even without accompanying physical harm.

***Dramatis Personae*** (in order of appearance)

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| Rebecca Gwilt | Judge |
| Ty Kayam | Plaintiff's Counsel |
| Rob Darling, M.D. | Plaintiff's expert |
| Joe McMenamin | Defense counsel |
| Jonathan Baugh, M.D. | Defense expert |

Not appearing:

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| E. Warren | Plaintiff |
| Mary Jones, NP, NP, MSN, CNRN | Defendant nurse practitioner |

## GLOSSARY of SELECTED TERMS

**Anticoagulant therapy** - the use of drugs to dissolve a clot in an artery.

**CNRN** - (Certified Neuroscience Registered Nurse). A registered nurse with advanced training in the diagnosis and management of diseases of the nervous system.

**Contralateral**: Situated on, pertaining to, or affecting the opposite side, as opposed to ipsilateral.

**Deep peroneal nerve**: A branch of the common peroneal nerve; supplies the extensor muscles of the leg and ankle. Damage to it causes foot drop.

**Dorsiflexion**: Movement of foot in which the toes are brought closer to the shin. This decreases the angle between the dorsum (top) of the foot and the leg. Compare plantar flexion.

**EMTALA** - Emergency Medical Treatment and Active Labor Act.

**Facial nerve**: The seventh cranial nerve. It controls the muscles of facial expression, and functions in the conveyance of taste sensations from the mouth and anterior 2/3 of the tongue.

**Innervation**: the distribution or supply of nerves to a part.

**Ipsilateral**: Situated on, pertaining to, or affecting the same side, as opposed to contralateral.

**Ischemic** - depriving tissue of oxygen which leads to their injury or death.

**Nasolabial fold**s: The two skin folds that run from each side of the nose to the corners of the mouth: "smile lines" or "laugh lines."

**Neuron** - The basics cell comprising the nervous system.

**Palsy**: Complete or partial muscle paralysis, often (not always) accompanied by loss of sensation and uncontrollable body movements or tremors.

**Plantar flexion**: movement of the foot in which the foot or toes flex downward toward the sole. Compare dorsiflexion.

**Thrombectomy** - The surgical removal of a clot from a blood vessel; in this case a patient's artery in the brain.

**Tibial nerve**: A branch of the sciatic nerve that provides innervation to the muscles of the lower leg and foot. The tibial nerve passes through the popliteal fossa, the shallow depression at the back of the knee joint, to pass below the arch of the soleus, a muscle in the back part of the calf.