By the end of the year, nearly one million patients will open up a laptop or pull out their cell phone when they have a cold, ear infection, rash or depression. They will describe their symptoms to a physician and many will get prescriptions for short-term treatment. They can get medical care in the middle of the afternoon or at 2 a.m., from the comfort of their home.

This is a viable option for patients thanks to telemedicine, the use of which has grown dramatically in recent years. For patients, it may mean increasing convenience and access, but questions remain among providers as to how and when telemedicine should be used.

There is little question that telemedicine can be an effective way to improve access to care for patients in rural areas or allow physicians to consult with other providers on challenging cases. American Well, a Boston-based telehealth service provider, notes that 67% of healthcare providers are using, or planning soon to use telemedicine services.

Furthermore, the American Telemedicine Association (ATA) estimates patients will take part in 800,000 telehealth consultations in 2015. Consulting firm Towers Watson predicted last year that by the end of 2015, more than one-third of employers will be offering telemedicine to their workers.

“This is a new area of dealing with patients and we are just seeing the tip of iceberg,” says Jonathan Linkous, MPA, chief executive officer of the ATA. “It is important to regulate it and do it right, but you can’t stop it.”

A changing landscape

Telemedicine, inherently, allows for greater mobility in healthcare. It may be enabling healthcare providers to work across state lines, but it is still regulated at the state level, meaning physicians may be working under disparate rules, potentially creating confusion.
More than 25 states have considered proposals to revise or update telehealth regulations in the past year, according to the ATA. Some of the more stringent rules are beginning to create conflict between state medical boards and telehealth providers. Nathan Cortez, JD, associate dean of research at Southern Methodist University Dedman School of Law, says this battle is just the latest in states’ ongoing struggle to maintain oversight of healthcare services.

“State regulators have been fighting turf wars for decades,” he says. “This is all kind of a grand experiment and telehealth is just making it more interesting.”

States are subjecting the practice to greater scrutiny so quickly because of telehealth’s move into primary care, Linkous says. Although it has existed for decades, telehealth had been used primarily for consultations among providers and to reach remote areas where patients may not have access to specialty care. “Its move out into the general public is what has brought on the quick analysis of it,” Linkous explains.

At Teladoc, a Lewisville, Texas-based telehealth provider and major provider of telehealth services, the number of consultations has increased by 500% during the past three years. Consultations reached 298,000 in 2014 and, according to Henry DePhillips, MD, the organization’s chief medical officer, and he expects the number to top 525,000 this year. CVS Pharmacy recently announced that it plans to expand telehealth services as do The Walgreens Co. and Wal-Mart Stores Inc.

Relationships matter

Probably the biggest concern with telemedicine for many physicians is its potential impact on the doctor-patient relationship.

Earlier this year Teladoc battled with the Texas Medical Board over whether one phone consultation is a sufficient connection between patient and provider to prescribe medication. The Texas Medical Board (TMB) declined to comment to Medical Economics because the lawsuit is ongoing, but provided a statement previously released by its board.
According to the TMB, prescribing medication with no prior relationship compromises patient safety. “...[A] telemedicine scenario that allows a physician to prescribe to a patient remotely with no diagnostic data and no ability to follow up with the patient sacrifices safety for convenience, is not good medicine, and could result in further health complications for a patient,” the board wrote.

DePhillips says physicians have been caring for patients outside of the traditional office visit since the creation of the telephone. He also suggested that it may be fueled by economics instead of ethics. As telemedicine providers move into more states, it may mean they will take business away from local physicians.

“Just as they would in person, physicians use their firsthand professional clinical experience in treating a patient,” DePhillips says via email. “The TMB acted only when Teladoc consultations became sufficiently numerous to be perceived as a competitive threat to brick-and-mortar physician practices.”

David Fleming, MD, co-director of the Center for Health Ethics at the University of Missouri School of Medicine, says that before he used texting or the Internet to communicate with patients, he consulted frequently with rural patients by phone at his primary care practice. “I could get a lot of work done; there was a lot of positive communication there,” he says.

It was more difficult to practice by phone when he was on call, talking with patients he didn’t know very well, he says. It’s even easier to have a “trusting, warm relationship” with patients via video conferencing, though he concedes it’s not as solid as in-person interaction.

Telemedicine requires making ethical and clinical judgments based on the potential risks of prescribing medication for an unknown patient versus not doing so, Fleming says. If it’s late on a Friday night and the patient’s primary care provider is out of town, could a patient be harmed by not getting needed medication? Are there times it is better to tell the patient they need face-to-face care?

Phone discussions, Fleming says, are somewhat risky. A patient could have an ear ache or a brain stem tumor; glaucoma could be misdiagnosed as conjunctivitis.

As with most innovations in healthcare, good facts make good policy, says Kenneth Goodman, PhD, FACMI, director of the University of Miami Institute of Bioethics and Health Policy. And there simply isn’t
much empirical data proving whether the doctor-patient relationship is crucial to good care, he says, or whether established patients receive better care through video conferencing than would new patients.

“Doctors that can see and hear and touch are able to provide a standard of care,” Goodman says. “If we want to alter that, we should have a good reason like improved care or lowered readmission rates.”

Although this technology is exciting, Goodman says, it is important not to get ahead of what the data can tell us about it. He says it will be important to move carefully in the coming years, weighing the consequences and tradeoffs of telemedicine.

“We may look back in 25 years and say, ‘Remember the silly old days where we had to actually go to a doctor to get treatment?’” he says. “But that’s not now, now we are analyzing a new technology and its potential pitfalls.”

Ethical considerations

Many of the ethical challenges with telemedicine surround the lack of face-to-face contact that traditionally takes place in healthcare. “You are taking a chance when you don’t know the patient,” Fleming says. “You have to trust that what patients are telling you is accurate and you are getting the full story.”

Patient compliance with telehealth is an ethical issue unto itself, says Bonnie Kaplan, PhD, FACMI, lecturer in the Center for Medical Informatics at the Yale School of Medicine. With an unknown patient, physicians have to envision they are working with the ideal.

When treating by phone, “they have a whole bunch of assumptions that patients will be informed, cooperative and compliant with what you are doing,” Kaplan says. “For some, being able to take more responsibility is what they want and for others it is overwhelming.”

Much as with issues of patient responsibility, there are two sides to most of the ethical considerations of telehealth. Take for example the question of whether telemedicine will increase patient access to care. It has been shown to be effective in getting care to people living in rural communities and has brought access to specialists to areas where they are lacking.
But problems can arise if the technology is too complicated or expensive for everyone to use, Kaplan says. It can increase access disparities if insurers don’t cover it and it becomes cost-prohibitive for all but the wealthy, or if poorer people receive lower-quality care.

Telemedicine can provide access to care for a patient unable to travel to another state to receive specialized care. On the other hand, Kaplan says, such expanded access may result in people getting care that isn’t right for them.

“There is potential for abuse, but I don’t think it’s more than with face-to-face visits,” Linkous says. “In some ways there is less because there is documentation when care is provided this way that is electronic and easily audited.”

Err on the side of caution

Even with protocols in place at the state level to prevent the misuse of telemedicine, much of the industry is still taking a conservative approach to it. American Medical Association (AMA) guidelines emphasize that it is a supplement to “live visits” and should be used only in the context of an existing doctor-patient relationship. The World Medical Association also recommends having a prior relationship with the patient.

Linkous says the ATA agrees there should be an established doctor-patient relationship when using telemedicine, but that it should be permissible to establish the relationship by video. The ATA hasn’t taken a position on whether it is “efficacious to prescribe medication over the phone,” according to an organization statement. He says the ATA is looking at the issue in conjunction with organizations such as the AMA.

Most states, he adds, look positively on telemedicine, although many also are waiting to take their cues from lawsuits like the one in Texas. He cautions against getting into a situation where telemedicine is regulated more stringently than are visits with office-based physicians.
Kaplan says the profession is working to understand the importance of getting to know a patient, their situation, and family and medical history when making a diagnosis. Much of that process is not part of a first-time telemedicine consult.

“That personal relationship is considered a really important part of being a professional,” she says. “They are dealing with values here and they [medical boards] are inherently conservative and that’s for the good. We have a wonderful natural experiment going on, which is one of the values of federalism.”

Fleming says he conducted a study of doctors and residents to gauge their comfort with telemedicine. Not surprisingly, physicians who had used it were more comfortable with it than those who hadn’t. But even those who felt good about using it included the caveat that it works best with non-complex and established patients.

“Under ideal conditions,” Fleming says, “I would agree with them.”

A telemedicine battle in Texas

Telemedicine enjoyed a legal victory earlier this year when a Texas judge issued a stay on regulations that would have rolled back the use of telehealth in that state.

The ruling stems from an ongoing case pitting the Texas Medical Board against Teladoc. Earlier in the year the medical board created a rule that physicians must have established a face-to-face relationship with a patient to be able to prescribe medications. Teladoc—whose business is phone healthcare consultations for non-emergent conditions—fired back with an antitrust suit, claiming the regulation would hurt the telehealth industry and reduce access to the patients it serves.

At its core, the lawsuit is an argument about the regulatory power of state medical boards, but it may also become a bellwether for determining the way telehealth is used in the future.

The American Medical Association also visited the issue of ethics in telemedicine during the summer, attempting to create guidelines for all physicians. Eventually it postponed any decisions, in part because of the Texas battle.
Guidelines were proposed by the AMA’s Council on Ethical and Judicial Affairs stating that a valid relationship is required to treat new patients. This committee determined the relationship can be created through audio or video technology. The committee is reviewing the guidelines and will revisit them at a later time.

ACP recommendations on using telemedicine

The American College of Physicians (ACP) recently issued a policy paper offering more than a dozen statements and recommendations for the use of telemedicine in primary care. In the paper, the ACP noted it:

- Believes a valid patient-physician relationship must be established for a professionally responsible telemedicine service to take place.

A telemedicine encounter can establish a patient-physician relationship through real time audio/visual technology. A physician using telemedicine who has no direct prior contact or existing relationship with a patient must:

- Take appropriate steps to establish a relationship based on the standard of care required for an in-person visit, or

- Consult with another physician who does have a patient-physician relationship and oversees the patient’s care.

- Recommends telehealth activities address the needs of all patients without disenfranchising financially disadvantaged populations or those with low-literacy or low technological literacy.

- Believes physicians should use their professional judgment as to whether the use of telemedicine is appropriate for a patient. Physicians should not compromise their ethical obligation to deliver clinically appropriate care for the sake of new technology adoption.

In addition the ACP:
• Recommends physicians ensure their use of telemedicine is secure and compliant with federal and state security and privacy regulation, and

• Supports a streamlined process to obtaining multiple medical licenses that would facilitate the ability of physicians and other clinicians to provide telemedicine services across state lines while allowing states to retain individual licensing and regulatory authority.