Maryland
DEPARTMENT OF HEALTH

Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

2020 SESSION
POSITION PAPER

BILL NO: **HB 448**
COMMITTEE: **House - Health & Government Operations**
POSITION: **Committee Support with Amendments**

TITLE: **Health Care Practitioners-Telehealth**

BILL ANALYSIS: HB 448 authorizes all occupations licensed under the Health Occupation Article (physicians, nurses, pharmacists, dentists, psychologists and so forth) to utilize telehealth in their respective practice. The bill defines telehealth to include both synchronous (in real time) and asynchronous (not in real time) modalities and authorizes the prescribing of Controlled Dangerous Substances (CDS) using both modalities.

POSITION AND RATIONALE: The Maryland Board of Physicians supports HB 448 with amendments. This bill was created to override the patient evaluation requirements of the Board's recently adopted Telehealth regulations.

The Board Supports Telemedicine and Telehealth

The Board began regulating telemedicine in 2009. The Board in 2017 initiated a revision of its telemedicine regulations which resulted in the adoption of Telehealth regulations in 2019. The Board sought and received considerable stakeholder input and revised various drafts based on this input. The Board sought to promote health care access for practitioners and their patients and protect patient safety, a key element to the Board's mission.

These regulations significantly expanded the access to telehealth by expanding the practice to Physician Assistants and other Allied Health providers who may now practice telehealth under the Board's regulations. The Board's regulations authorize physicians and allied health occupations under the Board's jurisdiction to use telehealth in the practice of their occupation consistent with their scope of practice, provided they first do a real time, audio-visual patient evaluation.

The Regulations That Have Resulted in this Legislation

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The Board's Telehealth regulations that have generated the disagreement resulting in the legislation before you is on patient evaluation and states: "A telehealth practitioner shall perform a synchronous (in real time) audio-visual patient evaluation adequate to establish diagnoses and identify underlying conditions or contraindications to recommend treatment options before providing treatment or prescribing medications." The Board exempts interpretive services (such as radiology), remote patient monitoring, follow-up care, surrogate examiners and coverage situations.

The Board maintains that a physician or other practitioner for an initial encounter must examine the patient in-person or through a live audio-visual technology prior to diagnosing, and if appropriate, determine treatment and possible prescribing of medication, as is recommended by the American Medical Association, the American College of Physicians, and experts in the field.

The Board also expressly prohibits treatment and prescribing based solely on an online questionnaire, and opioid prescribing for the treatment of pain.

Several groups disagree with this approach. They argue that there is no need for a real time audio-visual patient evaluation prior to prescribing medication for patients and that the Board's requirements are unnecessary and an impediment to health care access. The Board considered but rejected this requested revision that would have removed the live audio-visual requirement. The Administrative, Executive, Legislative Review Committee placed a hold on the regulations which were eventually lifted with those Committee chairs informing us that legislation would be forthcoming in the 2020 Session and that has resulted in SB 402/HB 448 which is before you.

The Board consulted with stakeholders and experts again after the regulations were adopted. Based on the input from those entities, the Board determined that prescribing birth control pills without live audio-visual evaluation was generally deemed safe for patients. The Board, however, continues to have significant concerns with allowing prescribing and treatment without any real-time audio-visual encounter. The Board believes that prescribing authority without any live evaluation could lead to a serious compromise of patient safety especially from bad actors. Further study is required to determine the safety and efficacy of telehealth without live audio-visual evaluations.

What does the Medical Community Say?

College of American Physicians

In January 2019, the American College of Physicians issued a supplement that contained the seventh edition of the American College of Physicians Ethics Manual.[1] This ethics manual described the requirements for telemedicine. We have attached the full discussion about telehealth and include a summary of the guidance below:

[1] https://annals.org/aim/fullarticle/2720883/american-college-physicians-ethics-manual-seventh-edition?_ga=2.22116283.183773295.1580827508-1097467148.1580827508#208345953

There must be a valid patient–physician relationship for a professionally responsible telemedicine service to take place.

A telemedicine encounter itself can establish a patient–physician relationship through real-time, technically appropriate audiovisual technology.

In the absence of direct previous contact or an existing relationship before a telemedicine encounter, the physician 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 relationship with the patient.

The benefits of increased access to care through telemedicine must be balanced with risks from the loss of the in-person encounter—for example, misdiagnosis potential; overprescribing; absent in-person interactions, including the therapeutic value of touch, and body language; and continuity of care.

Investigative Journalism - See Attachment-New York Times Article

The New York Times described telehealth treatment approaches that are concerning to the Board. The New York Times describes the process as follows:

> The sites invert the usual practice of medicine by turning the act of prescribing drugs into a service. Instead of doctors making diagnoses and then suggesting treatments, patients request drugs and physicians serve largely as gatekeepers.

The New York Times also quotes medical experts in ethics and behavioral health expressing their concerns:

> "It's restaurant-menu medicine," said Arthur L. Caplan, a medical ethics professor at New York University School of Medicine.
>
> "Where are the regulatory agencies in this?" asked Dr. C. Neill Epperson, a women's behavioral health expert at the University of Colorado School of Medicine. "How can this just be O.K.?"

Other States

Twenty-one states and the District of Columbia do not authorize asynchronous practice or prescribing.

Twenty-five states that we have reviewed neither prohibit nor authorize asynchronous practice and prescribing.

To date only four states (Maine, Iowa, Florida and California) have authorized asynchronous (not in real time) prescribing. Florida, however, began their process with the Florida Telehealth Advisory Council formed in 2016, and only enacted their law, three years later, in 2019.

The bill authorizes asynchronous prescribing of Controlled Dangerous Substances

At a time when Maryland and many states are still battling opioid addiction, it is especially counter-productive to authorize the prescribing of controlled dangerous substances, including benzodiazepines and opioids, through static or adaptive questionnaires for a physician or other

prescriber who has never conducted a prior patient evaluation Indeed, Federal Law has required at least one in-person medical evaluation of a patient or a covering practitioner to be considered a "valid prescription" for the purposes of delivering, distributing, or dispensing CDS by means of the internet. *See* 21 U.S.C. 829.

The Board's position:

The Board of Physicians and other health occupation boards are concerned that HB 448 will compromise patient safety by authorizing all health care practitioner licensees to use asynchronous technology often involving the use of static and adaptive questionnaires. We are doubly concerned for practitioners with prescribing authority.

The State Medical Society (Med Chi) shares our concerns. Some insurance carriers share our concerns as well. Further both support our recommendation for a Task Force instead of passing this legislation.

Only four states authorize asynchronous physician and practitioner practice.

One of those four states, Florida established a task force which studied the issue in 2016 and only enacted its statute three years later in 2019.

The Board's mission is to protect public health and patient safety. The Board has too many concerns to support the bills as drafted. Consequently the urges the Committee to consider in the alternative the following two amendments to HB 448:

Support an amendment to authorize asynchronous prescribing of birth control pills.

Support an amendment that would strike the existing bill and replace it with a Legislative directed Task Force to Study Telehealth led by the Department of Legislative Services, in consultation with the Department of Health and the Board of Physicians. The Task Force study would include but not be limited to how other states address maximizing health access while protecting patient safety involving different telehealth modalities.

Attachments

New York Times article: Drug Sites Upend Doctor-Patient Relations: "It's REsturant Menu Medicine" 4/2/19

American College of Physicians Ethics Manual: Seventh Edition
"Initiating and Discontinuing the Patient-Physician Reltionship" 1/15/19

For more information, please contact Wynee Hawk, Manager, Policy/Legislation-at the Board of Physicians at 410-764-3786.

The opinion of the Board expressed in this document does not necessarily reflect that of the Maryland Department of Health or the Administration.

The New York Times https://nyti.ms/2K1wZV2

Drug Sites Upend Doctor-Patient Relations: 'It's Restaurant-Menu Medicine'

By Natasha Singer and Katie Thomas

April 2, 2019

The sites promise easy and embarrassment-free access to erectile dysfunction and libido pills. "E.D. meds prescribed online, delivered to your door," one said recently. "Starting at $2 per dose."

"Low sex drive? That can be optional," another one said. "Try today — $99."

The sites, Roman and Hers, as well as others now make obtaining lifestyle drugs for sexual health, hair loss and anxiety nearly as easy as ordering dinner online.

On the sites, people self-diagnose and select the drug they want, then enter some personal health and credit card information. A doctor then assesses their choice, with no in-person consultation. If approved, the medicine arrives in the mail days or weeks later.

The sites invert the usual practice of medicine by turning the act of prescribing drugs into a service. Instead of doctors making diagnoses and then suggesting treatments, patients request drugs and physicians serve largely as gatekeepers.

Some of these companies operate in a regulatory vacuum that could increase public health risks, according to interviews with physicians, former federal health regulators and legal experts. And federal and state health laws, written to ensure competent medical care and drug safety, have not kept pace with online services, they say.

"It's restaurant-menu medicine," said Arthur L. Caplan, a medical ethics professor at New York University School of Medicine.

After answering questions online, two reporters for The New York Times in California gained approval for generic Viagra prescriptions through Roman and Hims, a site run by the same start-up that owns the Hers site. A third Times reporter ordered Addyi, the libido drug, through Hers.

Whether the sites' screening processes are sufficient is open to interpretation. This year, a doctor in California, who had prescribed Viagra online through a site called KwikMed.com, surrendered his medical license after the state's medical board accused him of failing to provide standard medical care like examining the patient and taking vital signs.

Some start-ups, like Kick Health, sell blood pressure pills or other prescription drugs for unapproved uses like calming the symptoms of performance anxiety.

One drug, Addyi, which can cause fainting if taken with alcohol, arrived without the necessary safety warning protocols created by the drug's manufacturer.

Much like Uber, which argues that it is not a transportation company even as it connects drivers and passengers, the drug sites argue that they are tech platforms, not health providers. The sites connect consumers — and often process their payments — to doctors who may prescribe drugs and pharmacies that can ship the medications.

To comply with state laws, the doctors work for separate companies that cater to the sites. The doctors are typically paid for each health consultation, or by the hour, not the number of prescriptions written. The sites generate revenue for themselves by charging service or processing fees to consumers, the doctors or both.

Kick, Roman and Hims each said they complied with laws and did not influence the doctors' prescribing decisions.

Zachariah Reitano, the chief executive of Ro, the owner of Roman, said his site encouraged people to tend to their health who might not otherwise have done so.

"It provides more convenient, higher-quality, more affordable care for certain conditions and saves people a lot of time and energy," Mr. Reitano said.

Justin Ip, the chief executive of Kick, said his company was "trying to be careful and cautious" about complying with health laws. He added that federal marketing restrictions on drug makers did not apply to his company.

Federal drug marketing rules apply to drug manufacturers, drug distributors, packers and their representatives. Whether the consumer drug sites fall into any of those categories is an unsettled question. And there is no single federal or state agency in charge of overseeing online prescription drug services.

"Where are the regulatory agencies in this?" asked Dr. C. Neill Epperson, a women's behavioral health expert at the University of Colorado School of Medicine. "How can this just be O.K.?"

Prescribing Algorithms

The new wave of sites that market drugs directly to consumers began popping up several years ago, promising to streamline medical care with software.

Several gained traction with cheeky TV commercials, billboard ads and social media feeds featuring sexual imagery like cactuses. They use slick packaging, wrapping doses of Viagra in condom-size envelopes or sending chocolate along with birth control pills.

The premise is so attractive to investors that Hims and Ro have raised nearly $100 million each. They have also tapped experts for advice, including Dr. Joycelyn Elders, a former surgeon general who is a medical adviser to Ro, and men's health specialists at leading hospitals.

Dr. Elders said she had signed on to advise Ro to promote accurate information about sexual health.

Nurx, a San Francisco start-up that markets contraceptives for women, has raised more than $41 million. Keeps, a hair loss treatment site for men, is based in New York and has raised nearly $23 million.

"We believe this is a radical new way of providing care — by changing unstructured interactions into structured care, by shifting work from M.D.s to algorithms where possible," Andy Weissman, a managing partner at Union Square Ventures, wrote in a blog post in 2016 after his firm led an investment round in Nurx.

Limited Doctor Interaction

For people who get nervous before public speaking, there is Kick, a San Francisco start-up that operates in 12 states. The site offers consumers a blood pressure drug, propranolol, to calm a racing heart and shaking hands.

But the site's home page did not disclose that the medication was not federally approved to treat anxiety. In fact, it suggested the opposite: "FDA approved prescriptions tailored to you," the home page said.

After queries from a reporter, the site added a sentence on a drug information page noting that prescribing propranolol for anxiety was "off-label" — or not federally approved.

The Food and Drug Administration generally prohibits pharmaceutical companies from marketing medicines for unapproved uses, as they have not been federally vetted for safety and effectiveness. Over the last decade, Pfizer and Johnson & Johnson have each paid fines of more than $2 billion to settle government charges of illegally marketing unapproved drug uses.

Doctors are permitted to practice medicine as they see fit, including prescribing drugs for unapproved uses. Mr. Ip of Kick noted that doctors regularly prescribed propranolol to treat anxiety.

But state and professional ethical standards typically require doctors to establish relationships with new patients, and examine them, before prescribing a drug. The interactions with physicians through the sites can be quite limited.

After submitting the information to Hims and being charged, a reporter received a message from a doctor saying he was a good candidate for erectile dysfunction treatment and asking if he had any questions. The reporter had no questions and ordered the drug.

Roman, Hims and Kick each said they designed their systems to ask the questions doctors would ask of new patients. The companies said the questions changed based on a person's previous answers, allowing for individualized diagnoses. The companies use algorithms to flag or weed out people with medical conditions, like high blood pressure, that could make certain prescriptions inappropriate.

Some states specifically prohibit doctors from relying solely on online questionnaires to prescribe drugs to new patients. Hims, Kick and Roman said their processes were interactive and should not be considered questionnaires.

In Ohio, state regulators said doctors must — at a minimum — communicate with patients in real time, through audio or video, to meet their standards.

But Spence Bailey of Columbus, Ohio, said he had never spoken to a doctor by phone or on video when ordering hair loss medication from Hims, communicating only through the site's messaging system.

He said he was satisfied, but canceled his monthly subscription because it was too expensive.

Hims said it complied with state medical board rules.

On some sites, it can be unclear who is reviewing consumers' health data and prescribing the drugs.

A reporter in California who requested generic Viagra through Roman received a message from a doctor, including his name and a link to a page listing his medical school, qualifications and state licenses.

But a different reporter in California, who requested generic Viagra through Hims, received a message without a doctor's name.

After being asked about the interaction by a Times reporter, the company said it had changed its software to require doctors to include their medical credentials on such messages.

Incomplete Warnings

A week or two after reporters were approved for prescriptions, the medications arrived in discreet packages.

A shipment of the Addyi libido pills, from Postmeds, a pharmacy based in Hayward, Calif., came with a colorful "usage guide." "It's time to get busy," the guide said.

The Hers questionnaire, as well as an online message from the doctor, had explicitly warned about fainting risks that can arise from taking the drugs with alcohol. But the usage guide made no mention of it. That potential danger was included only in the required F.D.A. information insert printed in a tiny typeface.

Pharmacists dispensing Addyi "must counsel all patients on the need to avoid alcohol" with every prescription, according to protocols created by Sprout Pharmaceuticals, the drug's manufacturer.

Instead, the pills came with a card providing a phone number for a "drug consultation" with Postmeds.

"The idea here is that there must be an added layer of professional counseling," said Ned Milenkovich, a pharmacist and lawyer with the firm Much Shelist in Chicago.

Cindy Eckert, Sprout's chief executive, referred questions to Hers and the pharmacies it uses. Hers referred questions to Postmeds. Umar Afridi, Postmeds' chief executive, said the required medical insert contained the alcohol warning, satisfying the counseling requirements.

Blurred Lines

The start-ups have stayed under the regulatory radar partly by arguing that they are not health providers. But the lines between the companies and the entities handling the prescribing can blur.

Ro's terms of use policy says that another company, Roman Pennsylvania Medical, provides the sites' doctors. And Mr. Reitano, Ro's chief executive, said the start-up's clinical directors and the owners of the physician company did not hold equity in Ro.

But Roman Pennsylvania has the same address in New York as Ro, according to business registration documents. Its president, Dr. Tzvi Doron, is a Ro clinical director.

Keeps, the hair-loss site, also has links to a physician corporation, KMG Medical Group, that supplies doctors to its users. Steven Gutentag, Keeps's chief executive, said that KMG was an independent corporation and that Keeps did not control the doctors' decisions.

But the two entities are closely related. Keeps's customers pay KMG Medical Group for their doctor consultations, and KMG pays Keeps's parent company, Thirty Madison, for the patient software it uses and other business services.

Then there is Dr. Michael Demetrius Karagas, a Texas physician who is KMG Medical Group's owner. He, too, has close ties to Keeps: He is the father of one of its co-founders, Demetri Michael Karagas. Dr. Karagas did not respond to requests for comment.

Annals of Internal Medicine SUPPLEMENT

American College of Physicians Ethics Manual

Seventh Edition

Lois Snyder Sulmasy, JD, and Thomas A. Bledsoe, MD; for the ACP Ethics, Professionalism and Human Rights Committee*

Medicine, law, and social values are not static. Reexamining the ethical tenets of medicine and their application in new circumstances is a necessary exercise. The seventh edition of the American College of Physicians (ACP) Ethics Manual covers emerging issues in medical ethics and revisits older ones that are still very pertinent. It reflects on many of the ethical tensions in medicine and attempts to shed light on how existing principles extend to emerging concerns. In addition, by reiterating ethical principles that have provided guidance in resolving past ethical problems, the Manual may help physicians avert future problems. The Manual is not a substitute for the experience and integrity of individual physicians, but it may serve as a reminder of the shared duties of the medical profession.

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For author affiliations, see end of text.

> The secret of the care of the patient is in caring for the patient.
> —Francis Weld Peabody (1)

Some aspects of medicine, such as the patient–physician relationship, are fundamental and timeless. Medicine, however, does not stand still—it evolves. Physicians must be prepared to deal with relevant changes and reaffirm what is fundamental. This seventh edition of the Ethics Manual examines emerging issues in medical ethics and professionalism and revisits older issues that are still very pertinent. Major changes to the Manual since the 2012 (sixth) edition (2) include new or expanded sections on electronic communications; telemedicine ethics; electronic health record ethics; precision medicine and genetics; social media and online professionalism; the changing practice environment; population health; physician volunteerism; research and protection of human subjects; and a revised case method for ethics decision making (**Appendix**).

Changes to the Manual from the sixth edition are noted in **Box 1**.

The Manual is intended to facilitate the process of making ethical decisions in clinical practice, teaching, and medical research and to describe and explain underlying principles of ethics, as well as the physician's role in society and with colleagues. Because ethics and professionalism must be understood within a historical and cultural context, the second edition of the Manual included a brief overview of the cultural, philosophical, and religious underpinnings of medical ethics in Western cultures. In this edition, we refer the reader to that overview (3, 4) and to other sources (5, 6) that more fully explore this rich heritage.

The Manual raises issues and presents general guidelines. In applying these guidelines, physicians should consider the circumstances of the individual patient and use their best judgment. Physicians have ethical and legal obligations, and the two may not be concordant. Physician participation in torture is legal in some countries but is never ethical. Physicians must keep in mind the distinctions and potential conflicts between legal and ethical obligations and seek counsel when concerned about the potential legal consequences of decisions. We refer to the law in this Manual for illustrative purposes only; this should not be taken as a statement of the law or the legal consequences of actions, which can vary by state and country. Physicians must develop and maintain an adequate knowledge of key components of the laws and regulations that affect their patients and practices.

Medical and professional ethics often establish positive duties (that is, what one should do) to a greater extent than the law. Current understanding of medical ethics is based on the principles from which positive duties emerge (**Table 1**). These principles include beneficence (the duty to promote good and act in the best interest of the patient) and nonmaleficence (the duty to do no harm to the patient). Also included is respect for patient autonomy–the duty to protect and foster a patient's free, uncoerced choices (7). From the principle of respect for autonomy are derived the rules for truth-telling. The relative weight granted to these principles and the conflicts among them often account

See also:

Editorial comment 133

Web-Only
CME/MOC activity

* Members of the Ethics, Professionalism and Human Rights Committee, 2016-2018, who contributed to the development of this seventh edition of the Manual: Carrie A. Horwitch, MD, MPH (*Chair*, 2016-2017); Thomas A. Bledsoe, MD (*Chair*, 2017-2018); Omar T. Atiq, MD (*Vice Chair*); John R. Ball, MD, JD; John B. Bundrick, MD; Ricky Z. Cui, MD; Nitin S. Damle, MD, MS; Douglas M. DeLong, MD; Lydia S. Dugdale, MD; Jack Ende, MD; Susan Thompson Hingle, MD; Pooja Jaeel, MD; Lauris C. Kaldjian, MD, PhD; Daniel B. Kimball Jr., MD; Lisa S. Lehmann, MD, PhD; Ana Mar a L pez, MD, MPH; Susan Lou, MD; Paul S. Mueller, MD; Alexandra Norcott, MD; Sima Suhas Pendharkar, MD, MPH; Julie R. Rosenbaum, MD; Molly B. Southworth, MD, MPH; and Thomas G. Tape, MD.
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Box 2. Definition of *profession* as used in the Manual.

A profession is characterized by a specialized body of knowledge that its members must teach and expand; by a code of ethics and a duty of service that in medicine, puts patient care above self-interest; and by the privilege of self-regulation granted by society.

PROFESSIONALISM

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head," said William Osler (9). Medicine is not, as Francis Peabody said, "a trade to be learned, but a profession to be entered" (1). A profession is characterized by a specialized body of knowledge that its members must teach and expand; by a code of ethics and a duty of service that, in medicine, puts patient care above self-interest; and by the privilege of self-regulation granted by society (10). Physicians must individually and collectively fulfill the duties of the profession. The ethical foundations of the profession must remain in sharp focus despite outside influences on medicine, individuals. and the patient-physician relationship (11, 12).

The definition of *profession* is noted in Box 2.

THE PHYSICIAN AND THE PATIENT

The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess, the confidential nature of the relationship, the vulnerability brought on by illness, and the imbalance of expertise and power between patient and physician. Physicians publicly profess that they will use their skills for the benefit of patients, not for other reasons, including their own benefit (13). Physicians must uphold this declaration, as should their professional associations as communities of physicians that put patient welfare first (13).

The physician's primary commitment must always be to the patient's welfare and best interests, whether in preventing or treating illness or helping patients to cope with illness, disability, and death. The physician must respect the dignity of all persons and respect their uniqueness. The interests of the patient should always be promoted regardless of financial arrangements; the health care setting; or patient characteristics, such as decision-making capacity, behavior, or social status. Although the physician should be fairly compensated for medical services, a sense of duty to the patient should take precedence over concern about compensation.

Initiating and Discontinuing the Patient–Physician Relationship

At the beginning of and throughout the patient-physician relationship, the physician must work toward an understanding of the patient's health problems, concerns, values, goals, and expectations. After patient and physician agree on the problem and the goals of care, the physician presents one or more courses of action, with a specific recommendation for the patient. The patient may authorize the physician to initiate a course of action; the physician can then accept that responsibility. The relationship has mutual obligations. The physician must be professionally competent, act responsibly, seek consultation when necessary, and treat the patient with compassion and respect, and the patient should participate responsibly in the care including through informed decision making, giving consent to or declining treatment as the case might be.

Effective communication is critical to a strong patient-physician relationship. The physician has a duty to promote patient understanding and should be aware of barriers, including health literacy issues for the patient. Communication through e-mail or other electronic means can supplement in-person encounters; however, it must be done under appropriate guidelines (14). E-mail or other electronic communications should only be used by physicians in an established patient-physician relationship and with patient consent (15). Documentation about patient care communications should be included in the patient's medical record.

Guidance on patient-physician e-communication is noted in Box 3.

Aspects of a patient-physician relationship, such as the physician's responsibilities to the patient, remain operative even in the absence of in-person contact between the physician and patient (16). "Issuance of a prescription or other forms of treatment, based only on an online questionnaire or phone-based consultation does not constitute an acceptable standard of care" (16). Exceptions to this may include on-call situations in which the patient has an established relationship with another clinician in the practice and certain urgent public health situations, such as the diagnosis and treatment of communicable infectious diseases. An example is the Centers for Disease Control and Prevention-endorsed practice of expedited partner therapy for certain sexually transmitted infections.

Care and respect should guide the performance of the physical examination. The location and degree of privacy should be appropriate for the examination being performed, with chaperone services as an option.

Box 3. Patient-physician e-communication.

Effective communication is critical to a strong patient–physician relationship.

Communication through e-mail or other electronic means can supplement in-person encounters but must be done under appropriate guidelines.

E-communications should only be used by physicians in an established patient–physician relationship and with patient consent.

Documentation about all patient care communications should be in the patient's medical record.

Aspects of a patient–physician relationship, such as the physician's responsibilities to the patient, remain operative.

Box 4. Telemedicine and ethics.

There must be a valid patient–physician relationship for a professionally responsible telemedicine service to take place.

A telemedicine encounter itself can establish a patient–physician relationship through real-time, technically appropriate audiovisual technology.

In the absence of direct previous contact or an existing relationship before a telemedicine encounter, the physician 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 relationship with the patient.

The benefits of increased access to care through telemedicine must be balanced with risks from the loss of the in-person encounter—for example, misdiagnosis potential; overprescribing; absent in-person interactions, including the therapeutic value of touch, and body language; and continuity of care.

An appropriate setting and sufficient time should be allocated to encourage exploration of aspects of the patient's life pertinent to health, including habits, relationships, sexuality, vocation, culture, religion, and spirituality.

In the context of telemedicine, there must be a valid patient-physician relationship for a professionally responsible telemedicine service to take place (17). A telemedicine encounter itself can establish a patient-physician relationship through real-time, technically appropriate audiovisual technology. When there has been no direct previous contact or existing relationship with a patient before a telemedicine encounter, the physician 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 relationship with the patient. The benefits of opportunities for increased access to care through telemedicine "must be balanced according to the nature of the particular encounter and the risks from the loss of the in-person encounter (such as the potential for misdiagnosis; inappropriate testing or prescribing; and the loss of personal interactions that include the therapeutic value of touch, communications with body language, and continuity of care)" (17).

Guidance on telemedicine is noted in Box 4.

By history, tradition, and professional oath, physicians have a moral obligation to provide care for ill persons. Although this obligation is collective, each individual physician is obliged to do his or her fair share to ensure that all ill persons receive appropriate treatment (18). A physician may not discriminate against a class or category of patients.

An individual patient-physician relationship is formed on the basis of mutual agreement. In the absence of a preexisting relationship, the physician is not ethically obliged to provide care to an individual person unless no other physician is available, as is the case in some isolated communities, or when emergency treatment is required. Under these circumstances, the physician is ethically bound to provide care and, if necessary, to arrange for proper follow-up. Physicians may also be bound by contract to provide care to beneficiaries of health plans in which they participate.

Physicians and patients may have different concepts of or cultural beliefs about the meaning and resolution of medical problems. The care of the patient and satisfaction of both parties are best served if physician and patient discuss their expectations and concerns. Although the physician must address the patient's concerns, he or she is not required to violate fundamental personal values, standards of medical care or ethical practice, or the law. When the patient's beliefs—religious, cultural, or otherwise—run counter to medical recommendations, the physician is obliged to try to understand clearly the beliefs and viewpoints of the patient. If the physician cannot carry out the patient's wishes after seriously attempting to resolve differences, the physician should discuss with the patient his or her option to seek care from another physician.

The physician's responsibility is to serve the best interests of the patient. Under rare circumstances, the physician may elect to discontinue the professional relationship, provided that adequate care is available elsewhere and the patient's health is not jeopardized in the process (19, 20). The physician should notify the patient in writing, offer to transfer the medical records to another physician with patient approval, and comply with applicable laws. Continuity of care must be assured. Physician-initiated termination is a serious event, especially if the patient is acutely ill, and should be undertaken only after genuine attempts to understand and resolve differences. Abandonment is unethical and a cause of action under the law. A patient is free to change physicians at any time and is entitled to the information contained in the medical records.

Third-Party Evaluations

Performing a limited assessment of an individual on behalf of a third party, for example, as an industry-employed physician or an independent medical examiner, raises distinct ethical issues regarding the patient-physician relationship. The physician should disclose to the patient that an examination is being undertaken on behalf of a third party that therefore raises inherent conflicts of interest; ensure that the patient is aware that traditional aspects of the patient-physician relationship, including confidentiality, might not apply; obtain the examinee's consent to the examination and to the disclosure of the results to the third party; exercise appropriate independent medical judgment, free from the influence of the third party; and inform the examinee of the examination results and encourage her or him to see another physician if those results suggest the need for follow-up care (21, 22).

Confidentiality

Confidentiality is a fundamental tenet of medical care. It is increasingly difficult to maintain in this era of electronic health records and electronic data processing, patient portals, e-mail, texting, faxing of patient information, third-party payment for medical services, and sharing of patient care among numerous health