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policy & politics

e-Medicine: Policy to Shape the Future of Health Care

by Bette-Jane Crigger

Health care has finally made it into the Information Age, prompted in part by the need for systemic efficiencies and in part by the enthusiasm of "early adopters" like Beth Israel Deaconess Medical Center, whose PatientSite[1] offers registered patient-users online services that include prescription refills, lab results, appointments, and secure email with clinicians. Some health systems have gone even further—the Veterans Health Administration (VHA) began systematically delivering clinical services via telemedicine in 1997; the program is now significantly expanded and coordinated through a designated Office of Care Coordination.[2]

Some of the more interesting implications of this evolution haven't yet turned up on the policy radar, however. Privacy, yes. And related concerns about security in online transmission of personal health information, which we've addressed nationally in provisions of the Health Insurance Portability and Accountability Act. We've also raised questions about the nature of electronic patient-professional relationships, although we haven't come to consensus about whether or in just what way those relationships suffer or are enhanced.[3] These are vital and highly visible concerns, but they don't exhaust the range of issues around "e-medicine"—a term that for present purposes I will use interchangeably with "telehealth," "telemedicine," "e-care," and "e-services." A robust institutional and public policy must do better.

So far, we've largely neglected several lower-profile concerns that are equally important to crafting well-thought-out policy, not to mention well-thought-out systems of e-medicine. I'd argue that the tasks of system design and implementation pose ethical challenges that merit careful attention they haven't yet received. Specifically, we must address nasty, complex questions about which clinical services should or shouldn't be provided in this way and which patients should or shouldn't receive care in this way, intertwined with questions about how to allocate the human and material resources needed to provide e-medicine. It's the usual policy work of setting boundaries and defining expectations, but now with a cyber twist.

So, setting boundaries. Responsible practice surely requires at the outset that we determine what clinical needs could "appropriately" be met through e-medicine services, and from there go on to identify criteria for deciding which of those needs the system will actually try to meet. That means taking account not only of the particular needs of the patient population(s) to be served, but also of how clinical e-services must be structured to provide value for patient-recipients. It also means developing a clear, comprehensive picture of the technological and human resources needed to deliver e-care appropriately. And thinking critically about which patients are well positioned to benefit from e-services, and which are not.[4]

This last is going to be especially tricky. Matching the "right" patients with the right e-care is not a trivial task, not least because it can't rest solely on clinical considerations. We must define patient selection criteria that are adequate to protect individuals who may be vulnerable when services are not provided face to face—perhaps those who are extremely fragile, for example. At the same time, we must assure that we don't unduly exclude patients who might benefit from e-services—those who with a little extra help could use the requisite technology effectively. We must also assure that our criteria are on the whole fair to the overall population of patients served by the e-medicine system. When we already struggle to bring people into the health care system, how much can or should we do to enable patients who don't have reliable access to a telephone or computer to utilize e-services effectively? Could we rest content with an e-medicine that works only for the wired, computer-literate middle class?

Then there's that matter of sorting out expectations. Who will provide e-care, for example, and what qualifications must e-practitioners have? Clinical skills obviously, but more particularly skill in providing clinical e-services. How adept should we expect e-practitioners to be at troubleshooting their technology? How should we think about the role of e-medicine's information technology specialists vis-a-vis the caregiving team? Health care systems can't function without nonclinical technical staff to keep the equipment running, of course, but do we yet have a way to understand whether clinical IT specialists are a different category of staff? The point is not that the question isn't answerable; perhaps it won't even turn out to be very challenging. I'm not persuaded we've given it enough thought even to know whether it matters.

In looking toward policy we'd also do well to explore the likely "ripple effects" on workflow for clinical and other staff of implementing e-services. Shaking habits up a bit and fostering new patterns can be invigorating—or it can destroy working relationships and professional commitments, with potential consequences for patients. Creating an e-medicine environment that sustains professionalism is another piece of the puzzle, then. Just recently, Kaiser Permanente reported on the disruptive effects on institutional life of its efforts to implement a new system of electronic medical records.[5] The authors of this qualitative study couch their report as a cautionary tale for others.

Voluntariness will doubtless strike many as a much bigger deal. It's all well and good to say that patients have the right to consent to or decline e-care, just as they can consent to or decline care face to face. But what if, as e-medicine evolves, it becomes clear that e-care really can offer better health outcomes, at least for certain patients receiving certain kinds of care? Or what if it offers equally good outcomes at lower cost?—for example, for patients with chronic obstructive pulmonary disease who receive home telehealth as part of their overall plan of care.[6] As we try to think proactively about policy, can we imagine richly enough the trade-offs we may find ourselves trying to make when we think about allowing patients to opt out, providing optimal care, and containing cost?

Voluntariness may also be a concern for health care professionals. If there's clearly a benefit for patients and/or the system in e-medicine, might we reasonably *require* clinicians to accept it? It's been suggested that health care organizations could reasonably require reluctant providers to accept online patient-clinician communication under similar circumstances.[7]

This doesn't exhaust the range of questions we need to ask by any means. But it's a place to begin thinking about issues we've tended to avoid so far. Like it or not, we will have e-medicine; the task now is to decide *how* we will have e-medicine. We're getting pretty good at setting technical standards for information technologies in health care like security and interoperability. To make policy that addresses the fuller range of concerns we face when it comes to actually using those technologies, however, I'd say we've got a deal more work to do.

Disclaimer

The opinions expressed are those of the author and do not reflect the views of the Veterans Health Administration or the Department of Veterans Affairs.

Acknowledgment

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[1] https://www.patientsite.org/.

[2] http://www.va.gov/occ/default.asp.

[3] T.E. Miller and A.R. Derse, "Between Strangers: The Practice of Medicine Online," *Health Affairs* 21 (2002): 168-79; T. Delbanco and D.Z. Sands, "Electrons in Flight—Email Communication between Doctors and Patients" [Perspective], *New England Journal of Medicine* 205 (2004): 1705.

[4] See, for example, VHA guidance for telemental health; http://www.va.gov/occ/Telemental/telemental_toolkit.asp, last accessed November 26, 2005.

[5] J.T. Scott, T.G. Rundall, T.M. Vogt, J. Hsu, "Kaiser Permanente's Experience of Implementing an Electronic Medical Record: A Qualitative Study," *BMJ* 331 (2005): 1313-16.

[6] T. Koizumi et al., "Trial of Remote Telemedicine Support for Patients with Chronic Respiratory Failure at Home through a Multistation Communication System," *Telemedicine and e-Health* 11, no. 4 (2005): 481-86; "Telemedicine Project Cuts Stays in Hospital by Half," *PublicTechnology*, September 26, 2005; available at http://www.publictechnology.net/print.php?sid=3707.

[7] VHA National Ethics Committee, "Online Patient-Clinician Communication: Fundamentals of Ethical Practice," July 2004, available at http://www1.va.gov/vhaethics/download/reports/Email_2004.pdf; last accessed November 27, 2005.