Telemedicine

ETHICAL RULES

for Remote Medical Treatment

SEPTEMBER 2019
Preface – IMA President

The modern era is characterized by rapid technological development, offering many new opportunities, as well as unprecedented risks. Progress has created innovative means of communication and treatment that affect and change the physician-patient treatment setting.

Technological means can bridge many gaps in society, facilitate a fair distribution of resources, narrow disparities between central Israel and the periphery, make services available to those with limited mobility and transcend boundaries of time and place in medical treatment. In addition, technological means of providing remote medical care (telemedicine) can strengthen the relationships and collaboration between physicians and other caregivers, which results in improved care for the patient.

On the other hand, the use of telemedicine carries a price. The changes in the treatment setting harm the delicate fabric of relations between physician and patient, the interpersonal and human connection, and the physician’s ability to act with compassion. Physicians need to be very sensitive in exercising their discretion and identifying when telemedicine, despite its advantages, is unsuitable for treating a specific case. Physicians must recognize the limitations of telemedicine.

As physicians, we must adapt ourselves to the new forms of communication with our patients, while remembering that our professional responsibility—including medico-legal implications and legal-ethical duties toward our patients and colleagues—remains unchanged.

Therefore, it is very important to formulate the ethical rules for proper conduct, as compiled and written in this booklet. I would like to thank the members of the Ethics Board team who devoted their time and energy to formulating and writing the rules of ethics for telemedicine. These rules will serve as a compass for physicians in the new situations they face in an ever-evolving world.

Prof. Zion Hagay
President, Israel Medical Association
Introduction

The Internet and advanced communications have become close and dear friends for all of us. Patients and physicians are “connected” via the mobile phone, the computer, electronic devices and all available means of communication.

This availability offers fertile ground for software developers and high-tech personnel who seek additional areas in which to interest their customers. If we add the fact that medicine and health are the most common topics in Internet search engines, it is natural for computer professionals to connect the two, to encourage and urge physicians to enable follow-up, treatment and 24/7 availability for all patients and people interested in their health.

In 2007, the Ethics Board wrote an initial position paper on telemedicine. This was followed in 2014 by a booklet outlining the rules of medical ethics in digital communication and social media. In these rules of ethics, we warned physicians not to respond to every medical question on every platform, not to expose themselves to the public in ways they might not have intended, to comply with the rules of advertising, and more.

In the years since the rules were written, the HMOs and hospitals have faced growing demands to provide treatment and respond to individual patients via telemedicine. The Ethics Board discussed these demands and formed a committee to study the changes that had occurred and to define detailed and up-to-date rules on telemedicine.

The committee members: Dr. Baruch Chen – chair, Dr. Uzi Dan, Dr. Yossi Walfisch, Dr. Mauriciu Cohn, Dr. Rebecca Brooks and Dr. Yoav Geva.

The committee members devoted thought, effort and time to composing this booklet, including repeated discussions in the Ethics Board plenum. I thank the committee members for their efforts and dedication.

The booklet is important in recognizing that physicians who decide to engage in telemedicine must set boundaries – for themselves, for their patients and for other parties.

Christina Maslach, who studied pressure and burnout at work, defined work-related pressure as an imbalance: Work demands more from you than you’re capable of giving, and gives you less than what you need. In particular, it is essential to set the following boundaries:

- **Time limits:** Physicians should define the amount of time they can devote to telemedicine as part of their professional and personal schedules. They should guard their own health and wellbeing: like any other person, the physician needs time to rest. Patients who are not presented with the required boundaries are liable to expect the physician to be available to them 24/7. The greater the expectations, the greater the disappointment. Therefore, it is important for physicians to avoid creating exaggerated and unrealistic expectations among the patients, and to set boundaries according to their ability and availability.

- **Boundaries of professional capability:** Physicians should avoid treating a patient via telemedicine when it seems that the treatment requires a face-to-face meeting with the patient, or when the equipment available to the patient or physician is unsuitable or insufficiently precise.

- **Boundaries of protecting medical confidentiality:** Physicians are duty-bound to protect the privacy and medical confidentiality of their patients, and this includes the use of telemedicine. Therefore, when treating patients, the physician must be careful not to use insecure technology that exposes medical information for all to see.

I hope that this booklet of ethical rules will serve as a guide for physicians when using the tools of telemedicine.

I have no doubt that the technologies will soon change and improve, and we will again need to discuss the subject and add rules, guidelines, comments and insights for physicians who treat patients via telemedicine.

I would like to thank attorney Benny Avissar, who worked closely with the committee members in the process of writing the booklet, and Keren Mashia-Zwang, the coordinator of the Ethics Board, who, as usual, closely monitored the writing, editing and publication of the rules.

Dr. Tami Karni
Chair, Ethics Bureau
**Key points**

This document contains a compilation of rules pertaining to treatment and consultation via personal telemedicine tools and technologies. While focusing on physician-patient treatment and consultation, these rules also apply to consultation between colleagues.

This document does not address subjects discussed in the Rules of Medical Ethics – Digital Communications and Social Media booklet, which deals with broad forums, social media and general consultation, which is often provided anonymously.

**General**

Technologies for telemedical treatment and consultation are already in use and are continually expanding. This booklet aims to present the boundaries of what is ethically permissible and prohibited in this type of treatment.

- **Advantages:** Good, rapid and equitable consultation and treatment—without the limitations of physical distance and time. These advantages are very relevant to issues of distributive justice; for example, telemedicine can bridge disparities between central Israel and outlying areas.

  Telemedicine can offer great benefit because of its ability to manage the patient’s treatment, coordinate between members of the treatment team, and provide urgent consultation in real time.

- **Disadvantages:** Telemedicine is a new tool that may potentially introduce new problems of a different nature, unfamiliar to the world of medicine. There is real concern about violating the trust between the physician and the patient. It is not always possible to provide treatment or consultation via telemedicine. Technological tools cannot fully replace the direct physician-patient interface.

  The availability and speed of telemedicine may lead to excessive requests for medical diagnosis and treatment; some of these requests may be administrative or unnecessary, further burdening the medical system and resulting in duplication of treatment.

  We must be cognizant of the fact that telemedicine has the potential to change the physician-patient relationship as we know it today, in a way that might harm the quality of medical care and affect the ability to convey compassion in the absence of a face-to-face meeting. In addition, the use of telemedicine poses risks to privacy and medical confidentiality.

**Principles**

- **Professional responsibility:** Virtual medicine is medicine in every way; therefore, the physician bears professional responsibility when providing consultation and treatment remotely. All of the rules of ethics apply to virtual medicine.

  Physician-patient relations should be based on a meeting between them. In cases that do not require a medical examination, the meeting may be either face-to-face or virtual. Telemedicine should also be based on the patient’s medical history and on mutual trust between the patient and the physician.

  It is preferable to have prior acquaintance before jointly deciding on treatment via telemedicine.

  An effort should be made to conduct a face-to-face meeting periodically, according to the physician’s discretion.

  When using equipment or instrumentation in a telemedical framework, physicians should take into account the type of equipment or instrumentation used, their familiarity with it, deviations and errors that might occur in measurement or when used by the patient in relevant cases.

- **Managing the treatment:** A physician who asks a colleague for a second opinion or additional consultation on a patient remains responsible for the ongoing management of treatment.

- **Documentation:** There should be orderly documentation of the consultation and treatment provided via telemedicine, as part of the general obligation to maintain the patient’s medical record. Documentation is also very important for ensuring proper continuity in treatment.

- **Patient autonomy:** The patient’s informed consent is required before using telemedicine. The service provider of the technological system used for telemedicine must request this consent, as is customary in other electronic means and applications. No use of telemedical technology is allowed before receiving the patient’s consent.

  Consent to receive treatment via telemedicine should be requested the first time the patient contacts the physician, and patients should have the option of retracting their consent at any time. Patients should also have the choice of opting out of particular areas in which they prefer not to use telemedicine. It is also possible to define certain issues as requiring additional, specific informed consent before addressing them via telemedicine.

1. When providing telemedical services to a patient in another country, physicians should consider whether a license is required to practice medicine in that country. They should also check their professional liability insurance coverage.
The physician should also receive the patient’s informed consent for treatment when using remote health services, as is customary.

When referring patients for tests, the referring physician should state his or her opinion on the possible need for professional guidance and interpretation upon receiving the test results. When appropriate, the physician should include the patient in the decision of whether to have the test results delivered directly to the patient, to the physician or to both.

- **Physician autonomy**: A physician is not obligated to provide treatment or consultation via telemedicine.

Physicians should exercise their discretion in deciding whether a case or topic they face is suitable and worthy of telemedical treatment or consultation.

Physicians should not be obligated or compelled to use telemedicine against their will or professional opinion.

Physician autonomy includes setting limitations on treatment via telemedicine, based on the physician’s ability and availability to consult or treat remotely. Physicians should also take into account the obligation to protect their own health and personal wellbeing, and should reduce their availability if it prevents them from fulfilling this obligation.

Physicians are entitled to discontinue telemedical treatment, at their discretion, if they determine that the remote treatment or consultation compromises the quality of treatment provide to the patient. In this framework, physicians should also take into consideration the extent of their previous acquaintance with the patient and the patient’s medical history. When appropriate, at their discretion, physicians may ask the patient to schedule a face-to-face examination.

- **Defining frameworks and boundaries, coordinating expectations of the physician and the patient**: Telemedicine can potentially offer the patient virtual availability 24/7. Therefore, physicians must specify the hours when they are available to answer calls, the types of calls they will answer, and the types of patients for whom telemedicine is appropriate. Physicians should make the following clear: their extent of availability, the accepted frequency of calls, the expected response time, etc.

In this document, we do not set arbitrary, uniform and sweeping rules. Instead, the emphasis is on the importance of setting rules based on transparent criteria, leaving room for the physician’s discretion in accordance with availability, circumstances and the particular patient.

- **Information security and protecting medical confidentiality**: A physician must not provide medical consultation or transfer medical information via online communication that is not protected by a computer security system commensurate with the sensitivity of the medical information. Using a hospital or HMO system meets the requirements for information security commensurate with the sensitivity of the medical information. A physician who uses other systems should verify that they are protected and appropriate for the information. To remove any doubt, it should be noted that applications and social media such as Facebook or WhatsApp are not secure tools for providing individual medical treatment or consultation.

Before providing consultation or treatment, the identity of the caller must be confirmed. This may be done via the electronic system being used or in some other way—for example, through the physician’s prior personal acquaintance with the patient or by confirming identifying details.

- **Remuneration**: In accordance with the responsibility assigned to the physician, the treatment and consultation provided via telemedicine should be viewed as work that merits payment, like any other medical work.
Telemedicine

Introduction

Telemedicine, the use of electronic communication technologies in medicine, is a rapidly developing field that is becoming a prominent and influential part of our world.

The rapid emergence of this medical technology was fueled by technological developments and their increasing use among the population, an aging population, a higher rate of chronic illness, and inequity in the consumption of medical services stemming from social and geographic factors.

Consequently, telemedicine has attracted the attention of patients, physicians, insurers and policymakers in recent years, and has moved from the sidelines to a central place in medicine. Telemedical technology and tools have become an established fact. From this point of departure, this document addresses the principles and rules of conduct when using, or refraining from using, the tools of telemedicine.

As with any new medical technology, there is a need to examine whether telemedicine requires a different medical approach. For example, when the stethoscope appeared as a new technology, there were concerns (which, of course, did not materialize) that physicians would listen to the heart and lungs at the expense of listening to their patients. The field of genetics is another example: Our knowledge in this field did not engender the selection of genetic material to create children according to the parents’ desires – at least not yet.

The goal of this booklet is to conduct an ethical discussion on this new technology, to identify the best ways to exploit its advantages for the patient, the physician and the health system, and to proactively address possible obstacles (such as impairment of the physician-patient relationship, autonomy and medical confidentiality) that could damage the profession and the society. The ethical discussion is conducted in accordance with the principles of medical ethics.

Telemedicine includes the use of many technologies in medical services for a wide range of situations, populations and workplaces. Many specialties are now using it throughout the course of treatment, for patients of all ages. Telemedicine is a dynamic component in medicine, reflecting the rapid change occurring in the technological environment.

Telecommunication and information technologies are used to share information, to provide medical treatment, for education, to promote public health, remote administration and more.

Telemedicine is also known as telehealth, eHealth and mHealth. Telemedicine appears in various forms: videoconferences, information streaming, exchange of images, wireless communication and wireless monitoring. These technologies can remotely deliver medical response and education for patients and health providers, as well as support for treating the chronically ill in their homes.

We collected a wealth of information on the implications of using telemedicine in various areas: (A) in different work settings: the home, community, hospitals, clinics, pharmacies, imaging centers, institutions for chronically ill patients, etc.; (B) in different medical indications; (C) from various medical supply units; (D) from different technologies.

Telemedicine is being used at various levels, ranging from open mass media, to preventive medicine and the promotion of health services, to professions like pharmacy, imaging, psychiatry, dermatology and intensive care, and for treatment of an individual patient by a primary physician.

This document addresses the issue of remote treatment and consultation via the tools and technology of personal, individualized, "one-on-one" telemedicine. This mainly refers to the provision of consultation and treatment between a physician and a patient, but these rules also apply to collegial consultations between physicians.

This document does not broadly address publication, consultation or discussion in the framework of social media or the Internet. Rules on those topics were formulated in the Rules of Medical Ethics – Digital Communications and Social Media booklet, produced by the Ethics Board specifically to address these issues.

Advantages

The technology of telemedicine facilitates rapid, readily available and wide-ranging communication. It is changing medical treatment, making it more patient-centered. This change requires responsible and advanced use for the benefit of the patient and the society.

The new range of technological possibilities enables physicians to communicate with their patients electronically, to coordinate various monitoring measures (including automatic interactions), to send reminders and improve administration of the patient’s treatment when the patient is not present in the physician’s office. In addition, the new technological options can enhance the medical team’s relations and the coordination of treatment.

There is enormous potential in this technological development. Its salient advantages, when used properly, include: sound utilization and fair
Setting up a telemedical array in parallel to the existing system may stir over-diagnosis of patients, burdening the medical system and resulting in duplication of treatment and over-diagnosis of patients. The availability and speed of telemedicine may lead to an excessive assessment of patients, ostensibly available 24 hours a day. Boundaries of the physician-patient relationship may be compromised because the physician is not physically close to the patient. Interactive systems may lead patients to breach the boundaries of the physician-patient relationship because the physician is not physically close to the patient. The use of telemedicine requires a redefinition of the boundaries of responsibility and accountability. Malfunctions, improper use or malicious activity may cause harm. A telemedical system depends on its level of technological quality, and this reflects the advantages they find in it. However, the data published in scientific journals on the benefits in terms of cost and resource utilization is still insufficient. Data is also lacking on structural changes in the health system engendered by the use of telemedicine, how it has affected the earnings of medical personnel, and its impact on the fields of primary medicine and emergency situations, pediatrics, tele-dermatology and more.

Disadvantages

The rapid development of telemedical services also calls for an examination of its disadvantages. This examination is needed in several areas: physician-patient relations, remote monitoring, information storage and transfer. Telemedical systems are very costly; substantial funding is required to build them. Therefore, resources must be utilized judiciously and fairly. A telemedical system depends on its level of technological quality. Malfunctions, improper use or malicious activity may cause harm. The use of telemedicine requires a redefinition of the boundaries of responsibility and clinical propriety. Interactive systems may lead patients to breach the boundaries of the physician-patient relationship because the physician is not physically available around the clock. The availability and speed of telemedicine may lead to an excessive number of calls, some of them administrative matters or pointless inquiries, burdening the medical system and resulting in duplication of treatment and over-diagnosis of patients.

Setting up a telemedical array in parallel to the existing system may stir competition or duplication of treatment, and could also hinder the continuity of treatment, which is essential for confirming the diagnosis, assessing the response to treatment and complications arising from it. The use of telemedicine may delay treatment, including in emergencies. The technical use of new technologies creates an inter-generational gap in mastering them, among physicians and patients alike. This may stir resistance among older people, difficulties in adapting and disparities in medical access and in salaries.

Other dangers involved in the use of telemedicine include violation of the principle of autonomy, informed consent and medical confidentiality (see below). However, the core issue is the absence of a direct, unmediated connection between the physician and the patient. While the disadvantages described above can be mitigated by the quality of the infrastructure, legislation and regulation, the damage to the physician-patient relationship is inherent in this method and harms the quality of medical treatment. Assuming that the damage to the physician-patient relationship cannot be repaired completely, the focus should be on minimizing the damage and its adverse effects.

Treating a patient without direct contact diminishes the human connection in the physician-patient relationship. This is particularly evident and significant in primary medicine. This may not only be detrimental to the fabric of interpersonal relations, empathy and support, it may also become a source of mistakes and disruptions in diagnosis and treatment, and in coordinating expectations. The dramatic decrease in non-verbal communication, and in listening to and examining the patient, detracts from the quality of medicine.

The foundation of any medical treatment, especially primary care, is the close connection between the physician and the patient. A deep mutual commitment develops between empathetic physicians and the patients who expose their body and soul to them. This connection grows from the unmediated meeting between the physician and patient.

The damage can be minimized by stipulating the need for an initial, direct meeting, along with other meetings as the need arises, in accordance with the medical field or medical problem, and with the assistance of a person close to the patient (spouse, relative, etc.) in appropriate cases and with the patient’s consent.

From the physicians’ perspective, a change in the system of employment could lead to their exploitation by service providers, employers and patients, creating a situation in which they provide services without suitable remuneration.
Patient autonomy

Patient autonomy

Autonomy means that patients have the full right to freely and independently make decisions regarding the medical treatment offered to them. Medical consent should be given based on medical information conveyed to the patient by the physician in an honest, transparent, reasonable and balanced way. Autonomy also means the patient’s right to refuse or reject medical advice without having it forced upon them. Respect for the patient’s independence means guarding every person’s human dignity, privacy and medical confidentiality.

The two foundations – informed consent and medical confidentiality – are particularly critical in telemedicine.

Informed consent

Informed consent is built on two levels: First, informed consent is required to receive medical treatment via telemedicine. Second, informed consent is required for the particular consultation or treatment the patient is offered. The patient’s general consent to receive treatment via telemedicine must be given in advance via the entity responsible for the technological system being used, as is customary with other electronic means and applications. Even after giving such general consent, the patient should be allowed to opt out of particular fields, excluding them from the use of telemedicine. Certain issues may also be specified as requiring additional informed consent before using telemedicine to address them.

It would be appropriate if the entities facilitating this consensual discourse allow for selective informed consent for each physician, or for a distinct medical field (for example: informed consent in principle for telemedicine in the field of internal medicine, the field of gynecology, the field of mental health).

The HMO, hospital, medical institution and entity responsible for their telemedical system are required to receive the patient’s informed consent to use telemedicine and to secure the information transferred in the system, in order to enable physicians to conduct an open dialogue with the patient and contribute to the quality of the care provided.

Regarding the patient’s informed consent in each specific case, the physician must also receive the patient’s informed consent for treatment when using remote health services, as customary.

Medical confidentiality

There is a formal distinction between physicians active on the Internet (in its medical-communications aspects) on their own initiative, and physicians whose workplace offers or requires such activity as part of its routine work. In both cases, the physicians are obligated to protect medical confidentiality. According to the rules of ethics, a physician must refrain from providing medical advice or transferring medical information via online communication that is not protected by a computer security system commensurate with the sensitivity of the medical information.

Thanks to the dynamic improvement of information protection systems on the Internet, physicians participating in a dialogue at their workplace (HMO, hospital or other medical institution) that requires or allows this, can trust the reliability of the system offered to them as a platform for online medical dialogue. This assumption requires the employers to take the initiative and responsibility for providing optimal protection against the leakage of unsecured information and to continually update these protection mechanisms.

This fundamental requirement – maintaining the rules of information security and using secure systems when providing remote treatment – is also incumbent upon physicians who are independently active.

Confirming the patient’s identity

Before providing consultation or treatment, the identity of the caller must be confirmed. This may be done via the electronic system being used or in some other way – for example, through the physician’s prior personal acquaintance with the patient or by confirming identifying details.

Physicians who are active on the Internet of their own initiative (and under their full personal responsibility) with unfamiliar patients, and not via regulated entities, should be cautious about the caller’s uncertain identity, as well as the incomplete background and information they receive. Physicians should consider the need to provide a personal and individualized medical response while carefully guarding medical confidentiality and the type of information; they should consider providing consultation only after the patient signs a waiver of medical confidentiality. Physicians should refrain from taking responsibility and becoming involved without receiving signed consent in advance.
Involving a patient’s significant helper in telemedicine

Patients often are assisted by a family member, caregiver, dear friend or other close and significant person, whom the patient trusts. Relying on such persons and receiving their assistance are the foundation for early release from the hospital, lower hospitalization loads and a growing transition to home care.

Telemedicine can serve as a basis for home medical care, as part of the reduction of the burden entailed in hospitalization. Transferring patients to their natural surroundings is easier when there is an accessible connection between medical personnel and the patient/significant people close to him.

A “smart” home with devices like signal sensors and treatment reminders may create a burdensome medical environment in the home of patients and their families and violate their privacy. However, home hospitalization has advantages in comparison to staying in a medical institution.

When receiving assistance from a person close to the patient, it is important to avoid violating the patient’s own privacy or medical confidentiality. The patient’s consent is required for sharing medical information and details with a family member or significant helper. The patient, of course, should be allowed to retract this consent at any time. Physicians should also remember that many patients do not want to share their medical affairs with others.

Physician autonomy

The expanding information bandwidth provides space for various levels of accuracy, bias, availability of sources, forms of expression and presentations at different levels of understanding.

The expanded availability, diversity and amount of information create built-in asymmetry between the obligations of physicians engaged in telemedicine with their patients and the latter’s expectations of the physician responding/conversing with them.

In addressing the question of the obligation to respond remotely to a patient and the physician’s ability to do so, we distinguish between patients familiar to the physician and other patients. The distinction is necessary because this obligation is affected by the physician’s familiarity with the medical file, continuation of treatment and commitment to respond. In the case of a one-time virtual consultation via the Internet, these factors are not always at play, and physicians (while acting within the bounds of knowledge) may be limited in their ability to provide ongoing consultation and individualized investigation via telemedicine.

This is attributable, in part, to the patient’s reliance on a small amount of information, in comparison to the physician’s broader perspective and the scope of information the physician analyzes when responding to the patient’s call.

Physicians may face an intolerable burden in responding to calls on medical problems that are not handled, in their view, in the appropriate medical method. Repeated calls and a variety of responses create a “dialogue” between the physician and the patient that is not necessarily led by the physician, and is sometimes a response to fears, questions and the desire to “receive a full picture.”

In an ideal world, where free time and patience are suitably rewarded and limitless, such dialogue would improve communication and educate the patient in light of the ability they attribute to the physician as a source of information and, in particular, as someone who filters the information, choosing what is most relevant for the individual patient.

In reality, which unfortunately differs from the ideal world, physicians must guard their autonomy to choose which calls to answer, in which timeframe, at which level of urgency, according to which priorities and frequency. As always, the physician should be able to suggest a face-to-face visit.

Telemedicine has the potential for offering the patient virtual availability 24/7. Therefore, it is important to clearly define boundaries — that is, the hours when calls are answered, the types of calls that are answered and the patients for whom telemedicine is appropriate.
In this document, we do not set arbitrary, uniform and sweeping rules. Instead, the emphasis is on the importance of setting rules based on transparent criteria, leaving room for the physician’s discretion in accordance with his or her availability, the specific circumstances and the particular patient.

Physicians are entitled to discontinue telemedical treatment, at their discretion, if they determine that the remote treatment or consultation compromises the quality of treatment provided to the patient. In this framework, physicians should also take into consideration the extent of their previous acquaintance with the patient and the patient’s medical history.

When appropriate, at their discretion, physicians may refer the patient to undergo a face-to-face examination.

Physicians will exercise their discretion in deciding whether a case or topic they face is suitable and worthy of telemedical treatment or consultation.

Physicians should not be obligated or compelled to use telemedicine against their will or professional opinion.

Interactions

Medical dialogue via the Internet should be considered a part of modern life today, and its advantages outweigh its disadvantages. Nonetheless, it is essential to maintain criteria that enable telemedicine to be adopted as a work routine.

The patient is entitled to make a telemedical call on any matter. Clearly, this sweeping permission allows for a mix of calls on medical issues (urgent and routine) and administrative matters, as well as superfluous calls.

It should be noted that there is a hierarchy of treatment quality, ranging from a virtual dialogue to a face-to-face visit with the patient. Physician-patient meetings can be viewed as a pyramid: The broad quantitative base represents the virtual connection between physician and patient, while the real meeting in the physician’s clinic is at the top of the pyramid.

In contrast to a routine, face-to-face visit, which requires a deliberate effort by patients and thus expresses the value they attribute to it, patients may attribute less value to a virtual visit since it is so easy to initiate – just a few clicks. Therefore, the physician should monitor the attention and time he devotes to this method of communication.

Since medical activity via telemedicine is already being assigned to physicians as part of their routine work, they should allocate a structured unit of time for this method of communication.

The allocation of time for this unique objective warrants suitable remuneration in itself.

Documentation

Orderly documentation of telemedical consultation and treatment is required as part of the patient’s medical records. This documentation is also very important for providing proper continuity of treatment to the patient.

Distributive justice in telemedicine

Distributive justice is based on equality of opportunities and fair standards that foster high-quality medicine, which is available and accessible to the population in an efficient way.

A medical system is fair when no one is rejected from receiving treatment due to religious affiliation, gender, age, geographic place of residence, etc., and when medical care is provided at a satisfactory level of quality, within a reasonable timeframe, without exorbitant costs.

The central problem in distributive justice is how to divide the resources in a reality of constant shortage: between the center and the periphery, between preventive and therapeutic medicine, between the medical and paramedical teams, and between costly specializations and inexpensive treatment.

The same questions pertain to the use of telemedicine. In addition, when discussing home-based telemedicine, questions arise concerning the relations in the household – regardless of whether the household consists of a biological family.

In Israel, the National Health Insurance Law of 1994 establishes the right of every person to receive medical service. However, since access to high-quality health services is no less important, there may still be inequality.

Internet and telemedical systems can help to reduce geographic disparities and mobility problems.

Quality means not only avoiding mistakes; it also means professional medicine characterized by compassion and respect. There is concern that these components may be compromised in telemedicine as part of the detrimental impact on physician-patient relations.

Availability and accessibility in distributive justice means that individuals and populations will receive needed medical services without incurring an excessive financial burden, such as the need to purchase computers and Internet services and an additional cost for this service.

In a reality of home-based telemedicine, equality of opportunities may require regulation enabling online access for everyone (with special attention to special population groups, such as ultra-Orthodox Jews, the elderly and the incapacitated). Affirmative action should also be considered for the poor or for those living in the periphery. Furthermore, there is a need to overcome the “digital divide” separating those who are proficient in the use of digital technology from those who lack this proficiency (although the scope of this problem is decreasing).
In a reality of chronic shortage of resources, efficiency is a key tool. It is essential to minimize waste, errors and the duplication of services by physicians treating a patient. The use of online services can reduce such waste by coordinating and managing data. On the other hand, we should be aware that errant management may result in repeated calls and duplication of treatment.

As in any ethical discussion, conflicts may arise in telemedicine between the important principles of distributive justice – fairness, efficiency, quality, availability and accessibility. For example, availability and accessibility may conflict with quality. That is, the significant improvement in access to medical services and medical information provided via online services may come at the expense of quality, privacy and the physician-patient relationship. Despite the great availability of information for patients, the reliability and relevance of the information may suffer.

Nonetheless, in situations of limited medical services or complete lack of medical services, patients can enjoy the advantages that telemedicine offers, whenever this type of treatment is possible and appropriate.

Training, standards and guidelines

Training, standards and guidelines

The goal is for physicians who engage in telemedicine to have undergone dedicated training for it. Such training requires time and resources, and this must be taken into account. In light of the fact that telemedicine is already operating, and considering the large number of physicians engaged in this field, it might take some time to fulfill this goal.

There are already guidelines for telemedicine in some fields, and physicians should adhere to them. Additional guidelines are needed for all of the other pertinent fields, with an emphasis on emergency medicine and primary medicine.