Telemedicine Could Reduce the Role of Family Physicians to Case Managers

Ruth Kannai, MD[1]
Aya Rice (Alon), MA[2]

[1]Department of Family Medicine, The Haim Doron Division of Community Health, Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel

[2]Department of Counseling and Human Development, Haifa University, Haifa, Israel

ABSTRACT

The COVID-19 pandemic led to the widespread and continuing use of telemedicine in primary care. Despite telemedicine's benefits, it threatens to reduce the role of family physician to that of gatekeeper and case manager, nullifying decades of experience and medical intuition that is more difficult to develop and apply virtually. Additionally, many values of family medicine have eroded during this global process. The narrative presents 3 vignettes that illustrate different ways in which we contend with this complex issue. The challenges presented by telemedicine require us to re-examine our professional and personal values such as maintaining the centrality of the therapeutic relationship with patients. The greatest concern, however, relates to the future of the profession and the ability of new family doctors to overcome the challenges of telemedicine in an increasingly digital world.

Ann Fam Med 2024;22:63-64. https://doi.org/10.1370/afm.3049

At the height of the COVID-19 pandemic, an empty and quiet clinic awaited me each morning with a list of "telephone appointments" and written requests. The health maintenance organization (HMO) in Israel where I have worked for the past 25 years as a family physician has adopted a digital platform called Al-Tor. Patients are given the option to come into the clinic or request a telephone appointment. They are also given the option to send in written requests. Although the height of the pandemic is behind us, the use of telemedicine has remained quite prevalent. Nearly one-half of my daily caseload remains virtual; nearly half of these virtual conversations end with my suggestion to come in for a physical examination.

One such request comes through. A mother requests a referral for her child, aged 14 years, to a dietician, not stating a reason. When I ask, the mother immediately replies: "Moran is not eating anything." "Make a frontal appointment," I respond.

Moran's case represents perhaps the most complex issue that I fear may be lost through telemedicine: the uncovering of mental health issues. The conversation with Moran and her mother about her very apparent eating disorder could not have transpired virtually. Meeting Moran and her mother underscore for me the gnawing understanding that telemedicine simply cannot replace the traditional tools of a face-to-face clinical meeting.

Moran and her mother arrive at the appointed hour. "Moran eats nothing" is not a metaphor. She has been starving herself for 6 months and lost her menses 4 months earlier. She is wearing a huge sack-like dress many sizes too large and with a flat glare she describes herself as "fat as a cow" and wants to meet a dietician to discuss with her which is better: lettuce or kohlrabi. I sadly sigh and begin the difficult conversation about her dangerous eating disorder. I measure her blood pressure, electrocardiogram (EKG), and weight, and refer her for a broad range of blood tests. I search for hints of some kind of abuse, either at home or at school. I discuss the need for a multidisciplinary team of practitioners. An hour goes by. We will meet again in 2 days, after the test results and the initial assessment. "I just asked for a referral to a dietician," says Moran's mother as we part at the door. "Look what you opened up." She is overwhelmed, yet thankful for our in-depth meeting.

And yet, I believe that with careful attention and a willingness to continue reaching out to our patients, this platform can still enable good care from afar. One such case is Shira. Shira sends a simple request through the Al-Tor system: she has an

Conflicts of interest: authors report none.

CORRESPONDING AUTHOR

Ruth Kannai
Giv'at Yeshayahu 144
9982500, Israel
rkannai@gmail.com

eye infection and requests a cream for it, and, "Since you're already writing, can you also prescribe an antibiotic cream because I have this pimple on my forehead." A moment before typing her prescriptions into the computer and moving on, I decide not to succumb to tedium or complacency in responding to electronic requests, and I call Shira. I reason, Shira is 45 and acne is not very characteristic at this age. I gather more history—she complains of pain in her left eye, which is slightly red, and above the eyebrow of the same eye she notes the pimple that suddenly appeared. "Please send me a photograph," I suggest, and offer her my private telephone number. Shira sends a photo, and we switch to a close-up video call on my telephone. I see a red and painful eye, a vesicle or perhaps 2 above the eyebrow. "I think you should go to the emergency room (ER). I think you have herpes zoster in your eye. This is an ailment that must be rapidly addressed, to avoid potentially irreversible damage to the cornea," I explain.

Despite anxiety about going to the ER, Shira understands the danger and goes. The diagnosis of herpes zoster is confirmed, and she is hospitalized. She receives medical care on time and her eye recovers. It was lucky I asked to transfer to a video call. It was lucky I did not simply prescribe an eye ointment and rush on to my next task. Was it luck? A real visit, of the old kind, in the clinic, would have evoked such a suspicion among any reasonable doctor. This emphasizes the need for clinical experience, intuition, and careful (also implying "care-full") attention when using telemedicine.

Another example of careful telemedicine is that of Ayala whom I have known since infancy. Born prematurely at 25 weeks, Ayala began her life in Pediatric ICU, contending with a myriad of challenges. Despite this inauspicious beginning, she survived and is a successful paramedical professional and mother. I am proud to care for such "grandchildren"—infants of parents who were my patients during their own childhood. Ayala's 4th son has infantile asthma. Every virus disrupts his respiratory system, leading to repeated hospitalizations, steroids, and oxygen treatment. Ayala has mastered all the medical terminology and usually remains unstressed. However, she now recognizes clear criteria for going to the ER. She asks me via the digital platform to prepare a referral for her. She lives in a distant village, a half-hour drive from the clinic. It is not easy to drive with a wheezing baby in the back seat. "Maybe I will see him, just for a bit, before I refer you to the ER," I suggest. Because she knows and trusts me, she agrees. Soon after, Ayala and her baby Ron arrive. Ayala's diagnosis is correct. Ron's wheezing can be heard even without a stethoscope, and his stomach and chest rise and fall rapidly. Reassuringly, during his physical exam, his air intake is good, and with some effort I am able to obtain a reliable and reasonably normal saturation check. Ron is alert and smiling, despite breathing "like a tractor" and even displays effective sucking. We advise by telephone with the lung specialist who is already familiar with Ron and with me, and after another inhalation treatment, we decide together a trial of oral steroids. We closely follow-up on the measures, which Ayala knows how to monitor. We agree to have a video call every evening and morning for a few more days, so I can see Ron's situation. The assessment in the clinic, together with the intensive monitoring from home, prevent his hospitalization. Through the cooperation of a mother, a family doctor, a specialist, and a happy wheezing baby we were able, other than the single office visit, to care for him at home.

Despite its benefits and efficiency in many cases, I have deep concerns about telemedicine. It threatens to reduce my role of family physician to that of gatekeeper and case manager, from a purely bureaucratic sense, and it threatens to nullify decades of experience and medical intuition that is so much more difficult to apply virtually. Additionally, many values of family medicine have eroded during this global process: shared decision making and the use of motivational interviewing, particularly its ability to encourage lifestyle changes. In face-to-face meetings I can identify issues the patient does not directly present—particularly relating to mental health issues, life crises, and violence. These issues do not easily present through telemedicine and over the years I have found my office to be the first place where such important issues have surfaced. Furthermore, the ease with which patients can request referrals and prescriptions through telemedicine can cause over diagnosis and over treatment.

The challenges presented by telemedicine invite us to re-examine our professional and personal values. For me, this means reaffirming my belief in the centrality of the therapeutic relationship with my patients and is a call for continued insistence on more traditional means of assessment. It has also sharpened my intuition, which now needs to "see through" and question seemingly simple requests. It has been a call for continued alertness and careful practice, and to not succumb to complacency, which the ever-increasing workload and the ease with which virtual requests may be answered may invite.

It requires clinical experience and a willingness to continue reaching out to our patients to overcome some of these shortcomings. Yet over time, and with increased use of virtual medicine as standard care, this expertise may not have the chance to develop, and these interpersonal values may decline. Family doctors may become both increasingly estranged from their patients, as well as less experienced due to less frequent contact with actual patients.

Telemedicine will continue to be a part of our lives. How we contend with this issue as family physicians requires renewed commitment to the interpersonal values underlying our profession and a greater reliance on our accumulated clinical experience. These 2 fundamental components must be emphasized as we train and develop caring and effective family physicians in an increasingly digital world.

Read or post commentaries in response to this article.

Key words: telemedicine; patient safety/medical errors; primary care issues: continuity of care; primary care issues: clinician-patient communication/relationship

Submitted February 27, 2023; submitted, revised, August 6, 2023; accepted September 19, 2023.