

Topic	Speakers
Overview and Introduction	Anne Suskind Anobel Odisho
Ethical considerations in determining which conditions are suitable for telemedicine	Antonella Giannantoni Roger Dmochowski
Ethical considerations around which patients are and are not suitable for telemedicine, including understanding of technology and cognitive/sensory impairments, and how to potentially bridge this gap	Martha Spencer
Panel discussion - this will be interspersed throughout the schedule	Anne Suskind, Anobel Odisho, Antonella Giannantoni, Roger Dmochowski, Martha Spencer

Aims of Workshop

In response to COVID19, care delivery and regulatory changes have rapidly accelerated trends in digital transformation across all industries, including healthcare. Among the most impactful changes is the fast implementation, adoption and expansion of telemedicine for healthcare visits. This workshop will focus on the ethical considerations surrounding the use of telemedicine for incontinence/pelvic health care. It will provide an overview of the international telemedicine landscape and will explore which pelvic floor conditions and which types patients are well-suited for this modality.

Learning Objectives

1. To gain a better understanding of the international landscape of telemedicine and its ethical implications.
2. To explore the ethical considerations when determining which ICS conditions and which components of the patient evaluation are suitable for telemedicine.
3. To explore the ethical considerations around which patients are and are not suitable for telemedicine, including understanding of technology and cognitive/sensory impairments, and how to potentially bridge this gap.

Target Audience

Urologists, Urogynecologists, physical therapists, nurses and any healthcare professionals caring for individuals with pelvic floor disorders.

Advanced/Basic

Intermediate

Course Description

Overview and Introduction

Digital health was first defined in 2000 by Seth Frank as “the convergence of health care and the internet”. Now 20 years later, constant connectivity and the COVID-19 pandemic has dramatically reshaped health care delivery. While telehealth utilization was slow at first, the public health emergency forced us to rush headlong into telehealth, without time to consider ethical issues. Primarily, leaders and practitioners must consider the quality of care being delivered and if care is being delivered equitably.

During the COVID pandemic, telehealth visits increased from less than 5-10% to nearly 70% of outpatient visits, practically over a weekend in the United States. This was driven by necessity and enabled by relaxation of reimbursement policies. The first portion of this workshop will describe trends in telehealth utilization, the telehealth landscape, and the spectrum of virtual care opportunities. These include modalities like video visits, eVisits, electronic consults, and virtual check-ins.

We will then discuss current quality metrics to monitor telehealth outcomes and opportunities for research and quality improvement. Future work is necessary to define quality outcomes and patient satisfaction from video visits, and which patient conditions are amenable to video visits. And now that patients have the option of either in-person or video, will high telehealth volumes persist?

Despite the interest in telehealth, there are many barriers to equitable access. Technological barriers include challenges with devices, adequate bandwidth, and technological literacy. Patients in rural areas, lower socioeconomic status, with limited English proficiency, and in lower/middle income nations may be disproportionately impacted by these issues.

Telemedicine offers efficient and versatile options for patient care in the post-COVID era, but we must ensure we are providing high quality, equitable care. After this session, attendees will better understand the current state of telehealth delivery and how to ensure they are working towards higher quality, more equitable telehealth care delivery.

Ethical considerations in determining which conditions are suitable for telemedicine

Telemedicine has been around for decades, nevertheless, the uptake of these services has remained low despite the myriad of reported benefits. However, coronavirus pandemic is putting telemedicine into the spotlight. What lessons have we learned from virtual medicine application specifically in Female and Functional Urology? Available data show that ideal candidates for telemedicine services are established patients not requiring a physical examination. However, new patients appreciate establishing a relationship with a physician, even before an in-person visit is possible, and may benefit significantly from non-surgical treatment options. In addition, patients can replace their scheduled preoperative visit with a virtual discussion of alternative therapies. Urge, stress, and mixed urinary incontinence can be discussed and treated with telemedicine, with behavioural therapy and PFM rehabilitation programs being the major fields of discussion and/or treatment. Incontinent women demonstrated significant improvement and/or complete resolution of their condition along virtual follow-up. Smartphone applications (apps) can be used to help teach and track Kegel exercises. Some evidence shows that postoperative females after mid-urethral slings with no symptoms of UI or after native tissue pelvic organ prolapse (POP) repairs can be appropriately assessed with virtual follow-up, with high levels of satisfaction and no increase in adverse events, emergency room visits, or primary care visits. Nevertheless, postoperative patients with UI, and those after mesh surgery for POP correction require in-person visits, to both adequately assess types of UI and presence of mesh erosions in asymptomatic patients. With regards to treatment of urinary tract infections (UTIs), telemedicine allows to prescribe empiric antibiotic therapy, which appears to be effective, and it lowers costs. But this seems to result in more prescribing and therefore may negatively impact antibiotic resistance. Telemedicine can be also used in the routine management of patients affected by neurogenic bladder, with evidence in helping monitor physiologic parameters to reduce UTIs in this population. Given these limitations perhaps a distributive access to testing (such as urinalysis and urine culture, and post void residual determination) may further enhance and direct telemedicine indicated options.

Despite all these benefits, also in the field of female and functional urology, critical elements of transitioning to telemedicine are represented by maintaining trust, privacy and information-sharing that occur between health-provider and patient. The few available information, coming from females affected by pelvic floor disorders, indicate that virtual visits can provide similar patient satisfaction, as in-person visits, by building strong therapeutic relationships with patients through education, active listening, and shared decision-making. However, we currently lack validated questionnaire assessing patient satisfaction with telemedicine care; no clear guidelines exist on the use of telemedicine in the field of female and functional urology; finally, no information exists about patients trust in telemedicine in our field of application. Again, several questions remain open, particularly for elderly patients: which kind of virtual visit or technology platforms are most useful for them? How to avoid potential inequality linked to different Internet availability and economic resources? Do other access options function as alternatives, such as simple mobile phone or even electronic mail interaction?

Evidence of Telemedicine benefits in female and functional urology seems to require more extensive research, particularly aimed at standardizing methodologies, both from a medical and ethical point of view.

Ethical considerations around which patients are and are not suitable for telemedicine

Although telehealth has been an invaluable resource during COVID, it is not suitable nor acceptable for all patients. Firstly, it may disadvantage those of lower socioeconomic class who do not have access to the required technology. Similarly, some older adults may not have the availability or familiarity to technology to partake in certain types of virtual visits. In both of these cases, the ethical principle of justice is jeopardized as delivery of care is not equal among all possible recipients. Virtual visits may also not be feasible for those with significant hearing impairment for whom telephone and video formats may make it challenging for the patient to fully participate in and understand the conversation. This is especially true for high-stakes conversations such as obtaining consent for a procedure or breaking bad news. Those with cognitive impairment may face similar challenges interacting with technology in a meaningful and for some, this may cause increased anxiety or fear. In those with both sensory and cognitive impairment, confidentiality will be lost if a caregiver or other support needs to be present to act as a moderator for the appointment. Additionally, patient autonomy may be sacrificed if a caregiver or other support is required to act as a surrogate decision maker for those who are unable to engage with telehealth.

As telehealth technology is likely here to stay in some capacity, it is important that patient barriers to telehealth be addressed so that we don't further disadvantage vulnerable patients and communities. As the pandemic slows, it is important to return to a focus on what works well/best for the patient instead of what is most convenient and cost-effective for health care providers. Ensuring that patients can be fully engaged in discussions around their health is a basic right of all patients and should always be our top priority when deciding on visit modality.