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Ethical Considerations of Telehealth: Access, Inequity, Trust, and Overuse

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WHAT IS TELEHEALTH?

In today's U.S. healthcare context telehealth is expanding. The World Medical Association defines it as "the practice of medicine over a distance, in which interventions, diagnoses, therapeutic decisions, and subsequent treatment recommendations are based on patient data, documents and other information transmitted through telecommunication systems" (World Medical Association, 2018). Moreover, "Telemedicine can take place between a physician and a patient or between two or more physicians including other healthcare professionals" (Wosik et al., 2020).

Telehealth was growing steadily for decades (Barnett et al., 2018) and then markedly accelerated during the early phases of the COVID-19 pandemic (Advisory Board, 2020; Kyle et al., 2021; Mehrotra et al., 2020, 2021; Wosik et al., 2020). As of July 2021, telehealth visits stabilized at 38 times the pre-pandemic levels (Bestsenny et al., 2021). As Conrad et al. write, "The U.S. health care system is attempting to improve health care access during the pandemic, and its primary strategy has been a rapid expansion of telehealth" (Conrad et al., 2020). The uptake varies across specialties and settings, but is fast becoming a mainstay in mental health care and chronic disease management—clinical areas that require frequent follow up, but not necessarily frequent physical exams (Mathieson et al., 2017; Sharma et al., 2021).

In this paper we explore how telehealth impacts trust building between patients and clinicians, consider how telehealth improves access and quality of care, and discuss the unintended consequences of exacerbating healthcare disparities and the overuse of healthcare (Lee et al., 2019).

The ethical framework that guides our reflection and critical assessment is a vision of health that is just, at the personal and social level, by allowing access to healthcare services to all those who need them; by promoting a quality of care that benefits patients, healthcare professionals, and the whole society; by fostering trust in healthcare interactions and in the overall healthcare system; by integrating public health dimensions, including preventative measures that address the social determinants of health as well as global health perspectives.

At the same time, in the case of healthcare systems, social justice implies sustainability. Hence, it is necessary to consider how telehealth increases or reduces cost and how trust in healthcare interactions and in the whole healthcare system might be affected.

ON TRUST

As Burgoon, Dunbar, and Jensen stress, "Regardless of discipline, most scholars conceptualize trust as entailing some level of risk, uncertainty, or willingness to be vulnerable, and that it creates an expectancy about future behavior since one must assume that a person, group, or organization will behave in a particular way" (Burgoon et al., 2021; Lewicki et al., 1998; Rousseau et al., 1998).

Both healthcare professionals and patients know well when they experience trust in a healthcare interaction and system (Tarrant et al., 2010). Patients feel heard, understood, respected, appreciated, cared, and helped. They know when can rely on their healthcare team to be at their service, committed to promote their well-being as much as possible. While trust does not eliminate the existing power

imbalance between patient and clinician, what prevails is a dynamic centered on alliance that does not reach the level of a shared equality, reciprocity, and mutuality, but that, nonetheless, promotes the patients' individual agency and well-being. Concretely, when trust is experienced, patients are less likely to second guess what the healthcare professionals suggested to them as a diagnostic follow-up, therapy, or life-style advice. An expert opinion might still be needed and searched for, but as the expression of a relationships informed by trust (Bennett, 2020; Sparrow & Hatherley, 2020). Trust neither implies dependence, nor a surrender of one's discerning abilities. Trust is always vigilant and critical.

On their part, when patients experience trust in their relationships with their clinicians, practitioners feel they are recognized and appreciated, as human beings and experts, in light of their knowledge and competence. They are confirmed in their vocation to promote health, well-being, and flourishing in their patients and within society (Thom et al., 2011). The important institutional and social role of healthcare professionals is reaffirmed and strengthened. As practitioners, they continue to examine their competence, and what they do to promote individual and collective health in the social fabric. At the same time, they are also careful in trusting their patients, collaborators, team members, and administrators by considering attitudes and dynamics that deserve critical assessment. Trust is a scarce and precious commodity that cannot be presupposed, but that can be examined and promoted (Shaughnessy, Vaswani, et al., 2017). Trust needs to be earned, time after time. Being well disposed to trust people, structures, and systems, as well as being open to be trusted, are helpful dispositions, but vigilance should be constant, because trust is a precious relational commodity. Moreover, trust is vulnerable and it can be hurt (Rogers & Ballantyne, 2008). It might be difficult to recover from losing trust in oneself and others, including healthcare systems and practices.

Finally, from systemic and structural points of view, both patients and healthcare professionals, acting with high levels of trust, might refrain from requesting and relying on extra or unnecessary diagnostic procedures and therapeutic treatments. In this way, they avoid further overstressing healthcare clinics, hospitals, and labs, and limit overspending. Hence, despite its elusive and fragile character, increasing trust within healthcare contexts could ultimately be beneficial in multiple ways—subjective and objective, relational and social, financial and organizational (Linzer et al., 2021).

Besides being a value in itself, trust facilitates deeper relational interactions, continuity of care (Loxterkamp, 2021), the quality of the services provided, and facilitates opportunities for cost containments. On the contrary, when trust is lacking, dissatisfaction, disappointments, and frustrations appear to dominate and compromise the experiences in healthcare settings as well as each one's striving for health—in the case of patients, professionals, institutions, or systems.

Whether one focuses on people or institutions, trust is built overtime. Making available more opportunities to interact with healthcare professionals and to build trust serves this purpose. Some authors propose the spiral theory of trust, which purports that "trust, once established, remains relatively fixed, but spirals over time to increase or decrease trust in response to the verbal and nonverbal behaviors of participants" (Burgoon et al., 2021). This functional approach, first allows to specify the key communication goals and desired outcomes (e.g., building trust, shared decision-making to include patients' values, and managing uncertainty) that need to be accomplished in order to have quality health care. Second, it embraces the notion that communication to build trust is essentially goal-oriented and aims at achieving communication outcomes that contribute to improving, or sustaining, a patient's health and well-being. Finally, such theoretical grounding helps predict how to reach the goals that have been identified.

How telehealth influences the quality of the interactions between patients and clinicians, and how it affects trust, is not yet fully known and is likely largely dependent on the frequency of visits, the context of care, whether the relationship is previously established and what is the level of digital literacy of both patients and clinicians. For example, on the one hand, some specialties, such as addiction medicine or mental health care, can require weekly visits, which enable relationships, and

therefore trust, to grow over time. However, on the other hand, in the setting of urgent care, where patients are present for more episodic illness, a telehealth visit may be more transactional and focused mostly on managing patient requests rather than engendering trust. Indeed, in some settings, telehealth visits are associated with less exchange of information than in person visits (Hammersley et al., 2019).

In both of these examples there seems to be high patient satisfaction because telehealth offers enhanced and increased access to care that does not necessarily require in-person encounters. High patient satisfaction with telehealth is correlated with high patient trust in clinicians (Orange et al., 2021). However, the impact of telehealth on trust in other settings is more ambiguous. In primary care, where longitudinal relationships are important and visits often require physical exams, telehealth may threaten the ability to build rapport, connection, and an implicit understanding over time. The loss of physical presence and less reliance on established patient-clinician relationship may be rendering primary care telehealth visits more transactional.

POSITIVE EXAMPLES

Data on telehealth are emerging to help determine which settings and specialties are uniquely compatible to telehealth and where telehealth offers substantial benefit (Evans et al., 2016; Fitzner et al., 2014; Hark et al., 2018; Josipovic et al., 2021; Lindquist & Erickson, 2018; Mack et al., 2007; Morrow et al., 2009; Olayiwola et al., 2011; Roh, 2008). As mentioned previously, the uptake of telehealth among mental health care clinicians is much higher than other specialties, which enabled nationwide psychiatric visits volume in the U.S. to remain stable during the initial stages of the global COVID-19 pandemic when visits dropped substantially in all other areas (Patel et al., 2021). Telemental health visits were up 556 percent within the Department of Veteran Affairs (Connolly et al., 2021) and 26-fold for outpatient psychologists (Pierce et al., 2021). The ability to maintain access to mental health care was critical during this period when the prevalence of mental illness rose dramatically (Cénat et al., 2021; Connolly et al., 2021; Holland et al., 2021; Wu et al., 2021; Zalsman et al., 2021).

Telehealth may be particularly helpful for a subset of mental health patients—i.e., those with opioid use disorder who require weekly visits to maintain pharmacotherapeutic treatment. Such patients often face financial and logistical challenges to sustain weekly in-person appointments and have come to depend on the convenience of telehealth visits. Studies conducted during the pandemic suggest that telehealth is effective at keeping established patients with opioid use disorder in treatment (Huskamp et al., 2021), may help new patients access treatment (Huskamp et al., 2021), and likely produce quality outcomes equivalent to in-person care (Mark et al., 2021).

For broader populations, telehealth offers convenience for routine issues, increases access for patients with mobility issues (Donaghy et al., 2019), reduces travel time to appointments for patients in rural areas (Mehrotra et al., 2017), decreases waiting time for specialist consults (Barnett et al., 2017), and reduces barriers to attend appointments for other at-risk populations (Dhalla et al., 2014; Ray et al., 2015; Reed et al., 2020). For these reasons, many clinicians are calling for permanent and expanded adoption of telehealth to address the shortage of care within rural and underserved areas.

NEGATIVE EXAMPLES

While telehealth clearly offers opportunities to improve access to care for some populations, it is important to consider the unintended consequence, in terms of who is left out and how telehealth may contribute to the overuse of healthcare systems. Even though telehealth is on the rise globally, rural and high-poverty counties are largely excluded from this broad adoption (Patel et al., 2021), due in part to limited bandwidth in these less-resourced areas (Lam et al., 2020). In addition, older patients are much less likely to use telehealth than younger patients (Donaghy et al., 2019). These dynamics interact to further widen the digital divide (Chang et al., 2021; Schmeida & McNeal, 2007) between rich and poor,

urban and rural, and consequentially exacerbate the same disparities in accessing healthcare (Hood, 2004; Pierce et al., 2021).

Telehealth is also at risk for potentiating the overuse of healthcare services in two ways. First, telehealth may generate higher volumes of unnecessary care, as a product of being a moral hazard. In other words, for some conditions, patients may seek telehealth care because it is easy and convenient where they would otherwise not seek care for an in-person visit because it is more difficult to acquire. There is some evidence that this is true for physical care visits as the vast majority (90 percent) of telehealth visits are adding to, rather than substituting for, in-person care (Ashwood et al., 2017; Mehrotra et al., 2017). Furthermore, there is a risk for telehealth generating low-value care, which is defined as excessive, unnecessary care that does not improve quality, but does increase costs and waste in the healthcare system (O'Reilly-Jacob et al., 2021).

Second, telehealth may delay care for serious problems—for instance, clinical exams during telehealth visits—thus reducing the capacity to detect subtle signs and symptoms of serious disease. Delayed physical examinations may lead to more intensive diagnostics later, thereby increasing resource utilization and unnecessary costs and potentially worse prognostics and outcomes. As delayed care during the pandemic continues to be explored (Czeisler et al., 2021; Czeisler et al., 2020), a better understanding on how telehealth either prevents or facilitates delayed care will emerge.

RELATIONSHIP SCIENCE AND HUMAN COMMUNICATION RESEARCH CONTRIBUTIONS

Research in relationship science and human communication brings explanatory frameworks and evidence for understanding the process of trust and relationship-building. Human communication skills involve capacity for relational human connection as a foundational skillset for structuring patient-centered (also known as relationship-centered) healthcare and an ability to reflectively integrate better communication tools and design more productive interactions over time (Duggan & Shaughnessy, in press). Communication skills first include creating and sustaining therapeutic relationships with patients for the purpose of diagnosis and (shared) decision-making to address the patient's needs. Necessary foundational communication competencies include building rapport, asking questions to obtain necessary information to diagnose symptoms, actively listening with empathy and openness to patient experiences, and coming to a (shared) decision about what comes next. Trust and relationship-building, the ability to move from "what's the matter" to "what matters" involves more than interpreting data in consultations and communicating the risks and benefits of diagnostic and management options for symptoms (Duggan, 2019). Uncertain evidence and the uniqueness of a patient's healthcare issues often make it difficult to identify the best course of care. Being able to and choosing to spend time on understanding what truly matters to patients when making decisions together is an achievement that makes the work of clinicians meaningful and rewarding (Pieterse et al., 2019). The flourishing of the "patient-centered" approach in patient care has enriched medicine by adding the recognition of the crucial part played by social, psychological, and relational factors in the process of medical care (Beach et al., 2006; Gulbrandsen et al., 2020).

Building trust is about *connecting with* patients. Negotiating an agenda with the goal of encouraging patients to identify what is most important to them is key; primary care providers should focus on what is actually most important to the patient (Sanders et al., 2020). Adopting a listening posture, without interrupting the patient, contributes to presence, to the purposeful practice of awareness, focus, and attention with the intent of understanding and connecting with patients (Cifu et al., 2020; Zulman et al., 2020).

Shared decision-making can be considered both a communication process and an outcome of the interaction. The literature on shared decision-making includes consideration of patients' views on treatments. Moreover, measures to address shared decision making have often been developed based

on an ill-defined underlying relational construct and many assess physician behaviors only by focusing on a single physician-patient encounter (Bomhof-Roordink et al., 2019).

After more than forty years of research and policy endorsement, adoption of shared decision making into routine practice has been remarkably slow. Honorary professor of evidence informed decision making Neal Maskrey blames a lack of focus on doctors' broader communication skills (Maskrey, 2019). He describes the scientific core values as rightly dominant in the medical curriculum but also points to the fact that healthcare is delivered within relationships, and relationships are formed and sustained by communication, not by hard science, evidence, or data (Maskrey, 2019).

Evidence based medicine (EBM) has formalized the scientific approach and a classic 1996 *British Medical Journal* editorial defined it as the incorporation of the best available evidence into the traditional consultation, using clinical expertise and the patient's views and preferences (Sackett et al., 1996). EBM provides a methodology for constructing systematic reviews and guidelines but has not tackled the challenge of how to best incorporate the evidence into individual consultations (Maskrey, 2019). As Gulbrandsen writes, "The complexity of shared decision making is under-rated. Doing it as an ethical duty (respect for autonomy) is not inspiring, particularly when patients don't seem to get the point or want to throw the ball back to the doctor" (Gulbrandsen, 2020). He continues, "Prescriptions and decision aids for shared decision making are biased towards balanced presentations of scientific knowledge with risks and benefits framed in numbers" (Gulbrandsen, 2020).

While communication advice provides broad recommendations, the vulnerability of illness brings an unanticipated aspect to patient understanding that requires understanding trust as emergent, as not yet fully formed in words (Duggan, 2019). Attentive and reflective capacity involves recognizing that intentions are not always within our cognitive ability to give words or to ask for what we want; we discursively produce and create our understanding (Shaughnessy, Allen, et al., 2017). Similarly, we produce and create moments of trust, or lack thereof.

ASSESSING TELEHEALTH

The opportunities, possible ambiguities, ethical concerns, and risks associated with telehealth should lead to promote high-quality healthcare. To recognize the importance of trust informing and improving relationships, structures, and systems can serve this worthy goal. Moreover, because social contexts and relationships matter, to reflect ethically on telehealth it is necessary to consider how this technology can benefit specific at-risk populations. Finally, while it is still unclear how telehealth influences trust between patients and clinicians, insights articulated by relationship science and human communication can inform both our critical reasoning and the process of understanding and addressing the inherently human desire to be seen.

To put it bluntly, in healthcare can we build trust and ensure high-quality care through a screen? Are we reducing the interaction to a set of transactions that seemingly achieve a goal but miss the nuanced complexities of trust and relationship-building? To answer, we need to define how we use telehealth in the context of patient-clinician relationships. First, settings that rely on established and ongoing relationships may be well suited for telehealth—as we indicated by describing the follow-up of physicians with their well-known patients with substance use disorders. In this case, regular and frequent screen encounters continue to enrich the existing relationship. Second, follow-up visits to communicate test results after in-person exams could be another example. However, it is quite different to think about an initial encounter with no previous interaction or, as was happening decades ago, a triadic model—with the patient and the nurse in a room and the physician connected via telehealth (Guzley et al., 2002). Third, telehealth could also be used in case of a first-time visit, which could lead to further developments that will require in-person interactions.

In each one of these three examples communication skills and training informed by relationship science help in creating conditions that might protect, facilitate, strengthen, and expand trust. On the

contrary, limited communication capacities, and contextual factors that might intervene (e.g., lighting and audio quality, physical locations, bodily postures, voice pitch and volume, and language barriers) further compromise any attempt to establish meaningful and nourishing reflexivity about communication patterns indicative of patient values beyond what is being explicitly stated. These communication qualifiers—together with all non-verbal factors and cultural influences that intervene in framing any relationship (e.g., bodily postures and bodily cues, lived experiences and how they influence personal behavior and interactions, gender dynamics, relational biases, and cultural phenomena)—can promote high-quality healthcare interactions.

In case of *healthcare professionals and institutions*, it is necessary to examine how telehealth might improve, modify, or affect relationships with consequences—whether beneficial or ethically problematic—for the persons involved as well as for the institutional practices. An implicit presupposition is that the complexity and difficulty of interactions in healthcare benefit greatly from personal encounters that, ethically, could be defined as virtuous. In these relational contexts, the other is encountered in ways that foster mutual and reciprocal understanding, promote care and well-being, and satisfy both patients and healthcare professionals. As we indicated above, the opportunity offered by telehealth could be at the service of ongoing relationships in healthcare settings by maintaining trust and even expand it in time.

Focused training, centered on communication and ethics (Kaplan, 2016), could help *healthcare professionals* to examine the multiple relational dimensions engaged in healthcare praxes and practices, to identify possible improvements aimed at enhancing and strengthening the quality of their interactions in healthcare settings.

Both in case of in-person interactions or encounters mediated by telehealth, *patients* should experience that they can place their trust in professionals and healthcare institutions without fear of being deceived (Subrahmanian et al., 2021) and betrayed, or without risking that their trust is used for different purposes than their well-being and the promotion of health in society. Trust should not be abused to pursue corporate interests, sheer financial gains, or fame.

For *patients*, their self-reflective abilities and their ethical discernment, as well as their relational strengths and limits, should help them to critically examine their relational engagement, as well as what could foster interactions that depend on well-placed trust and that promote it.

REGULATING TELEHEALTH

The COVID-19 pandemic created a remarkable opportunity of disruption to rapidly test the effects of telehealth on access and quality and costs. Emergency provisions were implemented across federal and state governments to reimburse telehealth for many different kinds of visits (Volk et al., 2021). Additionally emergency rules enabled clinicians to provide telehealth across state lines with the aim of reducing geographic maldistribution of providers. These provisions have proven enormously helpful during the public health emergency, but it remains to be seen to what extent the expansion of telehealth will be permanent.

There are signs that the support will continue. Increasing broadband access in rural communities was an important part of the Bipartisan Infrastructure Deal and is intended to reduce disparities in access (White House, 2021). The Centers for Medicare and Medicaid will continue to reimburse telehealth through 2023, at which point they will re-evaluate whether telehealth should be permanently included in the Medicare program (Centers for Medicare & Medicaid Services, 2021). During the COVID global pandemic twenty-two states implemented laws to require insurance companies to cover telehealth visits (Volk et al., 2021). Now, states are actively debating how telehealth should be reimbursed and regulated. As telehealth is more rigorously studied and specific efforts are made to ensure that quality is not compromised and costs do not rise, telehealth will become, to some level, a permanent and integral part of the U.S. healthcare system.

TO PROMOTE TRUST, ADDRESS INEQUITIES

Besides what policy makes possible, to promote trust within healthcare institutions increasing efforts to address existing inequities are urgently needed. In other words, the implementation of telehealth is a new opportunity to foster a more inclusive social justice in healthcare.

As we indicated, trust is vulnerable, limited, bound, and provisional, always requiring confirmation, validation, and protection. Constitutive elements of one's personal and social location, history, culture, and religion contribute to create the conditions for trusting relationships and dynamics in healthcare settings. However, these factors can also inhibit and hurt one's possibilities of experiencing and nurturing trust. Such a fragile and contextual understanding of trust requires recognition, acceptance, and proactive engagements to foster and strengthen it, whether in relational settings—between patients and healthcare professionals—as well as in institutional interactions and arrangements and in social contexts. The continuing racial discrimination and the ongoing social inequities in health access exemplify how it is wrong and harmful to trust when people are socially discriminated, excluded, and marginalized. When reflecting on telehealth, to focus on trust allows us to consider and examine the multilayered factors that intervene in shaping, strengthening, or inhibiting trust. We are also compelled to find ways to address these social determinants of health to promote health in just and inclusive ways.

We stressed how significant are *constructive communicative strategies* that foster trust and that depend on human capabilities to reflectively engage, to care, and to be cared for, and how these strategies frame one's personhood as well as institutional dynamics. At the same time, attention to existing social inequities, which demand intervention and reform, invites to examine how the possibility of trust is burdened by unjust social and political determinants. Patients, as well as healthcare professionals and institutions, suffer because of these inequities. Constructive and successful attempts to address and change these inequities are feasible and very successful in promoting justice, well-being, health, and in creating relational, institutional, and social trust that promotes health exponentially (Hughes et al., 2021).

Relational aspects of trust are not disconnected from the structural systems in which relationships occur. In Boston, the commitment of the Boston Medical Center to offer low-income housing to unhoused people recognizes this context and exemplifies an approach that potentially addresses profound social inequities; promotes health; strengthens trust between citizens, healthcare professionals, and administrators; expresses trust in social arrangements to address health needs; and drastically reduces reliance on expensive, repeated, and frequent demand of emergency services when people do not have stable access to their own housing (Boston Medical Center, 2021). Hence, healthcare institutions can contribute to address structural and systemic factors that cause social hardships. In doing so, these institutions foster trust in the commitment of healthcare professionals to care for people in need; increase the citizens' trust in clinicians and providers; improve social living conditions; reduce healthcare expenditures caused by relying primarily or even exclusively on the services offered by emergency departments; and, finally, contribute to foster social trust.

We argue that a critical attention given to promoting trust in healthcare relationships—including telehealth—as well as in institutional and social contexts, encompasses relational, structural, and systemic approaches. The benefits experienced and expected concern the quality of the healthcare interactions as well as of the services provided, including reduced overblown diagnostic costs and avoiding overburdening the healthcare systems with procedures motivated more by lack of trust than medical needs.

CONCLUSION

In the U.S. healthcare system, the increasing reliance on telehealth that occurred during the COVID global pandemic is part of a progressive expansion of telehealth services. We discussed examples

showing how using telehealth can be beneficial for patients, clinicians, healthcare institutions and systems, and, at the same time, how attention should be given to ways in which telehealth can exacerbate existing inequities. Furthermore, we stressed how the ethical assessment of telehealth invites us to consider anew how trust is integral to healthcare relationships and how studies in health communication contribute to critically examine what promotes and inhibits trusting interactions.

Further interdisciplinary research should expand the scope of the inquiry regarding telehealth uses—in the U.S. as well as internationally, in the Global North and in the Global South. Critical assessments should examine how telehealth contributes to offer services in ethically sound ways that contribute to promote the quality of care offered to all citizens—particularly those in greater need and more vulnerable compared to the rest of the population—and to strengthen trust in healthcare interactions as well in the whole healthcare system. A vigilant and constructively critical approach could lead to focused uses of telehealth that integrate and renew healthcare practices between care recipients and providers as well as structurally and systemically.

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