Prohibitions on long distance treatment: Historical roots and continuities in limiting the use of electronic telemedicine

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Many jurisdictions restrict the treatment of patients at distance via telemedicine. The article reviews the origins and justifications behind the limitations.

Keywords: eHealth, health law, prohibition of long distance treatment, telemedicine

INTRODUCTION

One of the advantages of telemedicine is its capacity to overcome the physical distance between a patient and a physician. Telemedical ICT technology, such as live-video interaction, may enhance patients’ access to a wide variety of healthcare services¹, especially in areas that suffer from the shortage of physicians. With the help of technology, doctors could remotely treat patients situated in rural areas, other states or countries. However, in many jurisdictions, the availability of direct-to-consumer telemedicine is subject to legal constraints, such as prohibitions or limitations on offering long-distance medical treatment.

The legal norms that limit the use of telemedicine have the most straightforward impact on its adoption. These norms may take the form of a straightforward prohibition on long-distance treatment or on its important elements, such as diagnosis.² The limitations may also be more subtle; for example, they may focus on setting qualifications for consultations or examinations of the patient or criteria for medicine prescriptions.³ Although present in many jurisdictions, we found no systematic review on these legal rules or their background.⁴ In order to gain an understanding of the interests at stake and justifications behind the limitations of the provision of telemedicine, we will review the

² In Germany, the prohibition on long distance treatment is still in force in the federal states of Brandenburg and Mecklenburg-Vorpommern, § 7 (4) of their respective Berufsordnung; in Russia, Article 36.2 of the federal law of 29.07.2017 N 242-FZ “On Amendments to Certain Legislative Acts of the Russian Federation on the Use of Information Technologies in the Field of Health Protection” prohibits a diagnosis without a face-to-face visit of the patient, see also: Mikhail Zhuravlev, ‘eHealth Regulatory Challenges in Russia’ in this publication.
³ On the federal level, see Ryan Height Online Pharmacy Consumer Protection Act, Pub L 110-425, § 2-3, 21 USC § 829 (e), § 831 (h) (2008) (Ryan Height Act of 2008). In addition, many US states require the telemedicine provider to establish a relationship with the patient before issuing prescriptions and limit the provision of certain substances at distance. See for example Ind Code § 25-1-9.5-7 and § 25-1-9.5-8 (2018).
historical background and recent legislative developments in the telemedicine legislation in the US and Germany. Both of the countries have federal political systems and limit the provision of telemedicine. However, in the US, the limitations were enacted as a reaction to the digitalisation of medical care\(^5\), whereas in Germany, the prohibition of long-distance treatment has historical origins dating back to the nineteenth century.\(^6\)

**LIMITATIONS ON TELE MEDICINE IN THE US**

In the US, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was enacted to tame online prescriptions of controlled substances\(^7\) and the unlawful use of such substances by making them conditional on the performance of an in-person examination and regulating the registration of online pharmacies.\(^8\) The act was motivated by a desire to prevent drug abuse by adolescents and was named after a young overdose victim.\(^9\) Telemedicine-based prescriptions of controlled substances were permitted under seven very narrow exceptions.\(^10\)

On the state level, telemedicine is not prohibited in the US. However, the regulations on online prescriptions vary dramatically between states.\(^11\) Beyond the Ryan Haight Act of 2008, many states have additional, often stricter regulations on the prescriptions of controlled substances.\(^12\) In addition, many states also make prescriptions of non-controlled substances conditional on the pre-existence of a physician-patient relationship. Some state laws explicitly specify that such relationship may be established via telemedicine.\(^13\) As an alternative approach to legal drafting, some states permit the establishment of the relationship via telemedicine when it aligns with relevant standards of care.\(^14\) Occasionally, the states impose further conditions, such as requiring live, real-time com-

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\(^5\) Ryan Height Act of 2008; see Anca M. Cotet and Daniel K. Benjamin (n 4) 407; the Russian limitations on the provision of telemedicine were also enacted as a reaction to modern ICT technology, see Mikhail Zhuravlev (n 2).

\(^6\) In Japan, the principle of face to face examination also dates back to the Medical Practitioners Act legislated in 1906, see Kazuyuki Nakayasu and Chiaki Sato (n 4) 3.

\(^7\) See Anca M. Cotet and Daniel K. Benjamin (n 4) 407.


\(^13\) See for example Kan Stat Ann §40-2, 212 (b) (2018); DC Mun Regs Tit 17, § 4618.4.

communication for the establishment of the relationship or when conducting an examination or prohibiting the use of online questionnaires or telephones for these purposes.

The latest changes to the federal telemedicine regulation in the US have been motivated by the drive to address the opioid crisis. Paradoxically, the limitations of the Ryan Haight Act of 2008 on telemedicine prescriptions have been found to hinder the effective treatment of opioid addiction. As a consequence, the SUPPORT for Patients and Communities Act of 2018 widens opportunities to give telemedicine prescriptions of controlled substances for the purposes of medically assisted treatment of opioid use disorders.

Besides state and federal legislative efforts to use telemedicine to intervene in the opioid crisis, another legislative trend is evident in the US. In recent years, several US states have explicitly required in-person performance of medical abortions. The norms are not justifiable on the basis of the evidence on patient safety; instead, they appear to reflect a political agenda to narrow the rights to abortion in the US. By virtue of the U.S. Supreme Court’s ruling in the case of Roe v. Wade, the right to choose an abortion is protected in the US under the right to privacy. More recently, several states have passed extremely strict anti-abortion bills, which would take effect if Roe v Wade were overturned.

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17 Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act P.L No 115-271, Preamble, Sec 1 (2018) (SUPPORT for Patients and Communities Act).
19 SUPPORT for Patients and Communities Act, P.L No 115-271, § 3201-3204, § 3232 (2018); Congressional Research Service, SUPPORT for Patients and Communities Act (n 17), 12-14, 17.
21 There is no significant difference in the safety of a medical, telemedicine-observed abortion in comparison to the delivery of a medical abortion in person. See Daniel Grossman; Kate Grinday, ‘Safety of Medical Abortion Provided Through Telemedicine Compared with In Person’ (2017) 130 Obstetrics & Gynecology, 778. However, a quarter of the patients who had been treated with a telemedicine-assisted medical abortion have reported having preferred being treated in person. Daniel Grossman et al. ‘Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine’, (2011), 118 Obstetrics & Gynecology, 296.
In the US, the majority of federal and state norms appear to be justifiable and proportionate on the grounds of maintaining patient safety, a standard of care and preventing abuse of prescription medicine. However, the discrepancies between state rules burdens physicians that offer telemedicine services in multiple states by introducing legal uncertainty. Despite the trends towards more evidence-based telemedicine regulations, such laws are not free from the influence of other political agendas, such as the anti-abortion movement.25

PROHIBITIONS ON LONG-DISTANCE TREATMENT IN GERMANY

In Germany, before 2018, remote treatment of patients without any prior face to face examination by a physician was banned by the federal medical chambers.26 Historically, the ban can be traced back to the nineteenth century. Starting in the 1850s, so-called family magazines targeting an emerging educated middle class featured entertaining articles about the latest scientific discoveries and lifestyle tips.27 Medical essays were popular and physicians also answered reader’s medical questions in the magazines.28 Furthermore, it was common to advertise medical advice by letter correspondence and physicians even specialised in giving remote treatment only.29 Many physicians were opposed to this practice, and at the eighth German Medical Assembly on 30 and 31 July 1880 in Eisenach, they voted in favour of a declaration stating that giving medical advice in magazines or in letters was harmful for the reputation of the medical profession and inappropriate.30 However, the German Medical Assembly, which is a predecessor of today’s national medical chamber, had no legislative power. It was merely a meeting of local medical associations.31 Nevertheless, future professional codes of local medical associations took the declaration into account.32 In 1896, a draft of a professional code for physicians in

25 See Planned Parenthood of the Heartland v Iowa Board of Medicine No 14-1415 (Iowa Sup Ct 2015).
26 § 7 (4) Musterberufsordnung für Ärzte before May 10, 2018, for a comparison of the old and new norm see: <https://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Orde
27 n/MBO/Synopse_MBO-ÄF_zu_Aenderungen_7_Abs_4.pdf> accessed June 3, 2019. The ban however, not prohibi
28 ibid. Interestingly enough, the publishers were aware of the risks of giving medical advice to a patient they hadn't examined before and often included a disclaimer stating that only a physician examining the patient can diagnose an illness; Gunter Mann, ‘Die Familienzeitschrift “Ueber Land und Meer” und die Medizin des 19. Jahrhunderts’ (doctoral thesis, Goethe-Universität Frankfurt a.M. 1952) 43.
31 ibid 438.
32 Wolfgang Gerhard Locher (n 29) 515.
the Kingdom of Saxony forbade physicians from treating patients via letter correspondence only.  

Later, in 1927, a ban on remote treatment was introduced in the Weimar Republic. The law on sexually transmitted diseases (STDs) stated that it was unlawful for a physician to treat STDs such as syphilis and gonorrhoea via a long distance treatment or to give advice on self-treatment of STDs in writing, illustrations or presentations. Physicians could be criminally liable, with a sentence of up to one year in prison for even offering such health services. Apart from this aspect, the law represented a socially rather progressive and evidence-based approach to the control of STDs, which had been spreading at ever increasing rates since the beginning of the twentieth century. In the discussions regarding the act in the German Reichstag, a member of parliament explained the prohibition saying that physicians should not be allowed to take advantage of inexperienced and uninformed young people.

Until just one year ago, the ban on remote treatment remained in place in professional codes within state legislation. However, with the digitalisation of the healthcare sector, a debate has been going on about its legitimacy, even though the national medical chamber has clarified that even with the ban, telemonitoring would be allowed as long as there is prior face-to-face-examination. An initiative to lift the German ban on long-distance treatment took place on 10 May 2018, when the national medical chamber proposed a change in the federal codes of conduct permitting telemedicine if it is justifiable from a medical perspective and the required due diligence is maintained in the individual case; this emphasises the chamber’s view that face-to-face examination should remain the gold standard of medical advice. However, the decision by the national chamber is not binding, because only the federal states’ medical chambers have the legislative power to establish professional codes; the national chamber merely issues proposals to encourage uniformed standards.

35 Albrecht Scholz, Geschichte der Dermatologie in Deutschland (Springer 1999) 282. The law stated an obligation to seek medical care, § 2, but also ensured distribution of preservatives, § 13, and prohibited the quartering of prostitutes, § 17, and therefore fostered women's rights rather than moralisation, see also ibid.
38 § 7 (4) Musterberufsordnung für Ärzte.
39 § 2 Satzung der Bundesärztekammer.
Of the 16 federal states, 13 have already adopted the proposed phrasing by the national chamber. In the federal state of Baden-Württemberg, the medical chamber amended the norm on the prohibition in a stricter manner than the national chamber, allowing long distance treatment only in pilot projects approved by the chamber. The ban on remote treatment is still in force in Brandenburg and Mecklenburg-Vorpommern, after both medical chambers voted against adopting the national chamber’s proposal. Paradoxically, Brandenburg and Mecklenburg-Vorpommern have the lowest population densities in Germany and suffer from physician shortages, which could potentially be solved by telemedicine. On the basis of the freedom to provide services, every physician licensed within the EU can offer telemedical services in Brandenburg and Mecklenburg-Vorpommern. Therefore, the state prohibition on remote treatment has the effect of promoting telemedicine services provided by physicians not living there. Hence, patients living in Brandenburg or Mecklenburg-Vorpommern cannot consult via telemedicine with their family physician and would be forced to consult an out-of-state physician if they wish to avail of such services. Furthermore, physicians are discouraged from opening a general practice in these states, since they cannot offer telemedicine as another billable service.

The history of the prohibition on long distance treatments in Germany shows that there is nothing new about contemporary concerns regarding the diminished quality of remotely provided, technology-based medical treatments or regarding their implications for both patient health and the perception of the medical profession. However, modern technologies, such as video connections, provide physicians with much more comprehensive information on the patient’s health than the postal system of the 1880s, and should not be subject to similarly stringent prohibitions. Yet, limiting norms are of relevance where technology may enable an abuse of the healthcare system or of pharmaceuticals. Like the US legal system, the German legal system, with different levels of legislative powers, means there can be different standards for telemedicine at state level. While the recent relaxation of the ban on long-distance treatment addresses the opportunities of modern communication technologies, it has resulted in different norms being applicable

41 Bayern, Berlin, Bremen, Hamburg, Hessen, Niedersachsen, Nordrhein-Westfalen, Rheinland-Pfalz, Saarland, Sachsen, Sachsen-Anhalt, Schleswig-Holstein, Thüringen: see their respective Berufsordnungen.
42 § 7 (4) Berufsordnung für Ärzte in Baden-Württemberg; one pilot project of this kind is the telemedicine app Docdirekt by the association of statutory health insurance physicians in the federal state of Baden-Württemberg (KVBW).
45 See Art 28, Art 56 TFEU.
CONCLUSIONS

The prohibitions and limitations on long-distance treatments are one of the most straightforward obstacles to the adoption of telemedicine. However, these norms are necessary to ensure patient safety, address public health concerns and preclude abusive practices related to medical care and pharmaceuticals, both on behalf of medical professionals and patients. The norms should be tailored to reflect advances in information technology to deliver healthcare. There will always be contexts where it is paramount to examine and treat a patient in person – for example, when undertaking a neurological examination. However, there is no justification for maintaining prohibitions that were originally targeting the use of non-digital technology, such as post, to communicate with the patients or for allowing norms on the delivery of telemedicine to be influenced by professional lobby groups or political agendas that compromise access to safe medical care. Instead, regulations on telemedicine should be evidence based and reflect the need for safe, high-standard healthcare and other public health interests. Furthermore, especially in federal states, rules and policies should strive to create regional legal certainty. For example, norms that refer to the current standards of healthcare or establish conditions for the quality of technology used for telemedicine may offer the flexibility needed to address the relevance of telemedicine in diverse healthcare contexts and promote further advances in technology.

This unfavourable situation is well illustrated by a service to get a sick note via Whatsapp. AU-schein.de, the company providing the service, is based in Hamburg, whereas the doctors signing the sick notes were based in Schleswig-Holstein or Bavaria because their medical chambers had already lifted the ban on remote treatment, but Hamburg had not at the time the service entered the market. See Armin Himmerath, ‘Wie ich mich selbst als arbeitsunfähig einstufe’ Spiegel Online (Berlin, April 1, 2019) <https://www.spiegel.de/karriere/krankmeldung-per-whatsapp-wie-ich-mich-selbst-als-arbeitsunfaehig-einstufte-a-1260409.html> accessed June 11, 2019.
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