LETTERS

Telemedicine in addiction treatment: Ethical considerations

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The gradual move towards telemedicine for the care and service provided to patients with addictive disorders [1], has been accentuated during the pandemic [2-4]. Telemedicine facilitates expert medical care to those situated at distant locations, and reduces the indirect and direct healthcare costs. While the benefits of telemedicine have made it an exciting opportunity, some ethical concerns still remain [5]. Here, we discuss some of the ethical challenges in providing treatment to patients of addictive disorders through telemedicine.

First, assessment of the patient's physical condition becomes challenging in the telemedicine framework as important clues can be missed. For example, for a patient with alcohol dependence, examination of the central nervous system and palpation for enlarged liver might not be possible. Similarly, for patients on opioid substitution, the corroborative withdrawal signs of dilated pupils may be difficult to assess. Beneficence maybe compromised if the treating physician finds it difficult to take an informed decision. Dose optimisation of medications like buprenorphine may be deferred pending closer examination and evaluation.

Adherence to medication is a related issue. In opioid substitution treatment, supervised dosing is preferred. While such supervision may be possible online, autonomy may be curtailed in favour of better adherence. This is especially true of medications like disulfiram and naltrexone, where supervised administration may have better outcomes. Current restrictions on prescription of certain medications through telemedicine may compromise provision of adequate help to patients [6].

Telemedicine does offer an opportunity to contact patients who have dropped out of treatment or are likely to drop out, but this will impinge upon autonomy and free choice regarding treatment. Of course, when patients dropping out are contacted through telemedicine, they have the choice on whether to go through with the consultation or terminate it.

Provision of equitable care is difficult as telemedicine requires the availability of a device (eg, a smartphone), internet connection, understanding of video conferencing applications and dispensable medications, absence of which may create barriers for those seeking care through telemedicine. However, it needs to be weighed against the benefits of greater access in difficult times and wider geographical reach.

Another issue is provision of urgently needed care; eg, if a patient with poor motivation indicates an intention to use a substance during the consultation (or is seen taking a substance). In face-to-face consultations, the treatment provider aims to provide a "holding environment" till the intoxication subsides, or makes repeated efforts to urge the patient to continue the treatment, providing breaks to contemplate outside the consultation room, or may offer involuntary admission when a patient's behaviour indicates significant risk to self or others. In a telemedicine consultation, should the mental health professional try motivation enhancement to help quit substance abuse (at the discretion of the patient), or initiate the process of coerced treatment, or just end the case consultation process? On the other hand, if the therapist finds that a patient of alcohol withdrawal is slipping into delirium, should the therapist arrange for a treatment team to be despatched in the interests of beneficence, but at the risk of interfering with autonomy and confidentiality? The answer to this question may vary with the clinical situation, presence of psychiatric comorbidity, and availability of such community teams — though such teams that can be sent home are not available in India in the formal healthcare system.

Privacy and confidentiality concerns are also challenging. Digital media adds another device/agent in the care process, which may be susceptible to breach of confidentiality by intermediaries or even hackers. This is not under the control of treatment providers and the data might be stored internationally. Systems and policies are required to ensure confidentiality and restrict access to the data. Telemedicine may also facilitate easier referral to other professionals (with due consent of the patient) for related conditions through mail, instant messaging or other services/softwares. Care needs to be taken to maintain protocols of confidentiality throughout and after the referral. This could be through defining a data safety policy and implementing it.

Specific ethical concerns besides those in the regular healthcare system apply to the care of patients with addictive disorders — like privacy, autonomy and coerced treatment, surreptitious treatment, and weighing beneficence and harms while dispensing opioid agonists [7]. These have to be balanced with the benefits of telemedicine, using the lens of ethics. Also, the recent guidelines offer clear suggestions and expectations of the

enforcement of privacy and confidentiality concerns [6]. Telemedicine has the potential of wider reach and reduced costs of medical care delivery, thus serving the ethical tenets of justice and beneficence. It is a valuable tool, which should continue to be used expeditiously, in a responsive manner, in the treatment of substance use disorders. As telemedicine has become, an important part of healthcare, more discussion will help in shaping its use as a responsible, effective, and efficient mode of delivering healthcare.

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Ethical issues with MS (Ayurved) *Shalya Tantra/ Shalakya Tantra:* Need for public debate

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In November 2020, the Central government amended the Central Council of Indian Medicine Regulations, 2016, to introduce formal training in *Shalya* (general surgery) and *Shalakya* (diseases of ear, nose, throat, eye, head, oro-dentistry) specialisations for postgraduate students of Ayurveda [1].

Postgraduate (PG) trainees of *Shalya* and *Shalakya* will receive practical training in surgery and will be equipped to independently perform some pre-defined procedures after completion of their PG degree, as stated in the gazette notification issued on November 19 [1,2]. The students will be trained in two streams of surgery and will be awarded the degrees of MS (Ayurveda) *Shalya Tantra* (General Surgery), and MS (Ayurveda) *Shalakya Tantra* (diseases of the eye, ear, nose, throat, head, and oro-dentistry). Training modules for surgical procedures will be added to the regular curriculum of Ayurvedic studies.

This policy decision of the Government will allow Ayurveda practitioners to legally perform procedures such as skin grafting, cataract surgery, and root canal treatment. The list of procedures that will be taught includes — all types of skin grafting, ear lobe repair, excision of simple cyst and benign tumours (lipoma, fibroma, schwannoma, etc) of non-vital organs, excision/amputation of gangrene, traumatic wound management — all types of suturing, ligation and repair of tendon and muscles, foreign body removal from the stomach, colostomy, cataract surgery, local anaesthesia in the eye, rhinoplasty, hair lip repair, loose tooth extraction, dental caries tooth/teeth, root canal treatment etc [1,2].

It must be noted that the diagnosis and surgical management of a patient requires a multidisciplinary approach, involving various disciplines of allopathic medicine which have developed over a long period of time. Specialised branches like radiology, pathology, microbiology, and biochemistry are involved in the diagnosis of diseases. Any surgical procedure requires pre-anaesthetic check-ups involving disciplines like cardiology, and patients with complicated conditions may require clearances from nephrology, endocrinology, neurology, gastroenterology, etc. Anaesthesia was developed over many decades and is at present fully equipped to handle extremely complicated surgeries. Post-operative care requires a dedicated intensive care unit set up, especially for complex surgeries by qualified individuals from anaesthesia and critical care medicine.

Developing traditional medicine is a welcome step, but the skills and expertise of 8 to 10 domains are learned over a period of 8-10 years by students in the allopathic system. Is it possible to develop the so-called MS (Ayurveda) *Shalya Tantra / Shalakya Tantra* within a few years of training to develop the same degree of expertise, without prior tedious and comprehensive training on the surgical anatomy and pathophysiology of the diseases mentioned?

The Ayurvedic surgery system is not widely accepted at present, and it has not yet evolved to handle complex surgeries and their possible complications [3]. So, it is a major ethical issue to subject patients to surgery at the hands of Ayurvedic postgraduate students. It is unclear how the referral system will work in case of complications in these complex operations performed under general anaesthesia. A failure to debate these issues among stakeholders could have disastrous results in terms of patient care.