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Invited Editorial

Applause for telemedicine as an optimal platform for specific menopausal health-care visits beyond COVID-19

As the ancient Greek philosopher Heraclitus noted around 500 BCE, "The only thing that is constant is change." And certainly, this quote from centuries ago is extremely fitting today when describing current medical practice and how many clinician's offices have quickly morphed from physically seeing almost all of their ambulatory patients to remotely talking to or video communicating with most of their patients who do not require in-person evaluation. That is, patients do not routinely populate medical waiting rooms today unless there is a specific need to perform a physical examination or do laboratory testing or undertake imaging evaluation.

Before the pandemic hit in full force in 2020, there were emerging articles published on the benefits of telemedicine (the provision of remote healthcare services), which is part of the broad range of remote health care services designated as telehealth (which embraces clinical and non-clinical services, such as continuing medical education for the health care team), but few practices changed their health care delivery templates. This was despite the fact that the World Health Organization stated that modern information and communication technologies can be adapted to address global health problems and that this technology provides "access, equity, quality and cost-effectiveness" to populations of individuals who may not fully benefit from traditional algorithms of in-person care [1].

The impetus for rapid adoption of telemedicine can be dated to the early months of 2020 when the acute need surfaced for people to physical distance such that the COVID-19 infection was contained as much as possible. Without other options to care for preventive, intervention-geared and medical-management patient visits, the medical field had to basically move to 'stat' adoption of this technology, with the payers also recognizing the need for this remote type of patient service. For example, in the United States, Medicare is the major insurer for those over 65 years. With COVID-19, Medicare expanded its reimbursement for telemedicine visits to patients in all locales, a change from their previously reimbursing only for this service when people had to access their health care from remote areas [2].

For those practitioners who are just now getting accustomed to the type of visit, which is a 180 degree different type of practice from the good-old-days when clinicians actually made house calls which then morphed to the patient visiting the clinician in a medical office setting, it's refreshing to know that those belonging to the older generation also considered the adoption of this technology in the mid 1900's. This consideration of remote patient visits came on the heels of wide spread use of the radio as a remote way to communicate. With a radio/television foundation to build on, by the end of the 1950's, there were isolated practices that offered video consultations, with the number of sites adopting this technology expanding by the 1960's and 70'S, which parallels the rapid advances in this technology. Today, there should be no technologic barriers to telemedicine.

Although telemedicine has come into our clinical practices out of necessity, for the menopausal practitioner, it may actually herald in an extremely positive change even after the COVID-19 pandemic has resolved. For those who request management of climacteric symptoms, including menopausal hormonal therapy, a full consultation can be done by telemedicine. In fact, this is the way that many visits for menopausal issues can be handled from this point forward, what with low risk women not needing yearly cervical cytology screening (and no cervical cytology screening necessary after age 65 years in this low risk group) and for asymptomatic women breast screening by mammogram can be done directly through a visit to the radiology office. However for those with postmenopausal bleeding, screening with a telemedicine history will precede pelvic examination and ultrasound.

There are other benefits for the menopausal woman in her having telemedicine encounters instead of in-person ones. First and foremost, for midlife and older women it is a cost effectiveness visit for them, which requires no travel, no long waits in a crowded waiting room and no need to take time off from work or their other duties, such as caring for spouse or aging parents. These cost savings are not only for the patient, but also for the health care system as well, as noted by data presented by Nord and colleagues. In their study they found that patients who received care through a demand telemedicine program, saved the health system, per person, approximately $19-$121 [1–3]. Furthermore, with virtual visits there are not the sterility issues of keeping an office setting as clean as possible and, even with masks, not inadvertently infecting another patient sitting in a waiting area.

Despite the many benefits, there are barriers and telemedicine may not be suitable for all menopausal women. Some limitations include lack of internet and phone access, lack of technological knowledge, ensuring cybersecurity, and even lack of privacy for those who do not want family/colleagues to eavesdrop on their conversation with the clinician. However, from the perspective of viewing telemedicine from a half-empty/half-full perspective, the benefits of this technology clearly fill the cup almost to the brim.

Contributor

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