**Date**: April 26, 2017

**To:** Senate Committee on Health & Welfare

**From:**
Sharon Winn, Policy Director, **Bi-State Primary Care Association**
Louis Josephson, President and CEO, **Brattleboro Retreat**
Lucy Leriche, VP of Public Policy Vermont, **Planned Parenthood Northern New England**
Terry Rabinowitz, MD, Medical Director, Telemedicine, **University of Vermont Medical Center**
Devon Green, VP of Government Relations, **Vermont Assn of Hospitals and Health Systems**
Jessa Barnard, General Counsel & Vice President for Policy, **Vermont Medical Society**

**Re:** Informed Consent Section of S. 50, as passed the House

The above organizations support S. 50 and expanding access to telemedicine services. Telemedicine, where clinically appropriate, is a means to overcome barriers and connect people with health care.

However, we write to express our concern about the House-adopted language in Section 2 regarding informed patient consent. The language adopted by the House requires a clinician to obtain informed consent of a patient before providing telemedicine services to a patient. The informed consent must include a number of very specific elements that are more prescriptive than the standards established elsewhere, such as by the AMA Principles of Medical Ethics[1] or the Vermont Board of Medical Practice.[2]

Given the broad scope of this bill, the informed consent language contained in S.50 as passed the House will not be applicable in all circumstances. For example, issues of "therapeutic rapport" and "provider-patient interaction" may be more applicable in an ongoing therapist-patient relationship than in a one-time oral surgery or radiology consultation. Further, the requirement to provide "a referral to in-person services" if a patient requests to end telemedicine may simply not be possible. As witnesses testified, one of the benefits of telemedicine is the ability to offer services that may not otherwise be available in Vermont, such as consultations with an out-of-state specialist or access to a specialized type of group therapy. It may also not be possible to exclude individuals in all instances, such as medical staff assisting a distant site provider with a clinical task or with the telemedicine technology.

Clinicians should have the ability to modify their way of discussing telemedicine with a patient based on the actual clinical situation at hand. Also, if new technology or other new opportunities arise in telemedicine that create differences in how patients and providers utilize telemedicine, providers should have the flexibility to stay abreast of best practices and not be limited by statute. Finally, if a more flexible approach to informed consent is acceptable for providers working through a third-party vendor (allowed under section 2(c)(3)), many of whom will be located out of state, a more flexible approach should also be acceptable for in-state providers establishing their own telemedicine programs.

Thank you for your consideration and for taking steps to expand access to telemedicine services in the State.

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[1] AMA Principles of Medical Ethics 1.2.12 Ethical Practice in Telemedicine, https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf

[2] Vermont Board of Medical Practice, Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, http://www.healthvermont.gov/sites/default/files/documents/2016/12/BMP_Policies_Vermont%20Telemedicine%20Policy_05062015%20.pdf