

Is Telemedicine the New Normal or Is the Office Visit Still the Movement Disorder Option of Choice?

The COVID pandemic has forced major adaptations for patients and providing health care professionals. *Movement Disorders* and other major journals have gathered articles and special sections to focus on the challenges of this epoch.¹ In the context of quarantines and confinements, telemedicine, either by telephone or video platform, has allowed physicians and patients to remain in contact and to avoid travel and potential viral exposure. As the pandemic in the United States cycles toward mass vaccination, more secure travel, and greater social options, it is reasonable to pose the question of the enduring role of telemedicine in managing our movement disorder patients. Is its high usage rate “a new normal” or are movement disorder practices returning to the traditional office visit with telemedicine taking on its former adjunct position, only slightly more accessed than before the pandemic?

To address this issue in an urban university practice involving 10 full time movement disorder specialists, three

neuropsychologists, a psychiatrist, and two physician assistants, we examined the distribution of appointment types from January 2020, 2 months before pandemic restrictions were implemented and, then, monthly through April 2021 (Fig. 1). We charted the percent of visits that were in-office, telephone-, or video-based. Before March 2020, (first two columns) billable telephone encounters by doctors did not occur, video visits were a well-developed but infrequently accessed option, and almost all visits were in-office (green bars). Pandemic-related concerns abruptly altered the number and the visit mix over the next 12 months (columns 3–14, March 2020–February 2021) with a sharp reduction in office appointments, a shift to heavy video- (blue) and telephone-based (yellow) care. Over time, however, and starting as early as June 2020 (column 6) when city-based restrictions began to lift, we noted a slow and steady return to a predominance of office-based care. Since March 2021, (last two columns) and widespread vaccination efforts have dominated the city culture, 15% or less of all visits have been outside the in-office format. As such, we see this movement disorder university-based urban practice as having largely returned to the traditional model of in-office care, but we are pleased that alternate options exist for the small numbers of patients still needing them. We do not see a “new normal,” but instead a

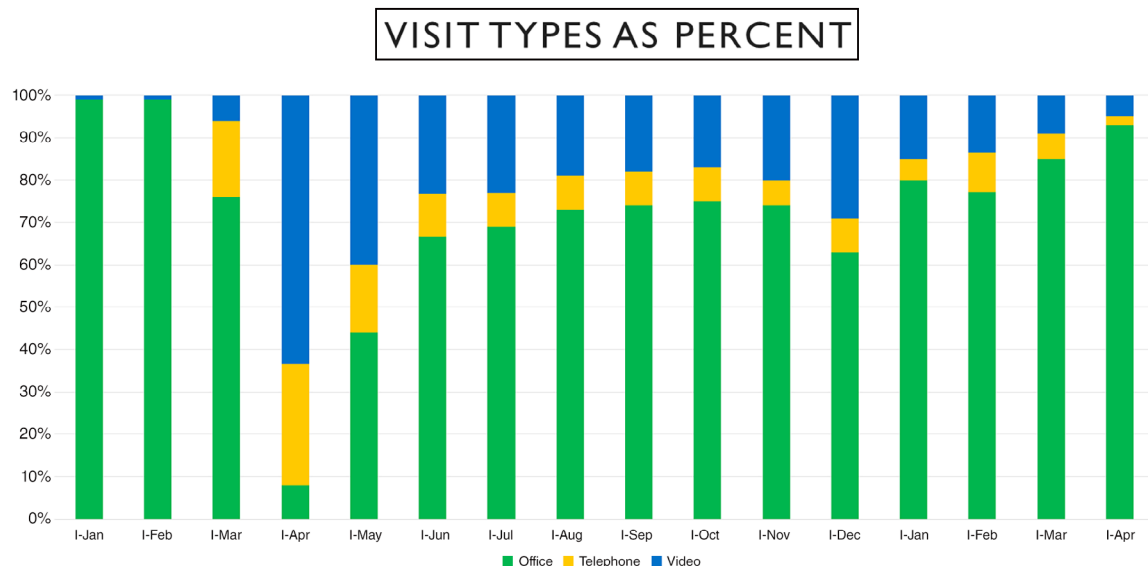


FIG. 1. Visits registered as % of total Movement Disorder visits by month divided by office (green), telephone (yellow) or telemedicine (blue).

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re-equilibration of practice patterns after a “roller coaster” of agile and adaptive responses to unexpected challenges.

We have pondered the reasons for this rapid return to the traditional format of care. Prior research by our group has established that our anchor rating scale, the Movement Disorder Society Unified Parkinson’s Disease Rating Scale (MDS-UPDRS), cannot be accurately used by video with a surrogate part 3 (motor examination) score, because the inability to assess rigidity and the danger of testing Postural Stability outside of a professional setting preclude a valid estimate calculation.² We have also previously published on the practicality of video-based examinations, and the loss of information in terms of assessment accuracy when rating patients with three-dimensional neurological disorders by a two-dimensional technique.³ As such, we recognize that doctors have, consciously or not, participated in the effort to return to the traditional model. In an effort to consider the patient’s voice in this observation as well, we have surveyed our patients and asked them the primary reason for their preferred return to an office setting. Despite travel time and cost, parking inconvenience, and urban hazards, representative remarks were: “I have been so isolated, it is good to get out.” and “I really felt I

needed to be examined.” In a charming reinforcement of the power of the doctor–patient relationship, especially in the face of a year of serious challenge, one of the leading comments was: “I missed my doctor.” ■

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References

1. Stoessl AJ, Bhatia KP, Merello M. Movement disorders in the world of COVID-19. *Mov Disord* 2020 May;35:709–710.
2. Goetz CG, Luo S, Wang L, Tilley BC, LaPelle NR, Stebbins GT. Handling missing values in the MDS-UPDRS. *Mov Disord* 2015;30:1632–1638.
3. Goetz CG, Stebbins GT, Theeuwes A, Stocchi F, Ferreira JJ, van de Witte S, Bronzova J. Temporal stability of the unified dyskinesia rating scale. *Mov Disord* 2011;26:2556–2559.