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TV DOCTOR

Asatullayev Rustamjon Baxtiyarovich [1]
[1] *Scientific supervisor*
Xolmatova Takhmina Azizovna[1]
[1] *Student*

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ABSTRACT:

Telemedicine has emerged as a transformative force in modern healthcare, particularly in the United States, where its adoption has expanded significantly. Initially introduced in the 1950s to provide medical care to remote populations and reduce healthcare costs, telemedicine has grown into a widely used service, with approximately 60% of primary care physicians, clinics, and hospitals incorporating it into their practices. However, despite its increasing utilization, telemedicine has not substantially reduced healthcare costs, which continue to rise due to monopolized healthcare systems, high operational expenses, and complex insurance structures. This paper explores the evolution of telemedicine, its role in different medical specialties—particularly radiology—and the challenges it faces within the U.S. healthcare system. It highlights how telemedicine offers flexibility for physicians, as illustrated by Dr. Claire Young's transition to a global telemedicine practice. Additionally, the paper outlines the pathway to becoming a telemedicine physician in the U.S. and compares it with international medical licensing requirements.

INTRODUCTION. Today, I would like to talk about telemedicine from the perspective of a primary care physician. My primary specialty is radiology, which is particularly well-suited for telemedicine, so I'll talk about my work. If you don't have time to read my very long article, please skim to the end. There's a bonus at the end: a guide for remote patients on how virtual appointments differ and how to make the most of

your time. My talk takes a lot of digressions to explain healthcare in the United States. First of all, because the United States is considered the birthplace of telemedicine (this is not entirely true - as early as the 1920s-1940s, medical centers in Italy, France, and Norway were providing wireless consultations to patients on remote islands and during long voyages), and also the country where it is widespread today. This is because in some countries, it is. According to one report, 60% of primary care physicians, clinics, and hospitals in the United States use some form of telemedicine. In addition, most of the economic studies on the feasibility of telemedicine have been conducted in the United States.

Telemedicine in the United States emerged in the 1950s with the aim of reducing healthcare costs and providing services to remote populations. However, at that time, telephone consultations were not particularly common. At the turn of the century, it became clear that the cost of healthcare for Americans was rising and something had to be done. Telemedicine seemed like a solution. 20 years later, it is clear that telemedicine has not lived up to expectations. Healthcare costs and insurance premiums have been steadily increasing: in 2017, the United States

spent $3.5 trillion on healthcare, or 18% of its GNP. According to Wikipedia, in the previous year (2016), Russia's federal budget was $21 billion. Reasons for High Healthcare Costs in the United States The reasons often cited include complex and expensive licensing, the high cost of medical education, a high level of service and technical equipment, and high salaries. However, these factors alone do not explain why the quality of services and staff salaries have not improved, despite the doubling of costs over the past decade. Despite the astronomical sums that the state spends on health care as the main payer, there are still no real means of controlling prices and costs in health care. Health care costs are enormous. Any attempt to introduce even limited government control is immediately branded as a sacrosanct attack on the free market. However, in reality, the free market has long ceased to exist. The US health care system is owned by big business (or at least a significant part of it) and is so monopolized that the laws of the market do not work: the average bill for a 3-5-day hospitalization is $ 25-30,000. It also pays for ambulance services. A one-day stay in the intensive care unit costs from $10,000 to $ 12,000. Large companies buy clinics in a network and decide who and under what conditions can accept patients there (the so-called privileges). Bills are issued with numerous markups and extra charges, which are often unjustified. $500 admission, $500 surgery, $213 nursing, $670 meds, $120 lab fees, $140 maintenance, $13,700. What kind of facility fee is that? It's a fee for being treated at that

hospital chain - basically a brand fee. And now they're charging a fortune for it. On one hand, this hospital is understandable. By law, every hospital is required to provide emergency care to everyone. Urgent care centers are overwhelmed with patients. In addition to those who genuinely need emergency care, there are homeless people, drug addicts, mentally unstable people, and who knows what else. When marginalized people have nothing better to do in their free time, emergency rooms are a good way to have a good time and attract attention. Almost every night, people come in with their lights flashing. As a result, waiting lists can take a day or more, and the clinic loses a lot of money because no one from the marginalized population pays for an appointment. The fee was originally intended to cover these costs. However, since there were no special limits on the fee, it quickly skyrocketed. It is understandable that no one wants to get a bill for pneumonia or a boil and be left without pants. That is why we need insurance. Health insurance is often provided by employers and ties employees to one place of work. This is because when changing jobs and taking out insurance, there is a high risk of getting unfavorable terms on the new policy or a refusal to pay current medical bills.

What is a telemedicine doctor? Primarily a general practitioner, but any doctor in any specialty can become a telemedicine doctor. Claire Young's example shows that even doctors can now become "digital nomads." After medical school and residency in the UK, Claire and her husband emigrated to Canada, where they ran a private practice for 12 years. Eventually, tired of the cold, she bought a camper trailer and spent winters in California. One of her patients introduced her to a telemedicine company, and Dr. Young decided to give it a try. She contracted with a telemedicine clinic in Canada and saw her first patient on the third day from her camper in California. She saw patients throughout the winter. In British Columbia, a province of 700,000 people, patients were thrilled. One in six of them lived or worked in places where health care was difficult to access and there was no other way to get it. Over the next two years, Dr. Young worked from home 10 to 12 hours a week. She connected her laptop to the Internet via a mobile phone hotspot. Contrary to expectations, the mobile connection was reliable throughout the United States, even when the van crossed the Mexican border. Beaches, deserts, jungles, and Indian villages pass by outside the window, but even in the Andes, at 13,000 feet above sea level, the signal is stable. All you need is an Internet card with 25 to 30 gigabytes per month, the exact figure varies by country. What began as a one-time winter stay in the United States has now become the beginning of a round-the-world trip. As you read this, Dr. Claire Young, a Canadian family physician, is hosting a TV show with a patient from a van in Colombia.

Her husband is an extreme sports psychologist who also conducts teleconsultations. The Youngs are planning to go to Russia next year, so maybe some of us will have the opportunity to meet them. My own telemedicine experience includes: practicing physicians for shift companies, teleconsultation therapists for insurance company subsidiaries, interns at the Highest Peak Mountain Clinic (providing telemedicine services in isolated valleys for several weeks during the December-March season), Poison Centers (consulting on poisons), and Suicide Prevention Centers. Interns, etc. I currently work as a radiologist in four or five regional hospitals, remotely interpreting images and chairing surgical and oncology meetings with Zoom.

How to Become a Doctor (Including Telemedicine Doctors) Anyone can become a doctor in the United States. To do this, you need to graduate from a medical school (not necessarily in the US, but from the list approved by the ECFMG (which includes almost all medical universities in the world), or from Saratov, Karakalpakstan or Bangladesh, if they are on the list approved by the ECFMG (which includes almost all medical universities in the world)) and pass the exam (the same as for US graduates) with a high enough score. exam (like for US

graduates). They must pass the exams with high enough scores (like US graduates). Then they are assigned to a specialty and begin an internship. After completing the internship (3-5 years), students must pass the medical licensing exam to become a doctor in the United States. Most countries in the world do not have such a transparent and simple system of access to medical practice: first, you need to find a job, get permission to work within the quota and fulfill a number of other conditions. At any stage, the result is not guaranteed and often depends not on individual efforts or talent, but on bureaucratic whim and blind luck. In the United States, everyone who wants to become a doctor is subject to the same requirements, and these requirements must be met. The path is open to everyone. Especially since now, as in the days when dinosaurs roamed the earth (and when the author of these lines was preparing for the USMLE exam), there are many resources on the Internet to help prepare for the exam, and there is no need to attend expensive in-person courses.

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