



PART 1

Read the text below and answer questions 1–13.

TELEMEDICINE: THE VIRTUAL CONSULTATION REVOLUTION

A

Telemedicine refers to the delivery of clinical services when patient and clinician are in different locations, using video, telephone, or secure digital messaging. Although “remote advice” existed long before smartphones, telemedicine became scalable only when infrastructure matured: broadband expansion reduced dropped connections, smartphones normalised high-quality cameras, and electronic health records made it possible to document virtual encounters in real time. Demographic pressure also played a role. Ageing populations and higher rates of chronic disease increased demand for frequent follow-up, while many health systems faced workforce shortages and long travel distances for specialist care. The single most visible catalyst, however, was the pandemic era, when infection-control policies forced rapid adoption and prompted regulators to loosen restrictions that had previously made virtual practice administratively difficult.

B

Clinical applications vary, and telemedicine is not a single mode. In synchronous care, patient and clinician interact live via video or phone. This suits medication reviews, post-operative check-ins, mental-health sessions, and many primary-care queries where history-taking is decisive. By contrast, asynchronous “store-and-forward” services involve sending images or data for later review, which can be particularly useful in dermatology (high-resolution photographs of rashes or lesions), radiology (remote reporting of scans), and ophthalmology screening. Remote interpretation can shorten waiting times for specialist input and reduce unnecessary referrals. Yet asynchronous systems also require clear protocols: image quality must be adequate, patients must follow instructions, and clinicians must be able to request additional information when the initial submission is insufficient.

C

The crucial safety issue is triage. Telemedicine works best when clinicians can separate low-risk problems from conditions that require hands-on assessment. Many consultations succeed because the diagnosis depends largely on a patient’s narrative, patterns over time, or review of existing results. However, certain “red flags” demand in-person evaluation. Abdominal pain with guarding may require palpation; suspected heart failure may need auscultation or immediate tests; neurological symptoms may



require a detailed physical examination to detect subtle deficits. Even when video quality is good, clinicians may miss non-verbal cues or physical signs that become obvious in a clinic. Consequently, telemedicine programmes typically develop triage rules and escalation pathways so that a virtual appointment can convert to an urgent face-to-face visit when risk indicators appear.

D

Telemedicine has also changed chronic disease management through Remote Patient Monitoring (RPM). Devices such as blood-pressure cuffs, glucometers, pulse oximeters, and wearable sensors can send readings to clinician dashboards, allowing continuous oversight rather than episodic clinic visits. In principle, early intervention can prevent complications and reduce hospital admissions. In practice, RPM can create data overload. A high volume of incoming readings may generate alerts that clinicians must review, and false alarms can be frequent if thresholds are poorly set. Without workflow integration—clear responsibility for monitoring, dedicated staff, and triage of alerts—RPM risks becoming an “extra layer” that increases workload. Successful systems redesign work allocation, automate routine responses, and specify which changes should trigger clinical action.

E

Access is often presented as telemedicine’s strongest claim, but the benefits are uneven. For rural patients, virtual consultations can remove travel time, accommodation costs, and the need to take a full day off work. For people with mobility limitations or caregiving responsibilities, telemedicine can be the difference between receiving timely care and delaying treatment. Yet these gains depend on connectivity, device availability, and digital literacy. Older patients may struggle with logins, camera settings, or troubleshooting audio, while low-income households may rely on limited data plans. In urban areas, connectivity may be strong, but overcrowded housing and irregular work schedules can still constrain use. Telemedicine can therefore reduce some disparities while introducing new ones, especially if virtual systems become the default pathway for initial contact.

F

Privacy and security concerns sit alongside equity. Virtual consultations involve transmitting sensitive health information, often through platforms provided by third parties. Secure encryption, authenticated access, and appropriate data storage are essential, yet implementation varies by provider and jurisdiction. The domestic setting adds another complication: patients who can speak freely in a clinic may lack private space at home. In crowded households, discussions about mental health, sexual



health, or domestic violence may be inhibited if others can overhear. Some services attempt mitigations, such as text-based check-ins, code words, or guidance on using headphones, but the underlying issue remains that privacy depends not only on technology but also on living conditions.

G

Regulation and payment systems strongly shape adoption. Historically, reimbursement rules often favoured in-person visits, reducing the incentive for providers to invest in virtual platforms. During public health emergencies, many systems introduced temporary payment parity and relaxed licensing barriers, enabling clinicians to consult across regions and accelerating uptake. As policies stabilise, debates continue over how to prevent fraud, how to maintain quality standards, and whether cross-border licensing should be broadened for specific services such as specialist follow-up. Looking ahead, most planners frame telemedicine not as a replacement for clinics but as a redesign of care pathways. The best models combine clear triage, secure platforms, and coordinated integration so that virtual care reduces friction where appropriate without weakening face-to-face capacity for complex needs.

Questions 1–5

Choose **TRUE** if the statement agrees with the information given in the text, choose **FALSE** if the statement contradicts the information, or choose **NOT GIVEN** if there is no information on this.

- 1 The passage suggests that telemedicine became scalable partly because digital infrastructure had matured.
- 2 The passage states that a high-quality video connection makes physical examination unnecessary for every condition.
- 3 The passage specifies how frequently Remote Patient Monitoring devices should transmit readings.
- 4 The passage indicates that poorly chosen alert thresholds can produce frequent false alarms.
- 5 The passage states that telemedicine's access benefits are distributed equally among patients.

Questions 6–9

Complete the sentences below. Choose **NO MORE THAN TWO WORDS** from the text for each answer.



- 6** A large volume of incoming readings means that RPM can create
- 7** The accessibility of telemedicine depends partly on device availability and
- 8** Sensitive discussions may be inhibited when patients do not have at home.
- 9** Effective telemedicine should be coordinated within care

Questions 10–13

Select the correct answer.

10 Why is triage essential in telemedicine?

- A** It determines whether submitted images meet specialist reporting standards.
- B** It distinguishes problems suitable for virtual care from those requiring in-person examination or urgent tests.
- C** It ensures all patients follow the same pathway regardless of their symptoms.
- D** It determines whether a provider receives reimbursement.

11 What challenge can Remote Patient Monitoring create?

- A** Continuous readings remove the need to assign staff to patient monitoring.
- B** Increasing the volume of data prevents false alerts from occurring.
- C** It can add workload when responsibility for reviewing and triaging alerts is not integrated into workflow.
- D** It is useful only when readings are collected during clinic visits.

12 What limits the access benefits offered by telemedicine?

- A** Rural patients benefit regardless of the quality of local connectivity.
- B** Making virtual care the default removes the importance of devices and digital literacy.
- C** Benefits depend on connectivity, devices, digital skills, and patients' practical circumstances.
- D** Reduced travel means that every social group receives the same benefits.

13 What role does the writer suggest telemedicine should play in future healthcare?

- A** It should replace physical clinics once licensing rules have been broadened.
- B** Payment parity should remove the need to assess which consultation format is suitable.
- C** Virtual and face-to-face services should operate as separate systems.
- D** It should be integrated into care pathways while preserving in-person capacity for complex needs.



Answer Key

1. TRUE
2. FALSE
3. NOT GIVEN
4. TRUE
5. FALSE
6. data overload
7. digital literacy
8. private space
9. pathways
10. B
11. C
12. C
13. D