



Identifying the Limitations of Telehealth in Urgent Care

■ Kristin Boddu, DNP, APRN, FNP-C, CNE, COI

Telehealth has drastically improved access to urgent care, allowing patients to seek evaluation for acute complaints without travel, time away from work, or many of the operational obstacles of in-person care. Federal telehealth guidance recognizes improved access, reduced travel, and time savings as important benefits.¹ For clinicians practicing urgent care through telehealth, convenience comes with the responsibility of recognizing when the patient needs something a screen cannot provide.

Physical examination limitations, diagnostic uncertainty, and gaps in triage and workflow remain key considerations in urgent and acute telehealth practice.² Patient-safety risks associated with synchronous telehealth have also been identified in recent literature.³ Examples include medication errors, communication failures, incomplete clinical information, and patient-identification concerns. These limitations do not make telehealth inappropriate for urgent care. They make identifying the limits of the modality an essential clinical skill.

Telehealth appropriateness is often considered before the encounter begins: This complaint is appropriate for telehealth; that complaint is not. Clinical practice is rarely that predictable. A recent systematic review found virtual care appropriateness is determined by multiple factors, including the patient, clinical presentation, point in the care process, provider, and available technology.⁴ The chief complaint alone cannot always tell us whether a virtual encounter will be sufficient. One patient with cough may have an uncomplicated upper respiratory infection. Another with the same complaint may additionally describe dyspnea or chest discomfort and have no reliable vital signs available. Or a patient with abdominal symp-

toms may initially seem appropriate for virtual evaluation until the history raises concern for a condition warranting palpation, laboratory testing, or imaging. This matters in urgent care because starting a visit virtually does not obligate us to finish it virtually. As the history unfolds, the patient's needs may exceed what the virtual environment can safely provide.

The Stethoscope Rule

I use a simple clinical heuristic to recognize that transition: the stethoscope rule. It provides a practical way to identify the clinical boundary of a virtual urgent care encounter and determine when the patient needs hands-on evaluation. When the patient's next step depends on a hands-on physical examination, objective measurement, or a diagnostic test that cannot be adequately obtained virtually, the patient needs access to a setting that can provide it.

The "stethoscope" is figurative. Sometimes I need to know what the lungs sound like. Other times, the needed capability is abdominal palpation, reliable vital signs, an electrocardiogram, a fluorescein examination, point-of-care testing, laboratory studies, or imaging. The tool itself does not determine the need for in-person care; the patient's need for that clinical capability does. This does not mean every limitation of a virtual examination requires escalation of care. A systematic review comparing digital and in-person examination components found relatively good reliability for many virtual assessments, although performance varied across examination types and substantial heterogeneity limited broader conclusions.⁵ Therefore, telehealth can provide clinically useful examination information.

The practical issue is recognizing when a patient requires a clinical capability not available through the virtual encounter. Trying to work around the limitation does not improve access. It only delays the care the patient needs.

In urgent care, this transition often becomes apparent



Kristin Boddu, DNP, APRN, FNP-C, CNE, COI, is a nurse practitioner with Advocate Health, where she practices in virtual urgent care. She is also a clinical assistant professor in the Department of Advanced Nursing Practice and Education at East Carolina University College of Nursing.

through the history rather than a predetermined list of “telehealth diagnoses.” Consider the patient with throat pain. Many uncomplicated presentations can be evaluated virtually. However, drooling, inability to handle secretions, significant neck swelling, respiratory difficulty, or another concerning feature changes the encounter. These red-flag symptoms may require direct examination, testing, airway assessment, or emergency resources that are unavailable through a video visit.

The same principle applies across chief complaints. Mild ocular symptoms may be manageable virtually, while ocular pain, vision changes, trauma, or a suspected foreign body may require examination techniques unavailable through a screen. A straightforward urinary complaint may be reasonable for virtual management, whereas systemic symptoms, significant flank pain, pregnancy, recurrent treatment failure, or another complicating feature may require examination or testing.

These examples are not intended to create a list of complaints that are “allowed” or “not allowed” through telehealth. That approach misses the clinical issue. What matters is the capability the patient requires at that point in the encounter. Diagnostic safety depends on gathering and interpreting sufficient clinical information to guide appropriate decisions.⁶ When the necessary examination, measurement, or testing is unavailable virtually, the modality needs to change. Recognizing that the patient needs hands-on care is only half of the decision. The next question is where that care should occur.

For many stable patients, an in-person urgent care center may provide what is missing from the virtual encounter: reliable vital signs, a focused physical examination, an electrocardiogram, radiography, point-of-care testing, or other basic diagnostic resources. A patient does not automatically need an emergency department simply because telehealth is no longer appropriate.

A patient with potential hemodynamic instability, respiratory compromise, a time-sensitive cardiovascular or neurologic process, or another condition calling for immediate intervention belongs in a setting equipped to provide those resources, such as an emergency department.

Still other patients may need neither urgent nor emergency evaluation. A stable problem requiring a nonurgent examination, longitudinal assessment, or monitoring may be better directed to primary or specialty care. The Agency for Healthcare Research and Quality noted that in higher-risk telehealth encounters, appropriate triage may be more important than establishing a definitive virtual diagnosis. Potential dispositions can range from remaining home, scheduling an in-person examination, going to an emergency department, or calling 911.⁷ For the urgent care

clinician, “go be seen” is not enough. A useful disposition should reflect what the patient needs, how quickly it is needed, and which setting can provide it.

Convenience Cannot Choose the Destination

Patients often choose telehealth for good reasons. Avoiding travel, time away from work, or the cost of childcare may make a virtual encounter appealing.¹ Those advantages are worth preserving whenever virtual care addresses the patient’s clinical needs.

The challenge comes when convenience and clinical necessity point in different directions. A patient may prefer not to leave home to seek care, and the clinician may know that an in-person referral creates additional cost, travel, or inconvenience. Those realities deserve acknowledgment but cannot substitute for a required examination or diagnostic capability. When a virtual encounter identifies the need for hands-on evaluation, diagnostic testing, or a higher level of care, escalation should not be considered a failure of telehealth. It is an appropriate clinical outcome.

If a patient needs a resource I cannot provide virtually, my responsibility is to recognize that need and direct the patient to a setting capable of addressing it.

Telehealth has earned an important place in urgent care. Its ease of use and convenience allow clinicians to reach patients who might otherwise face delays or barriers to care. Preserving those advantages requires being comfortable in recognizing when the modality has reached its limit. When the patient’s next step requires something that cannot be adequately examined, measured, or tested through telehealth, the patient needs access to a setting that can provide it. The skill is not simply knowing what belongs in telehealth. It is recognizing, during an evolving urgent care encounter, when the patient’s needs no longer can be met in telehealth. ■

References

1. Health Resources and Services Administration. Why use telehealth? Telehealth.HHS.gov. Updated July 29, 2025. Accessed August 10, 2026. <https://telehealth.hhs.gov/patients/why-use-telehealth>
2. Boddu K. Telehealth in urgent and acute nurse practitioner practice: scoping review. *J Nurse Pract.* 2026;22(8):105834. doi:10.1016/j.nurpra.2026.105834.
3. de Oliveira JSR, Fernandez RS, Molina MR, et al. Patient safety risk associated with synchronous telehealth: a scoping review. *PLoS One.* 2025;20(12):e0336992. doi:10.1371/journal.pone.0336992.
4. Alras A, Patel MA, Wang M, et al. Recommendations regarding the appropriateness of virtual care: a systematic review. *Telemed J E Health.* 2026;32(1):96-108. doi:10.1177/15305627251380328.
5. Lu AD, Veet CA, Aljundi O, Whitaker E, Smith WB II, Smith JE. A systematic review of physical examination components adapted for telemedicine. *Telemed J E Health.* 2022;28(12):1764-1785. doi:10.1089/tmj.2021.0602.
6. National Academies of Sciences, Engineering, and Medicine. *Improving Diagnosis in Health Care.* Balogh EP, Miller BT, Ball JR, eds. National Academies Press; 2015. doi:10.17226/21794.
7. Graber ML, Hunte HE, Smith KM. *Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis.* Rockville, MD: Agency for Healthcare Research and Quality; August 2020. AHRQ Publication No. 20-0040-2-EF.