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17 February 2023

Dear Dr Tonkin

Public consultation – Draft revised guidelines: Telehealth consultations with patients

1. We represent Eucalyptus, a leading digital health platform which provides high quality telehealth services to Australians. Since its founding in 2019, it has served almost 450,000 patients in over 700,000 consultations (including initial, review and follow-up consults).

2. We operate four brands which offer doctor consultations and treatment options for particular demographics and medical conditions: Pilot (men's sexual health, hair loss and weight loss); Juniper (women's weight loss and menopause); Software (skincare and women's hair loss) and Kin (contraceptive and fertility treatment).

3. We have been certified by the Australian Council on Healthcare Standards with EQuIP6 accreditation, the only online telehealth company in the country to have been assessed in this way.

4. Eucalyptus is grateful for the opportunity to provide comments on the Medical Board of Australia (**Board**)'s draft *Guidelines: Telehealth consultations with patients* (**Draft Guidelines**). We enclose our submission to the public consultation process.

5. The debate about the regulation of telehealth comes at a critical time in the Australian healthcare sector, in light of the recently published Strengthening Medicare Taskforce Report (which urged the federal government to improve access to healthcare, including for after hours and rural patients) as well as increasingly emotive commentary between the Royal Australian College of General Practitioners and the Pharmacy Guild of Australia about the future of prescribing.

6. The importance of these issues demands a dispassionate consideration of how best to implement guardrails for doctors' delivery of telehealth services. Such a consideration is impossible without a detailed understanding of how online telehealth platforms actually operate, including the clinical governance processes they adopt to ensure safety and quality for patients.

7. In short, and as our submission explains in more detail, we are concerned that the Draft Guidelines, in their current form:

    a. apply a blunt and misconceived method of regulating telehealth, when instead a more nuanced approach is required; and

    b. adopt an overly prescriptive approach, when instead doctors are best placed to employ their professional discretion to determine the most appropriate consultation modality.

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8. In our view, the Draft Guidelines should be amended so that:

    a. they recognise that asynchronous telehealth can be suitable for certain patients and certain medical conditions (but, of course, not all), including in initial consultations;

    b. they otherwise prioritise the prerogative of doctors to determine what is appropriate in a given situation, in accordance with the Board's *Code of Conduct* by which doctors are already bound; and

    c. in the event that they are not substantively amended, a formal transition period of at least 6 months is instituted to allow telehealth providers to maintain continuity of care for their patients and to adapt their processes accordingly.

9. More than 10 years since the publication of the current *Guidelines for technology-based patient consultations*, the process of drafting and refining the Draft Guidelines should be undertaken carefully, collaboratively and without haste.

10. We would be happy to discuss any of the matters in our submission.

Yours sincerely

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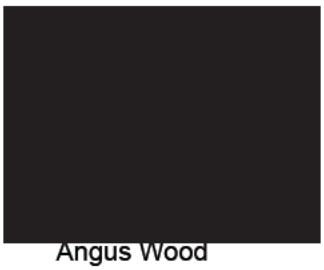

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Public consultation

Draft Revised Guidelines: Telehealth consultations with patients

Submission to the
Medical Board of Australia

17 February 2023

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Executive Summary

1. Healthcare regulation, like the practice of medicine itself, must be based in evidence and reason. So it should be with the Medical Board of Australia (**Board**)'s draft *Guidelines: Telehealth consultations with patients* (**Draft Guidelines**), which propose to restrict for the first time Australians' access to asynchronous (including text-based) telehealth.

2. However, in our submission the Draft Guidelines:

    a. proceed from a misunderstanding of the safe, comprehensive and high quality manner in which telehealth can be provided asynchronously; and

    b. are overly prescriptive, thereby diminishing doctors' capacity to determine an appropriate form of consultation and treatment in a given situation.

3. The touchstone of this debate should be the quality, not the form, of a doctor consultation. Telehealth, including asynchronous telehealth, can be and has been delivered safely and effectively to millions of Australians. As the country's leading telehealth platform, Eucalyptus embodies this proposition, and our data supports it.

4. The Board appears to assume that all asynchronous telehealth is a "*tick and flick exercise*" which does not allow doctors to ask the patient follow-up questions.[1] This is simply untrue.

5. Instead of bluntly prescribing when asynchronous telehealth is or is not appropriate, the Draft Guidelines should recognise that doctors — given their extensive training and their existing obligations under the Board's *Code of Conduct* — are best placed to make this decision.

The operation of asynchronous telehealth is misunderstood

6. Telehealth consultations can be provided in a myriad of ways. They may be *synchronous* (using real-time communication, generally by phone or video) or *asynchronous* (not in real time, using one or more of text-, image- and recorded audio/video-based communication).

7. For example, Eucalyptus's online platform offers primarily asynchronous consultations:

    a. a patient will visit the platform seeking treatment for one of a small number of supported health conditions;

    b. they will complete a detailed questionnaire (often with more than 50 questions) which collects a comprehensive medical history;

    c. their responses will be reviewed by a doctor, who will then initiate a text-based exchange of follow-up clarifying questions and answers, which may also include the provision of photos or videos; and

    d. if the doctor determines that a prescription is appropriate, it will be issued and then dispensed (if the patient so chooses) at one of Eucalyptus's partner pharmacies, which will dispatch the medication to the patient's home.

[1] H Carter, 'Medmade says medical board crackdown on online scripts will disadvantage millions', *Pulse IT*, 24 January 2023, <https://www.pulseit.news/australian-digital-health/medmate-says-medical-board-crackdown-on-online-scripts-will-disadvantage-millions/>.

8. The Board appears to be labouring under the misapprehension that the only method of asynchronous telehealth is to provide nothing more than a questionnaire, without the opportunity for doctors to ask follow-up questions of patients. This is clearly not the case.

9. Instead, Eucalyptus's platform facilitates, and its clinical guidelines encourage, doctors to engage in a dialogue with patients, who routinely also ask their own questions. Doctors do not prescribe medication unless and until they are satisfied that they have sufficient information and that it is appropriate to do so.

10. Moreover, if a doctor determines that a patient is not suitable for telehealth (eg, because a physical examination is required), then they will be referred outside the platform. Up to 50% of prospective Eucalyptus patients are deemed inappropriate for treatment via telehealth. It is uncontroversial that telehealth is not appropriate for all conditions. We do not suggest otherwise, nor do we suggest that telehealth is or can be a complete substitute for in-person consults. Instead, our platform only offers healthcare for 8 primary conditions.

11. It is partly for these reasons that Eucalyptus is the only online telehealth platform in the country to be certified by the Australian Council on Healthcare Standards (**ACHS**) with EQuIP6 accreditation.[2] This involves independent assessment by an external accreditor and compliance with almost 50 criteria evaluating the quality and safety of the care provided, benchmarking against some of Australia's most trusted healthcare services.

12. In this way, Eucalyptus distinguishes itself from other telehealth platforms. Indeed, and as described further in our submission, in some respects Eucalyptus's quality and safety processes exceed those in traditional GP clinics. For example, Eucalyptus:

    a. collects, analyses and responds regularly to detailed data by reference to defined safety thresholds in all aspects of the platform;

    b. has a Medical Support team staffed by registered nurses and pharmacists who assist patients with side effects or other clinical inquiries;

    c. provides clinical autonomy to doctors, does not incentivise them to prescribe and does not offer one-off scripts; and

    d. has for some time only engaged specialist GPs who are Fellows of the Royal Australian College of General Practitioners (**RACGP**).

The Draft Guidelines misguidedly limit doctors' discretion

13. The Draft Guidelines proceed from the mistaken assumption that asynchronous telehealth is unsafe and of poor quality in all cases, and then — in proposing to prohibit it for all initial consultations with a new patient — seek to bluntly limit access to it.

[2] Evaluation and Quality Improvement Program (6th edition), in the category of Healthcare Support Services: see https://www.achs.org.au/our-services/accreditation-and-standards/accreditation-programs/equip6/healthcare-support-services.

14. In this way, the Draft Guidelines:

    a. would newly seek to prescribe the *form* in which that telehealth should be delivered at an initial consultation, despite continuing to permit doctors to determine whether telehealth *generally* is appropriate for a given patient;

    b. would not achieve the Board's implicit goal of improving the safety and quality of telehealth; and

    c. do not consider alternative, and arguably more effective, methods of regulation.

15. Instead, the Draft Guidelines should adopt a more discerning approach, recognising that:

    a. undertaken carefully and for certain patients and conditions, asynchronous telehealth can be delivered safely and effectively (for all consultations); and

    b. it is doctors, who must already comply with the standards imposed by the Board's *Code of Conduct*, who are best placed to assess whether it is appropriate to employ asynchronous (or any other form of) telehealth for a particular consultation.

The broader telehealth debate suffers from serious misconceptions

16. The present consultation process should also be placed within the broader context of the debate about the use of telehealth in Australia and its impact on the rest of the primary healthcare system, which the Health Minister recently described as being in "*the worst shape it has been*" in 40 years and lacking in "*digital health capability*".[3] In this regard, the Report of the Strengthening Medicare Taskforce, noting the "[g]*reat progress*" made in telehealth during the COVID-19 pandemic, also urged the federal government to improve access to healthcare, including for after hours and rural patients.[4]

17. And yet, at the same time, two of the country's peak bodies involved in primary care — the RACGP and the Pharmacy Guild of Australia (**PGA**) — have been engaging in an unedifying debate about the scope of prescribing authority of health practitioners.

18. The President of the PGA recently described GPs as "*twits*" who had allowed their sector to become commercialised,[5] while in response the President of the RACGP characterised the PGA as "*out of control*" and as addressing serious healthcare issues in a "*brazen*" manner.[6] These comments are only the latest in a long history of 'turf wars'[7] about doctors' and pharmacists' rights to prescribe to patients in certain circumstances.[8]

[3] L Tingle, 'Mark Butler says GP system 'in the worst shape it has been in the 40-year history of Medicare', *ABC News*, 24 January 2023, <https://www.abc.net.au/news/2023-01-17/mark-butler-says-gp-system-in-the-worst-shape-it/101865530>.

[4] Australian Government, '*Strengthening Medicare Taskforce Report*' (2022), <https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf> 8.

[5] M Haggan, 'GUILD LEADER OUTLINES SYSTEM SHOCK', *Australian Journal of Pharmacy*, 18 January 2023, <https://ajp.com.au/news/guild-leader-outlines-system-shock/>.

[6] R Ward, 'GPs blast 'out-of-control' pharmacists', *Australian Financial Review*. 20 January 2023, <https://www.afr.com/politics/federal/gps-blast-out-of-control-pharmacists-20230120-p5cebb>.

[7] N Crysanthos, 'Nurses, pharmacists held back by red tape, turf wars: health minister', *The Sydney Morning Herald*, 23 January 2023, <https://www.smh.com.au/politics/federal/nurses-pharmacists-held-back-by-red-tape-turf-wars-health-minister-20230123-p5cepk.html >.

[8] P Martyr, 'How rivalries between doctors and pharmacists turned into the 'turf war' we see today', *The Conversation*, 10 September 2019, <https://theconversation.com/how-rivalries-between-doctors-and-pharmacists-turned-into-the-turf-war-we-see-today-122534>.

19. Institutions such as the RACGP and PGA will likely always play an important role in national healthcare debates, but the potential limitations of their views should be borne in mind and should not distract from a dispassionate analysis of the issues.

20. The positions of the RACGP and PGA on the regulation of telehealth specifically also illustrate these limitations. The President of the PGA has derisively described the telehealth industry as being populated by "*cowboys*",[9] while the President of the RACGP has likened medical treatment via telehealth to ordering McDonald's and has accused telehealth providers of prioritising business over healthcare.[10]

21. Both sets of comments betray an inaccurately monolithic view of the telehealth sector and demonstrate an acute misunderstanding of the benefits to patients which can be presented, safely, by telemedicine. Instead, Eucalyptus seeks to offer a more nuanced, data-driven and objective account of telehealth services.

22. Disappointingly for a sector which has improved access to healthcare for millions of Australians, the public discourse on telehealth has suffered from two major shortcomings (in addition to a misunderstanding of how telehealth platforms actually operate):

    a. a misplaced concern about fragmentation of care; and

    b. hypocritical accusations of promoting profits over patients' health.

(a) Fragmentation of care

23. Bodies such as the RACGP often allege that the use of telehealth promotes fragmentation rather than continuity of healthcare for patients. Even if that were true, it would not be a reason for telehealth platforms not to exist or to place restrictions on doctors' practice on them. Ultimately, it is for the patient to choose where they would like to obtain healthcare.

24. Indeed, patients are increasingly not obtaining primary healthcare from the same GP. One recent Australian study found that as few as 57.8% of young people have a regular GP.[11] This is reflected in Eucalyptus's own internal data, which indicates that over 50% of its patients do not report having a regular GP.

25. Patients may seek care from a GP other than a regular GP for many reasons, including their regular GP being unavailable, their relocation to a new suburb or city, or the fact that they are suffering from a stigmatised condition which they feel uncomfortable sharing with their regular GP.

26. The purpose of continuity of care is to ensure that all relevant parts of a patient's medical history are available to the treating practitioner. Having a patient attend the same GP for their entire life is not the only means of ensuring this outcome. Every day of the week, GPs in community practice are faced with new patients whom they have not previously

[9] N Bonyhady, "Pill mills' or the future of medicine? The rise of the telehealth industry', *The Sydney Morning Herald*, 21 January 2023 <https://www.smh.com.au/technology/pill-mills-or-the-future-of-medicine-the-rise-of-the-telehealth-industry-20230117-p5cdb3.html>.

[10] Ibid.

[11] M Kang et al. 'The relationship between having a regular general practitioner (GP) and the experience of healthcare barriers: a cross-sectional study among young people in NSW, Australia, with oversampling from marginalised groups', (2020) 21 *BMC Primary Care*, 220, 1 <https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-020-01294-8.>.

consulted. The regulatory response to that reality is not to ban patients from seeing a new GP. Instead, that GP is permitted to treat those patients safely by obtaining sufficient information about their medical history (in the absence of a well-used My Health Record).[12]

27. Just as that process can be undertaken in person, so it can be undertaken via telehealth, which also facilitates follow-up consultations and efficient responses to patient inquiries.

(b) Profits vs patients

28. Another common charge levelled against telehealth platforms is that they are more interested in securing profits than they are in ensuring high quality and safe healthcare for their patients. While this argument does not in any event represent the practices of Eucalyptus, more generally it serves as a convenient distraction from the commercial reality of the entire healthcare sector.

29. That reality is that primary healthcare in Australia is primarily for-profit. That is not to say that primary health practitioners are *focused* solely on profit; but it is to say that the vast majority of those practitioners are not providing volunteer services.

30. In this way, for instance, Sonic Healthcare — the country's largest operator of medical services whose clinics contain more than 2,000 doctors[13] — is listed on the Australian Securities Exchange and in the 2022 financial year produced a record net profit of $1.5 billion, on record revenues of $9.3 billion.[14] More generally, GPs (almost all of whom run private businesses) enjoyed median gross profits of over $120,000 in 2021.[15]

31. Similarly, in the pharmacy sector, the average net profit of a community pharmacy is over $230,000[16] and pharmacy businesses are routinely sold for millions of dollars (in Sydney, often between $2 million and $5 million).[17] On this note, the RACGP asserts that the PGA's push to allow pharmacists to prescribe certain drugs is partly profit-driven.[18]

32. The hypocrisy of the argument described above is therefore evident.

33. Once again, the fact that an individual health practitioner, a GP clinic or a pharmacy is a for-profit business does not of itself mean that the healthcare provided is focused on

[12] M Davey, 'My Health Record: after 12 years and more than $2bn, hardly anyone is using digital service', *The Guardian*, 6 June 2022, <https://www.theguardian.com/australia-news/2022/jun/06/my-health-record-after-12-years-and-more-than-2bn-hardly-anyone-is-using-digital-service>.

[13] Sonic Healthcare, 'Primary care medical services', *Sonic Healthcare*, undated, <https://www.sonichealthcare.com/our-services/primary-care-medical-services/>.

[14] Sonic Healthcare, *Sonic Healthcare Annual Report 2022* (Annual Report, 2022) 2 <https://investors.sonichealthcare.com/FormBuilder/_Resource/_module/T8Ln_c4ibUqyFnnNe9zNRA/docs/Reports/AR/SHL_AnnualReport_2022.pdf>.

[15] A Scott, 'Some GPs just keep their heads above water. Other doctors' businesses are more profitable than law firms', *The Conversation*, 12 October 2022, <https://theconversation.com/some-gps-just-keep-their-heads-above-water-other-doctors-businesses-are-more-profitable-than-law-firms-192163>. See also A Scott, *Trends in the structure and financial health of private medical practices in Australia*, University of Melbourne, 2022, 12.

[16] S Paola, 'A lucrative year', *Australian Journal of Pharmacy*, 11 November 2022, <https://ajp.com.au/news/a-lucrative-year/>.

[17] A Patrick, 'The skewed morality of pharmacy owners', *Australian Financial Review*, 6 December 2021, <afr.com/companies/healthcare-and-fitness/the-moral-bankruptcy-of-the-pharmacy-owners-20211203-p59ehc>.

[18] M Woodley, 'GPs say politics and money behind NSW pharmacy prescribing push', *newsGP*, 14 November 2022, <https://www1.racgp.org.au/newsgp/professional/gps-say-politics-and-money-behind-nsw-pharmacy-pre>.

profits to the detriment of patients. Quality medical treatment may be provided profitably. But if it is unfair to make such an assumption in relation to traditional healthcare providers, then it is equally unfair to do so in relation to telehealth platforms (which, after all, are populated by the very same GPs who also practise in physical GP clinics).

34. Once it is recognised that telehealth companies are not unique in the primary health sector in operating as for-profit businesses, the present debate can shift to the more substantive topic of how healthcare is provided. The real question is not whether there is a commercial aspect to healthcare; instead, it is whether that healthcare is of a high quality and safe.

The Draft Guidelines should be reconsidered or a transitional period implemented

35. To return to the original point, any new regulation should be justified on the basis of solid evidence and careful reasoning. Public statements of the Board, and the wording of the Draft Guidelines, raise concern that it may be acting without the benefit of a complete understanding of the sector which it is proposing to regulate.

36. Eucalyptus is providing this detailed submission in order to outline the full scope of safety and quality benefits that asynchronous telehealth can (and Eucalyptus does) produce — by some measures, superior to the standards achieved in community GP clinics. In this way, we seek to demonstrate that the Draft Guidelines go too far in prescribing rules for a form of care whose appropriateness is best judged by doctors.

37. In the event that the Board resolves to enact the Draft Guidelines as currently framed, it is critical that a sufficient transitional period be provided, so that telehealth platforms can maintain continuity of care for their patients while implementing the significant engineering and operational changes necessary for compliance. In our view, this process would require at least 6 months of lead time.

38. In the meantime, we ask the Board to carefully consider the implications of the Draft Guidelines, which would represent the biggest shift in the regulation of telehealth since the present guidelines were released in 2012.

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I. Introduction

1. A medical consultation, whatever its format, is primarily composed of two parts:

    a. the exchange of information between patient and doctor; and

    b. an exercise of discretion by the doctor in determining the appropriate treatment.

2. Those two components are to some extent interlinked, in that the quality of the doctor's discretion will be undermined if the information collected from the patient is inadequate in either quantity or accuracy.

3. But the critical point to appreciate is that all doctors' consultations, no matter what form of technology (if any) they employ, contain those two elements. In any type of consultation, problems may arise in either element: a patient may withhold some relevant aspect of their medical history (or a doctor may omit to request it); a question may be misinterpreted or an answer misrecorded; a medication may be mistakenly prescribed; the potential side effects of a treatment may be incompletely explained.

4. Consequently, the same regulatory principles should apply to all types of consultations. The modality of the consultation does not affect the relevance of those principles but the manner of their application.

5. To take the example of a patient not providing some relevant aspect of their medical history, this could occur because: the patient feels uncomfortable raising it in an in-person context; or the patient mishears the doctor's question during a phone consult; or a video lag during a Zoom consult results in the doctor misunderstanding the patient's answer; or the doctor does not ask the question during an asynchronous consult.

6. In all of those situations, the quality of the doctor's discretion may have been affected, and depending on how precisely the issue arose and whether it is rectified, the doctor may have breached a regulatory principle.

7. The purpose of the foregoing is to demonstrate that asynchronous telehealth consultations do not form some separate regulatory category. They are all consultations, albeit employing a slightly different process. The role of the Board is to regulate the doctor, not the technology.

The Draft Guidelines and the Board's apparent concerns about telehealth

8. The Draft Guidelines propose to prohibit, for the first time, the use of asynchronous telehealth during an initial consultation between a doctor and a new patient, regardless of the patient's medical condition or other circumstances.[19] They do not propose to prohibit this form of telehealth for any subsequent consultations.

9. The starting point is that the Board has not explained in the consultation paper accompanying the Draft Guidelines why it considers this new prohibition to be warranted. While there are nebulous statements such as that asynchronous telehealth "*is not good*

[19] Draft Guidelines, page 11. The exception is if the doctor can establish that departing from this principle was "*appropriate and necessary in the circumstances*"; this is discussed in Part III of this submission.

practice" and may "*limit*[]" the "*standard of care provided*", there are no more specific concerns articulated such as may explain the need for this prohibition.

10. However, from a series of media statements,[20] we have been able to discern that some of the specific concerns that the Board appears to hold may include:

    a. a lack of adequate medical history being taken or adequate assessment by the prescribing doctor;

    b. the prescribing of drugs of dependence;

    c. prescribing by algorithm;

    d. failing to explain the possible side effects or contraindications of prescribed drugs to patients; and

    e. the potential cost to patients of prescribing medications which are not reimbursed by the Pharmaceutical Benefits Scheme.

11. As this submission will demonstrate, none of those concerns is exemplified by the asynchronous telehealth provided by Eucalyptus.

12. But more broadly, we are concerned that the Draft Guidelines betray an incomplete understanding of how asynchronous telehealth can (and does) actually operate, and consequently adopt an insufficiently nuanced approach to regulating it.

13. Accordingly, this submission seeks to outline, in considerable detail, the processes by which asynchronous telehealth platforms can (and Eucalyptus does) ensure a high degree of safety and quality in their provision of healthcare — in some ways, more effectively than traditional GP clinics.

14. If implemented, the Draft Guidelines would represent the most significant shift in the regulation of telehealth since the present guidelines were released in 2012. In those circumstances, in our respectful view the Board should only act with the benefit of a full picture of the form of healthcare that it is proposing to newly regulate.

Structure of this submission

15. This submission focuses on the healthcare provided via Eucalyptus's platform, which is a leading exponent of asynchronous telehealth in Australia.

16. We recognise that some other such platforms do not employ all the same processes that Eucalyptus does, but we are concerned that the Board is proposing to act on an assumption that asynchronous telehealth is of a uniformly inferior quality to synchronous (or in-person) care. We seek to demonstrate that that is not the case.

[20] Primarily J Attwooll, 'Crackdown on 'unsafe' online prescribing underway', *newsGP*, 15 February 2023, <https://www1.racgp.org.au/newsgp/professional/crackdown-on-unsafe-online-prescribing-underway>.

17. By way of background, Eucalyptus's platform operates generally as follows:

    a. a patient will visit the platform (via one of Eucalyptus's brand websites) seeking treatment for one of a small number of supported health conditions;

    b. the patient will complete a detailed questionnaire (often with more than 50 questions) which collects a comprehensive clinical history targeted to the particular medical condition;

    c. the patient's responses will be reviewed by a doctor, who will then initiate a text-based exchange of follow-up clarifying questions and answers, and may also include the provision of photos or videos; and

    d. if the doctor determines that a prescription is appropriate, it will be issued and the patient will be provided with written counselling about the use of the medication, possible side effects, and other relevant information;

    e. the medication will be dispensed (if the patient so chooses) at one of Eucalyptus's partner pharmacies, which will dispatch the medication to the patient's home;

    f. the Patient Experience and Medical Support teams triage, and respond to, any inquiries the patient may have during their treatment (including by referring them to the doctor if necessary); and

    g. the patient engages in regular review and follow-up consultations with their doctor (before further repeat scripts may be issued), in advance of which they complete an additional questionnaire seeking details about their experiences with the prescribed treatment.

18. This submission adopts the following structure:

    a. we first set out the context in which the Draft Guidelines should be analysed, by outlining the asynchronous telehealth landscape generally and then by describing key characteristics of Eucalyptus's platform specifically; and

    b. we then review the new prohibition being proposed in the Draft Guidelines and consider its implications, while also suggesting some possible alternative methods of regulation.

II. The Appropriateness of Asynchronous Telehealth

19. Asynchronous telehealth refers to the provision of healthcare in any manner that is not in real-time. While it commonly includes text-based communication, it need not be limited to that format: the exchange of photos, videos and voice recordings may all be used to deliver healthcare in this way.

20. While asynchronous telehealth is relatively new in Australia, it is frequently misunderstood. This misunderstanding relates not only to the mechanisms by which this form of telehealth operates but also to the opportunities for high standards of safety and quality which it presents.

21. That is not to say that asynchronous healthcare is the solution to every medical problem. We think it is uncontroversial that asynchronous telehealth (and, indeed, any form of telehealth) is not appropriate for all circumstances or all patients.

22. Part II of this submission seeks to provide a comprehensive overview of the telehealth landscape and the methods by which asynchronous telehealth platforms can (and Eucalyptus — as a leading player in this sector — does) provide a standard of care which is in some ways superior to that which could be obtained in a community GP clinic.

(a) The telehealth sector is not monolithic

(i) <u>There is not one type of 'telehealth'</u>

23. 'Telehealth' is a very broad concept and should be understood that way. As an alternative to physical, in-person doctor consultations, telehealth may fall into the following categories:

    a. **synchronous telehealth** — this employs *real-time* communication, generally by phone or video but may also incorporate text-based chat; and

    b. **asynchronous telehealth** — this involves communication *not in real time* , using one or more of text-based, image-based and recorded audio/video-based communication.

24. As is clear from the above, the very same forms of technology can be employed in both types of telehealth. The primary differences between these categories are twofold — one in form, and one in practice:

    a. the *immediacy* of the communication (synchronous consults involve the exchange of information instantaneously, or close to it); and

    b. the extent of *non-verbal data* communicated (video and phone transmission may convey more information through cues such as intonation and facial expressions).

25. As discussed further in the next subsection, whether or not these differences will have an impact on the quality or outcome of a doctor consultation will depend (among other things) on the medical condition being considered.

26. While there are reasons for choosing a synchronous consultation in certain situations, there are also unique benefits offered by asynchronous consultations:

    a. *improved record-keeping and richer, more consistent data* — since every doctor-patient interaction is recorded and there are fewer issues of information being incorrectly transcribed, misunderstood or missed;

    b. *greater convenience for both doctors and patients* — since consultations can take place at a time of each participant's own choosing (without having to schedule an appointment); and

    c. *more appropriate for stigmatised medical conditions* — since they may otherwise discourage patients from seeking treatment.

27. But given the large range of technologies which may be employed in a telehealth consultation (both in combination and separately), there are almost limitless methods of delivering telehealth. Describing something merely as a 'telehealth consultation' actually conveys very little about the method — or quality — of that interaction.

28. Indeed, even within the category of asynchronous telehealth (which Eucalyptus primarily offers), there is a range of methods of providing care.

29. For instance, many asynchronous telehealth platforms employ some form of questionnaire to obtain a patient history as part of the initial interaction. This may be compared with a new patient intake form which GP clinics often ask patients to complete. In both settings, the thoroughness and quality of the information thereby derived will depend heavily on the number, type and formulation of the questions.

30. But, consistently with the broad definitions outlined earlier, providing a questionnaire is not the only possible method of facilitating the delivery of telehealth asynchronously. It will virtually always be critical for the treating doctor, on reviewing the patient's questionnaire responses, to have the capacity to ask follow-up questions — whether to clarify something the patient has said or to gather more information, in order to make an informed diagnosis.

31. In a GP clinic using a patient intake form, these follow-up questions will be posed in person. An asynchronous telehealth platform may provide a chat function for the doctor to ask questions of the patient, and for the patient to ask questions of the doctor. These communications may not only be text-based: the patient may provide photos of a symptom they are experiencing; the doctor may pre-record a video explaining a medical concept; the patient may send a voice message to clarify an issue.

32. Once again, identifying a telehealth consultation merely as 'asynchronous' does not describe its modality, and in particular does not mean that it only involves a questionnaire. Ultimately, it is up to the treating doctor to determine whether they have enough information — in an appropriate format — to diagnose the patient and, if considered suitable, to propose a treatment.

(ii) There is a large range of telehealth platforms

33. Just as there is a spectrum of GP clinics and other primary healthcare providers, and just as there is a spectrum of GPs themselves, so there is a spectrum of telehealth platforms. And while it is largely the doctors on those platforms who deliver care, the infrastructure around them can play an important role in facilitating safety and quality.

34. One external validator of safety and quality is accreditation. In Australia, GP clinics may (but are not required to[21]) be assessed against the RACGP's *Standards for general practices* as part of a scheme administered by the Australian Commission on Safety and Quality in Health Care (**Commission**).[22] Around 85% of general practices in the country are accredited.[23]

35. There is no equivalent accreditation scheme developed specifically for telehealth platforms.[24] Nonetheless, Eucalyptus chose to be assessed against the Australian Council on Healthcare Standards' (**ACHS**) EQuIP6 accreditation and obtained accreditation.[25]

36. ACHS is authorised by the Commission as an accrediting agency (for standards administered by the Commission). EQuIP6 is a broad quality improvement program which is internationally recognised and ensures that organisations such as telehealth services "*adopt systems and processes to monitor and improve the quality of the services provided*".[26] Applicant organisations must meet almost 50 criteria in order to be accredited numerous categories including continuous assessment of patient need, medical records management, clinical governance framework and risk assessment.

37. Eucalyptus is the only online telehealth provider in Australia to be EQuIP6 certified.[27] In its written assessment report, the ACHS representatives stated that "*Eucalyptus has built the infrastructure for GPs to provide healthcare services to patients from the entry of the patient to the identified program to off-boarding whilst enabling high quality and safe delivery of telehealth care*".[28] The mechanisms by which Eucalyptus achieves this outcome are outlined in detail later in Part II of this submission.

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[21] See generally : mpconsulting, 'Review of general practice accreditation arrangements: Prepared for the Department of Health', 27 October 2021, <https://consultations.health.gov.au/primary-health-networks-strategy-branch/review-of-general-practice-accreditation-arrangeme/results/reviewofgeneralpracticeaccreditationarrangements-final-october2021.pdf>.

[22] Australian Commision on Safety and Quality in Healthcare, 'The National General Practice Accreditation Scheme', *Australian Commision on Safety and Quality in Healthcare*, <https://www.safetyandquality.gov.au/national-general-practice-accreditation-scheme>.

[23] See generally : mpconsulting, 'Review of general practice accreditation arrangements: Prepared for the Department of Health', 27 October 2021, <https://consultations.health.gov.au/primary-health-networks-strategy-branch/review-of-general-practice-accreditation-arrangeme/results/reviewofgeneralpracticeaccreditationarrangements-final-october2021.pdf>.

[24] We note that the Commission has developed National Safety and Quality Digital Mental Health Standards: see <https://www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards>.

[25] Evaluation and Quality Improvement Program (6th edition), in the category of Healthcare Support Services: see <https://www.achs.org.au/our-serNational Safety and Quality Digital Mental Health Standardsvices/accreditation-and-standards/accreditation-programs/equip6/healthcare-support-services>.

[26] Ibid.

[27] Another online health-related platform, Sonder, has also obtained this accreditation although it does not offer medical prescriptions: see R Evans, 'Why is ACHS accreditation important to us and our customers?', Sonder, 14 April 2022, <https://sonder.io/blog/achs-accreditation-sonder/>.

[28] ACHS, *Report of the Certification Review for the ACHS Evaluation and Quality Improvement Program*, EUC Services Pty Ltd (assessment date: 8 December 2022), copy on file with Eucalyptus.

38. By contrast, the leaders of some other Australian telehealth platforms have had conditions placed on their registration by the Board,[29] while those in other countries have had questions raised about the incentive structures they implement for doctor prescribing.[30] Similarly, some Australian telehealth platforms use extremely short questionnaires to support a prescribing decision, and in many cases do *not* provide the facility for follow-up questions (which, in our view, is *already* in breach of the existing *Code of Conduct*, as discussed in Part III of this submission).

39. In other words, the telehealth sector is not monolithic, and the term 'telehealth' is not synonymous with a certain level of quality or safety standards.

(b) Telehealth is not appropriate for all medical conditions

40. The Board's central proposition in the Draft Guidelines is that telehealth "*is not appropriate for all medical consultations and should not be considered as a substitute for face-to-face consultations*".[31] We agree.

41. In our view, general practice (ie, doctor consultations for any medical condition for which a patient may seek treatment) is almost by definition inappropriate for telehealth. It is hardly controversial that, for example, certain medical conditions require physical examination by a doctor in order to be properly diagnosed and treated.

42. However, it would be misguided to attempt to define which conditions are appropriate or not for telehealth consultations. That is as much a reflection of the wide gamut of medical conditions as it is the wide variety of forms of telehealth delivery. Some conditions, such as muscle-related injuries or other internal ailments, are always inappropriate for telehealth. Others, such as mental health conditions, may only be appropriate for video-based telehealth consultations (where they are appropriate for telehealth at all).[32]

43. But beyond that, there is in reality a spectrum of other conditions which may, with greater or lesser degrees of likelihood, be suitable for telehealth diagnosis and treatment — depending, always, on the particular patient, symptoms and other circumstances. Sometimes a consultation may commence via telehealth and then need to migrate to an in-person consultation (eg, due to a physical complication). The reverse will also be true. Indeed, the Board accepts that "[a] *mix of face-to-face and telehealth consultations can provide good medical care*".[33]

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[29] N Bonyhady, 'InstantScripts founder slapped with conditions on medical registration', *The Sydney Morning Herald*, 29 November 2022, <https://www.smh.com.au/business/companies/instantscripts-founder-slapped-with-conditions-on-medical-registration-20221128-p5c1qz.html>.

[30] See, eg, H Landi, 'Cerebral under federal investigation for possible violations of controlled substances law', 7 May 2022, *Fierce Healthcare*, <https://www.fiercehealthcare.com/health-tech/cerebral-under-federal-investigation-possible-violation-controlled-substances-law>.

[31] Draft Guidelines, page 8.

[32] For example, the Royal Australian and New Zealand College of Psychiatrists advises, in its *Professional Practice Guideline 19* for telehealth in psychiatry, that telehealth psychiatry consultations (especially initial assessments) be conducted by video and that phone consultations only be used for known patients where the clinical risk is low: see at <https://www.ranzcp.org/files/resources/practice-resources/telehealth-professional-practice-guideline.aspx>.

[33] Draft Guidelines, page 8.

44. We note, for instance, that the pharmacist prescribing trials which are currently underway in several Australian states[34] identify specific medical conditions and medications that a pharmacist may treat. What is common to those conditions is that they are generally on the lower end of the spectrum of complexity. Of course, pharmacists' training limits their scope of practice as compared to doctors and so these trials are not entirely analogous to the present debate; however, they provide a more nuanced example of an approach to the regulation of prescribing.

45. Eucalyptus only offers telehealth consultations for a tightly defined range of conditions, which are, primarily:

    a. for women's health — obesity, fertility, contraception and menopause;

    b. for men's health — sexual health conditions (chiefly erectile dysfunction and premature ejaculation), hair loss and obesity; and

    c. for all patients — skincare for acne and anti-ageing.

    It is worth noting that none of these conditions result in prescriptions being issued for drugs of dependence.

46. Our clinical guidelines require doctors to not prescribe if they consider that a physical examination of the patient is necessary or that telehealth is inappropriate for any other reason. As outlined in further detail in section (c), the rates at which doctors consulting on Eucalyptus's platform determine that a patient is inappropriate for telehealth can be substantial.

47. This approach is consistent with the RACGP's guidance on telehealth consultations,[35] which recommends that telehealth is likely to be inappropriate in at least the following situations:

    a. where a physical or internal examination is required to support clinical decision-making;

    b. where a patient's ability to communicate via telehealth may be compromised; or

    c. where there is any doubt about the appropriateness of treatment by telehealth.

48. That guidance also refers to the proposition that it is the doctors themselves who are best placed to make that determination. We agree.

[34] See, eg, NSW Government, 'State-wide pilot for appropriately trained community pharmacists to prescribe medications'', *NSW Health*, <https://www.health.nsw.gov.au/pharmaceutical/Pages/community-pharmacy-pilot.aspx>.

[35] Royal Australian College of General Practitioners, 'Guide to providing telephone and video consultations in general practice', *RACGP*, 6 April 2020 <https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Guide-to-providing-telephone-and-video-consultations.pdf>.

(c) Safety issues

49. In some ways, telehealth — and particularly asynchronous telehealth — presents the most effective framework within which to implement and enforce high safety standards. This is because of the unique capacity to collect and track all data associated with the provision of the care.

50. Consider a typical community GP clinic. While the doctors use common reception staff and prescribing software, they are often not coordinated in any other way in their practice. If they make errors in their prescribing decisions, or their patients experience poor health outcomes, or a patient suffers an adverse medical event outside opening hours or their doctor's availability, the doctor and clinic are limited in their ability to respond.

51. A prescribing error may, but frequently will not, lead to a complaint to a regulator. A poor health outcome may lead to further doctors' consultations, perhaps with a different doctor or at a different GP clinic. A patient suffering an adverse medical event will either try to manage the issue themselves or will end up at the (already overburdened) emergency department of a hospital.

52. In the rare event that a patient makes a complaint to a regulator — say, the NSW Medical Council or the Professional Services Review — the regulator will seek evidence of the conduct of the relevant consultations, and may ask for copies of the doctor's medical records and their recollection of the events. The records may be incomplete (or even paper-based); the doctor's recollections may differ materially from those of the patient. This may then impact the outcome of the regulator's review or even affect its capacity to render a decision.

53. Such a scenario is almost impossible in the context of asynchronous telehealth, because *every interaction between the doctor and the patient is recorded and can be analysed.*

54. This is a critical factor in favour of the safety potential presented by asynchronous telehealth platforms, and must be taken into account when the overall risk profile of telehealth is considered. It is a unique point of difference from physical GP consultations (and, to some extent, from video- and phone-based consultations).

55. Indeed, in a 2022 peer-reviewed study, the treatment of erectile dysfunction via asynchronous telehealth was compared to that via synchronous telehealth, with a focus on the rates of patient-reported side effects in each. The study found that there were no statistically significant differences in those rates and that, consequently, "[i]*n some circumstances, such as treatment for erectile dysfunction, asynchronous care can offer the same level of safety in prescribing when compared with synchronous care*".[36]

56. More generally, a 2021 study published in the *British Medical Journal Innovations* directly compared the use of asynchronous versus synchronous forms of communication between healthcare professionals within hospital operations in the UK. The study found that, apart

[36] L Broffman et al, 'Evaluating the Quality of Asynchronous Versus Synchronous Virtual Care in Patients with Erectile Dysfunction: Retrospective Cohort Study' (2022) 6(1) *JMIR Formative Research* 1, 1.

from improving the efficiency of communications, asynchronous platforms maintained the service quality levels of synchronous equivalents.[37]

57. By way of example, in this subsection we set out some of the safety-related purposes for which Eucalyptus collects and analyses data in relation to the telehealth consultations conducted on its platform. These could of course be implemented by any telehealth platform, either voluntarily or by force of a regulation or guideline.

(i) Use of data generally

58. In 2022, Eucalyptus instituted a project to define measurable safety thresholds in all aspects of the company's medical operations. This followed an exhaustive investigation into the most meaningful methods of measuring the safety of Eucalyptus's services. Each of these thresholds is monitored and reported on fortnightly.

59. The thresholds are defined in relation to each 'touchpoint', or category, of interaction between a patient and the Eucalyptus platform:

a. *Support* (ie, the Medical Support team, comprising registered nurses and pharmacists, as well as accredited practising dieticians, all of whom respond to patient inquiries which may have a clinical element but are not necessary to be escalated to a doctor);

b. *Prescribing* (ie, the prescribing practices of the doctors on the platform);

c. *Platform* (ie, the infrastructure supporting the collection and transfer of patient information as well as the prescribing and communication by doctors);

d. *Pharmacy* (ie, the dispensing practices of Eucalyptus's partner pharmacies, where a patient has chosen to have their medication dispensed there); and

e. *Treatments* (ie, patient safety events and other incidents as a result of the medications prescribed via the platform).

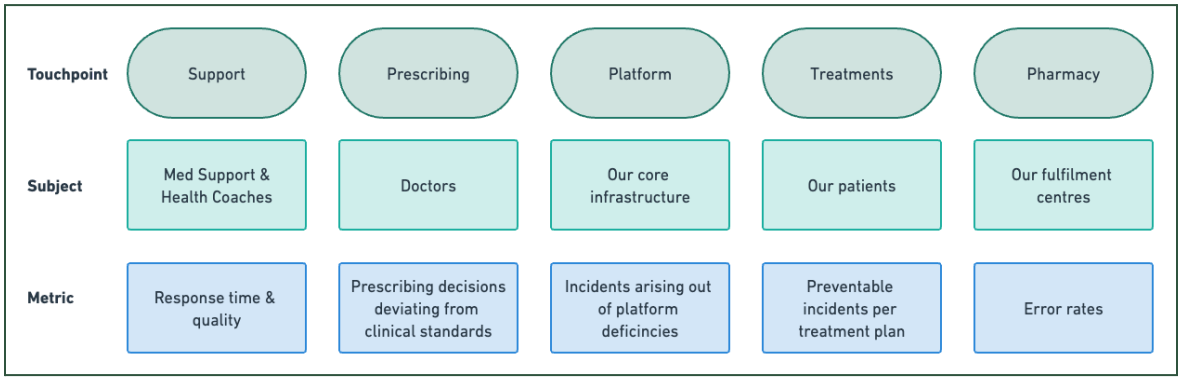

Figure 1: Categories of 'touchpoint' threshold employed to measure safety standards at Eucalyptus.

[37] Jhala et al, 'Examining the impact of an asynchronous communication platform versus existing communication methods: an observational study' (2021) 7 *BMJ Innovations* 68-74, <https://innovations.bmj.com/content/7/1/68>.

60. These thresholds have been defined and validated by reference to external sources and research. For instance, the safety standard that Eucalyptus adopts for pharmacy dispensing errors is no more than 0.04% of all medications dispensed: this figure was informed by a meta-analysis of 60 clinical papers published in the *International Journal of Pharmacy Practice*,[38] with 0.04% representing the lower end of the spectrum of error rates identified in that article as having been recorded by hospital and community pharmacies around the world.

61. Eucalyptus's Analytics team collects and digests the relevant data while the Clinical Safety team reviews, interprets and reports on it. The result is that a comprehensive view is generated of the overall safety of the platform, in sufficient detail to allow issues to be identified and, importantly, responded to. (Thus, for instance, if an individual prescriber is involved in a disproportionate number of safety events, the prescriber can be identified and additional guidance provided to them.)

62. It goes without saying that there is simply no equivalent to this approach in community GP clinics. Prescribing software does not ingest this data, let alone analyse it. To the extent that the clinical governance bodies of GP clinics consider the overall safety performance of individual GPs or their patients at all, that data is not often acted upon (whether in a coordinated manner or at all).

(ii) Physical examinations and rejection rates

63. As stated above, it is uncontroversial that telehealth consultations are not appropriate for all patients or medical conditions. A doctor, properly informed of a patient's clinical background, is best placed to make the determination about whether a consultation in this form is suitable or not. Such a decision may be made because the patient's circumstances require a physical examination, or referral to a specialist, or a treatment that is not easily managed via telehealth.

64. Eucalyptus's platform facilitates this decision and requires doctors to make it where they deem it appropriate. If a doctor determines that a patient could not be appropriately treated on the Eucalyptus platform, an explanation is provided to the patient and they are generally recommended to consult with their GP in person.

65. For each of the medical conditions treated on the Eucalyptus platform, in-house clinical protocols provide recommendations about appropriate treatment options. These guidelines are informed by credible external sources, such as those published by the RACGP, the British Medical Journal Best Practice, and similar publications. But they are generally *more conservative* than those external guidelines, precisely because Eucalyptus recognises that the circumstances in which it is appropriate to treat a patient in a telehealth context are narrower than those in an in-person context.

66. The rate at which doctors consulting on the Eucalyptus platform, for a given medical condition, determine that a patient is unsuitable for treatment on the platform (referred to as the "rejection rate") is recorded, monitored and regularly analysed. While it is to be expected that this rate will not be static, if there are unusual deviations from the mean by

[38] K Lynette James et al, 'Incidence, type and causes of dispensing errors: a review of the literature' (2009) 17(1) *International Journal of Pharmacy Practice* 9-30, <https://academic.oup.com/ijpp/article/17/1/9/6130520#229801569>.

particular doctors, their consults will be audited and, if necessary, they will be provided with further guidance or education.

67. For example, in the past 12 months, the rate at which doctors consulting on the Pilot platform — across the various medical conditions treated on that platform — determined that a patient was not suitable for telehealth was around 50%.

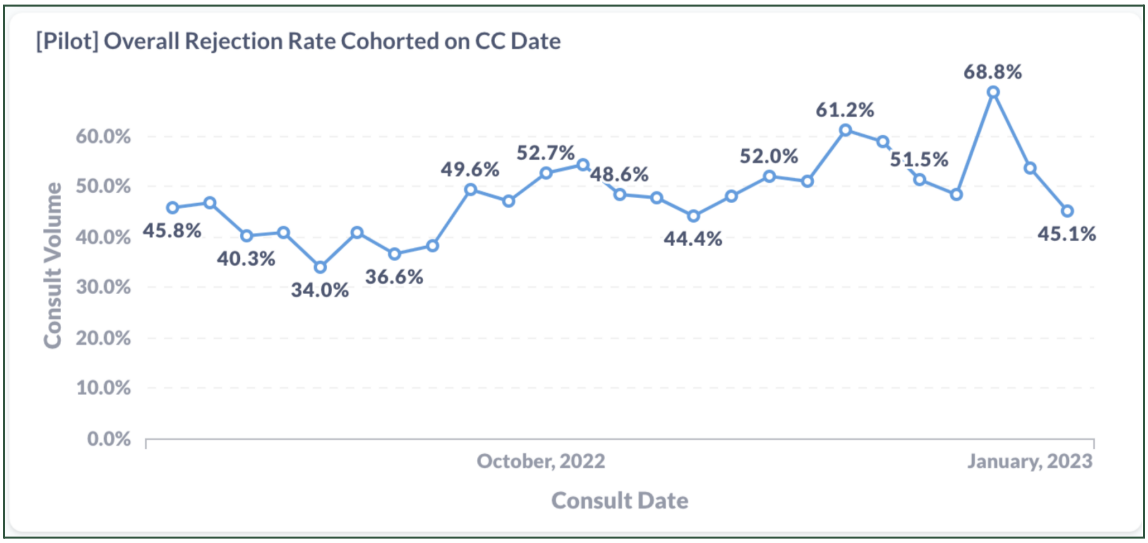

Figure 2: Rejection rate of overall Pilot patients based on the date on which they completed their initial medical history questionnaire.

68. Another manifestation of this safety-focused discretion applied by doctors consulting on Eucalyptus's platform is in the form of 'de-prescribing' and the raising of medical issues which had not been identified by the patient's previous GP.

69. For instance, Eucalyptus's fertility brand, Kin, facilitates the prescribing of the contraceptive pill to Australian women. Far from this process leading to easy access to that medication for patients (including those who may have previously been advised against taking it), the doctors consulting with Kin frequently 'deprescribe' patients where risk factors that would render the contraceptive pill unsafe for them are identified through the robust history-taking on the platform. In particular, patients who have been prescribed a combined oral contraceptive for many years who report obvious UK MEC 3 and 4 contraindications[39] are regularly identified and advised to cease their current medication.

70. Similarly, doctors consulting on Eucalyptus's platform frequently identify patients:

    a. with non-compatible medication regimens prescribed to them by community GPs, such as the 'triple-whammy' therapy[40] which every medical student, pharmacist and nurse knows should never be prescribed;

[39] The Faculty of Sexual and Reproductive Healthcare, 'UK Medical Eligibility Criteria for Contraceptive Use', *UKMEC*, 2019 <https://www.fsrh.org/documents/ukmec-2016/>.

[40] K Loboz and G Shenfield, 'Drug combinations and impaired renal function – the 'triple whammy'', *British Journal of Clinical Pharmacology*, (2005) 59(2) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1884747/> 239–243.

b. who have been prescribed many years of unnecessary antibiotic formulations for acne; or

c. who regularly use illicit drugs combined with pharmaceutical agents.

71. These are powerful illustrations of the effective operation of the rigorous eligibility criteria outlined in Eucalyptus's clinical protocols and applied by doctors consulting on its platform. By contrast to the perception that telehealth platforms are simply 'pill pushers' which seek 100% prescribing rates, Eucalyptus views its internal statistics (in which many prospective patients are deemed inappropriate for treatment via telehealth) as a sign of success.

(iii) Responding to complications etc

72. One facet of the stated concern about continuity of care advanced by opponents of telehealth is that only a regular GP can effectively respond to patients' healthcare complications when they arise. Only a regular GP, so the argument goes, can quickly triage a patient's concern by reference to their medical history and deal with it efficiently.

73. Of course, this does not represent the practical reality. Quite apart from the well publicised access issues of GP availability (discussed further below), patients often experience issues outside the business hours of GP clinics. As a result, many patients present at hospital emergency departments when their circumstances do not warrant it. Indeed, in 2021-2022, there were over 3 million potentially avoidable hospital presentations.[41]

74. Generally speaking, GP clinics have no effective mechanism to deal with these issues. This is another area in which telehealth is uniquely positioned to provide a real difference to patient safety outcomes.

75. Eucalyptus, for instance, manages a Medical Support team which is staffed by registered nurses and pharmacists. The team operates from 8am to 6pm on weekdays and regularly monitors emails (which is the primary means by which patients communicate with the team) outside those hours. They work on the basis of detailed triaging guidelines which allow them to identify the most important issues which demand a short turnaround time.

76. In addition, for patient issues which arise outside those time periods, Eucalyptus has developed an email auditing system that detects keywords for 'red flag' issues and responds automatically. For instance, if a patient emails at 1am complaining of chest pains, they will immediately receive a response advising them to call an ambulance.

77. Eucalyptus also tracks the proportion of patients who report side effects to the Medical Support team, which allows the team to calibrate its proactive patient education and to guide doctors in their consultations. The below graph illustrates this type of data during 2022:

[41] A Tillett, 'Report boosts case for Medicare overhaul, shift beyond GPs', *Australian Financial Review*, 2 February 2023, <https://www.afr.com/politics/federal/more-than-3m-australians-went-to-hospital-when-they-didn-t-need-to-20230201-p5ch38>.

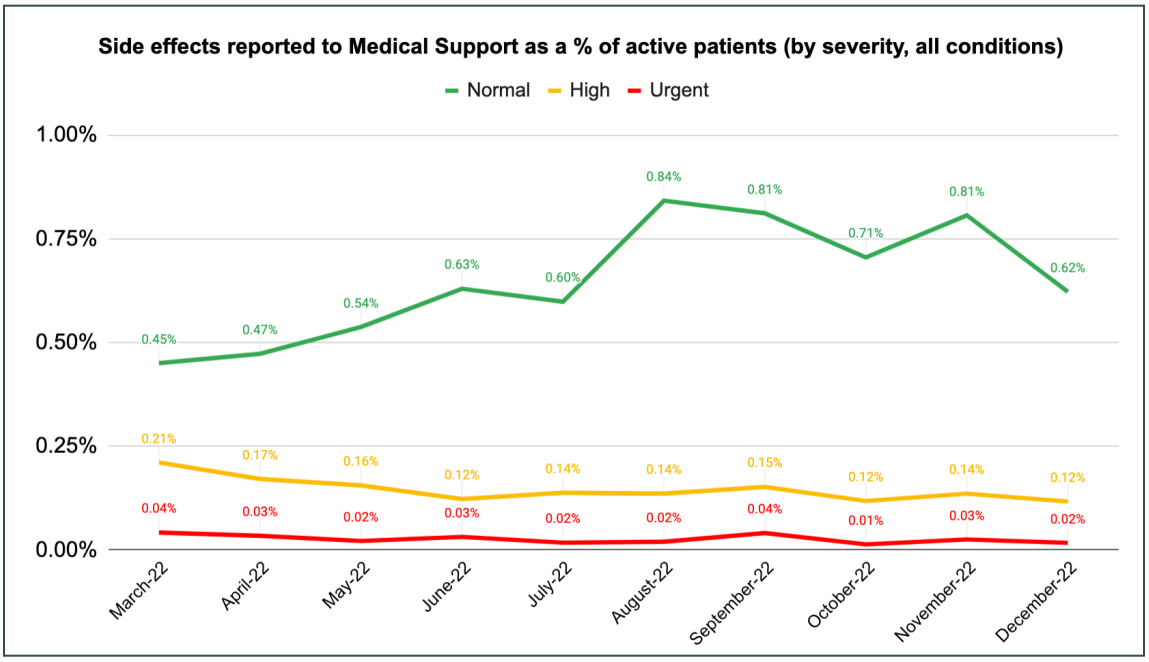

Figure 3: Percentage of active patients, separated by Eucalyptus brand, reporting side effects of their treatment during 2022.

78. We would be astonished if any GP clinic in the country collected and tracked data in this way.

(d) Quality issues

79. One of the most widespread assumptions about telehealth is that it is of uniformly poorer quality than physical consultations. Once a doctor has determined that a patient's condition is an appropriate candidate for telehealth (discussed further in section (b) above), on the basis of the practices adopted at Eucalyptus this assumption is simply inaccurate.

(i) Credentialing of doctors

80. It is often asserted that the prescribers on telehealth platforms are insufficiently qualified and may be merely medical graduates.[42] While we cannot speak for other platforms, at Eucalyptus this is certainly not the case.

81. Before being engaged to consult on the platform, prospective doctors are reviewed using a model designed by reference to the Royal Australian College of Medical Administrators' *Guide to Credentialling and Scope of Clinical Practice Processes*.[43] By applying this model, for

[42] See: 'Why health professionals are concerned about the future of telehealth', *The Conversation Hour*, ABC, 27 January 2023 <https://www.abc.net.au/melbourne/programs/theconversationhour/the-conversation-hour/14138082>.

[43] See Royal Australasin College of Medical Practioners. 'RACMA Guide to Credentialing and Scope of Clinical Practice Processes', *RACMA*, <https://racma.edu.au/resources/racma-publications/racma-guide-to-credentialing-and-scope-of-clinical-practice-processes/.

around two years the doctors engaged to consult on Eucalyptus's platform have met the following criteria:

a. registered with the Australian Health Practitioner Regulation Agency and based in Australia;

b. Fellows of the RACGP (ie, they have passed additional exams entitling them to practise independently, and are usually at least 5 years post-graduation);

c. experienced in community practice (the vast majority of doctors on Eucalyptus's platform work part time, and otherwise practise in a GP clinic); and

d. experienced specifically in relation to one or more medical conditions treated on Eucalyptus's platform.

82. Once a doctor has been onboarded to the platform, their performance continues to be assessed and support continues to be offered to ensure that they are able to meet the high quality standards outlined in Eucalyptus's clinical protocols. This is effected in the following ways:

a. on a weekly basis, the Incident Response and Clinical Audit teams meet to discuss any high impact patient events which have arisen and identify any resulting doctor issues requiring a response;

b. patient satisfaction indicators are continuously assessed and action taken in response where appropriate;

c. on a monthly basis, Eucalyptus's executive team receives updates on the platform's clinical safety and quality data;

d. on a quarterly basis, all doctors are invited to clinical meetings to discuss common patient issues that have occurred on the platform;

e. regular education sessions are organised in which external subject matter specialists provide additional guidance and insights from the latest research;

f. doctors are provided with education and continuous professional development resources to ensure that they are staying up to date with the latest evidence; and

g. regular feedback sessions with each doctor are organised, during which a review of their own data and patient feedback is provided (in line with the updated Board CPD requirements for practitioners[44]), with a particular focus on reviewing performance and measuring outcomes activities.

[44] Australian Health Practitioner Regulation Agency, 'Continuing Professional Development', *AHPRA and National Boards*, <https://www.ahpra.gov.au/Registration/Registration-Standards/CPD.aspx>.

(ii) Clinical independence

83. As noted earlier, a common (but misconceived) assertion advanced in opposition to telehealth platforms is that they prioritise profits over patients. Within this assertion is the implication that doctors prescribing on those platforms are somehow incentivised in a manner that boosts the profits of the company operating the platform (eg, prescribing more frequently than may be appropriate).

84. There are no such incentives to doctors who consult on Eucalyptus's platform. Instead, their clinical autonomy is protected at all times, including by way of the following:

    a. the contracts by which doctors are engaged, and Eucalyptus's internal protocols, explicitly underline doctors' clinical independence;

    b. doctors' remuneration and other benefits are unaffected by their decision whether or not to prescribe in a given situation (assuming that that decision is otherwise consistent with good clinical practice);

    c. no doctors are paid per script — they are either paid per consultation (adopting the same model as Medicare) or, for a smaller proportion of doctors, they are engaged on a salaried basis and so their remuneration is unaffected by the number of consultations they undertake; and

    d. doctors operate independently of Eucalyptus's finance and marketing teams, and are not exposed to the company's financial metrics.

85. As outlined above in subsection (c), the rates at which patients seeking care on Eucalyptus's platform are determined to be unsuitable for treatment via telehealth approach 50% for some conditions. This is, in our submission, a persuasive indicator that doctors on the platform are not incentivised to prescribe.

(iii) Continuity of care

86. Another concern often raised in relation to telehealth platforms is that they can lead to the fragmentation of patient care. The starting point is to recognise that Australians increasingly do not see the same GP in the first place (although that should not in any event affect the regulation of telehealth, since it is ultimately a patient's decision whether they wish to see a regular GP).

87. In particular, a 2018 study published by the RACGP indicated that 31.8% of Australians reported attending multiple general practices in the previous 12 months.[45] In other words, almost a third of the population attended a new GP clinic in which the doctor they consulted did not have access to their medical record, and instead was required to take a thorough history before proceeding to treatment. Accordingly, the notion that all patients have an excellent local GP with extensive medical records may be true for many, but is untrue for millions of Australians.

[45] The study found that 28% of survey respondents reported attending more than one general practice in the previous 12 months, and after excluding respondents reporting fewer than two visits during that period, the overall percentage rose to 31.8%. See M Wright et al, 'How common is multiple general practice attendance in Australia?', (2018) 47(5) *Australian Journal of General Practice*, <https://www1.racgp.org.au/ajgp/2018/may/how-common-is-multiple-general-practice> 289, 290.

88. In any event, Eucalyptus employs multiple tools to ensure that patients receive ongoing support after their initial consultation with a GP.

89. First of all, unlike some telehealth platforms, Eucalyptus does not offer one-off scripts. The primary purpose of treatment on the platform is long-term, 'high-touch' care. While some patients who seek treatment with Eucalyptus have previously obtained treatment for their medical condition (this includes the majority of patients seeking the contraceptive pill via the Kin brand), most of them are obtaining it for the first time.

90. A new patient's contact with Eucalyptus is not limited to their initial doctor consultation. In fact, on average a new Eucalyptus patient for certain medical conditions may receive at least 10 (and often more) touch points of communication with the platform within their first two weeks of treatment. Of course, the capacity to provide such regular points of contact is almost non-existent among traditional GP clinics.

91. Depending on the condition being treated, a Eucalyptus patient may receive emails from the Patient Experience and Medical Support teams, contact with accredited practising dieticians and health coaches, engagement with an online community of other patients, and educational materials provided in hard copy or on the Eucalyptus platform. Moreover, the contact is not only one-way: the Patient Experience and Medical Support teams also field up to 1,000 inquiries from patients on a daily basis, as illustrated in the below graph:

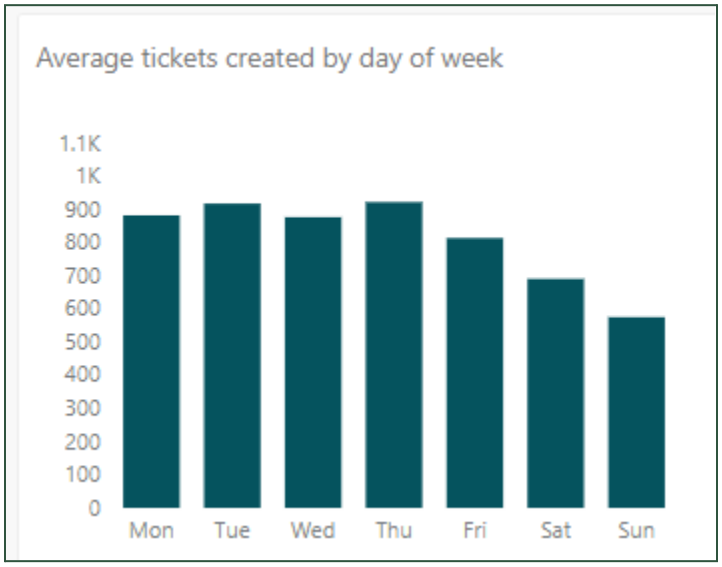

Figure 4: Average number of tickets created in response to a Eucalyptus patient inbound inquiry, per day of the week.

92. One way of measuring the effectiveness of continuous care is to analyse patients' health outcomes. Of particular relevance here are patients' outcomes in relation to Eucalyptus's weight management program, dealing with a medical condition which is uniquely sensitive to continuity of care.

93. This program involves not only prescription medication with doctor supervision but also dedicated dieticians and health coaches, a supportive online community of other patients, and tracking mechanisms via the patient's online account. This holistic approach ensures

effective behavioural intervention so that the patient's lifestyle factors, including diet and exercise, are properly addressed.

94. In this way, weight loss patients following the program offered by Eucalyptus's Juniper brand have so far experienced better weight outcomes than the most closely analogous clinical study using the same class of medication and similar forms of behavioural intervention.[46] By this comparison, after 7 months of treatment the average Juniper patient lost 11.76% of their body weight, compared to 8.24% of weight loss in the clinical study:

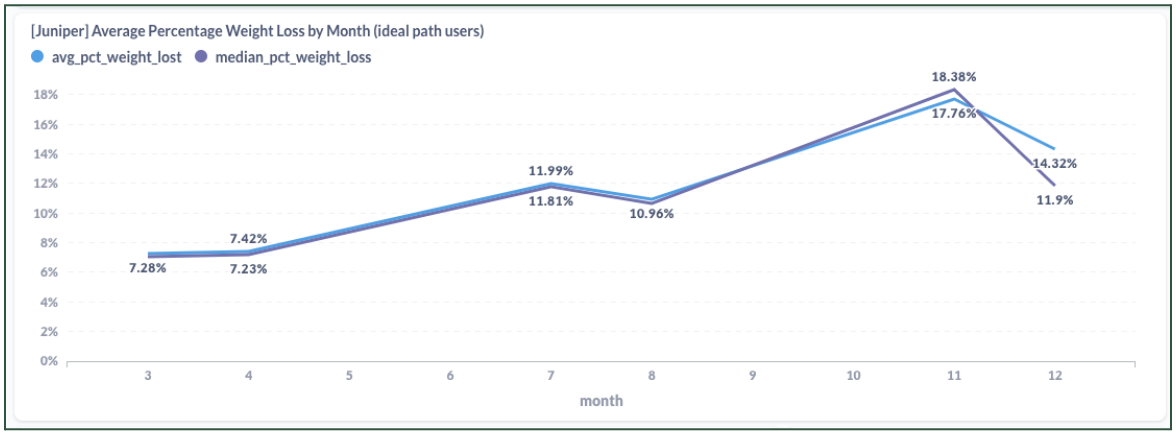

Figure 5: Average weight loss (expressed as a percentage of original body weight) by number of months following the weight reset program offered by Eucalyptus's Juniper brand.

95. Finally, to assist with continuity of care and the provision of effective safety netting, all patients are encouraged to discuss their treatment on Eucalyptus's platform with their regular GP (should they have one) and are provided with letters of correspondence to their GP, where requested and consented to by patients.

96. Moreover, Eucalyptus's in-house-built prescribing software was recently certified by the Australian Digital Health Agency for electronic prescribing following extensive compliance testing,[47] in connection with which Eucalyptus will soon have the capacity to upload all patient interactions to the My Health Record. This process is not routinely completed by GP practices in the community, despite this being the design intention of the Department of Health and the RACGP.

97. Indeed, this failure of adoption of interoperability was recently highlighted in the Strengthening Medicare Taskforce Report, which proposes "*sharing by default*"[48] — a recommendation with which a technology-native platform such as Eucalyptus is well equipped to quickly comply.

[46] X Pi-Sunyer et al, 'A Randomized, Controlled Trial of 3.0mg Liraglutide in Weight Management' (2015) 373 *New England Journal of Medicine* 11-22; accessible at: https://www.nejm.org/doi/full/10.1056/nejmoa1411892.

[47] Australian Government, 'Electronic Prescribing Register of Conformance, *Australian Digital Health Agency*, 12 January 2023, <https://www.digitalhealth.gov.au/sites/default/files/documents/ep-conformance-register-20230112.pdf>.

[48] Australian Government, '*Strengthening Medicare Taskforce Report*' (2022), <https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf> 9.

98. (iv) Thoroughness of consults

99. As stated above [17], and unlike some telehealth platforms, doctors consulting with Eucalyptus do not rely only on a patient's responses to a questionnaire in making clinical decisions — instead, there are further follow-up questions and answers before a doctor determines whether to prescribe a medication.

100. But even in relation to the questionnaire alone, Eucalyptus obtains an extremely detailed medical history from each patient — one which is, in our submission, far more comprehensive than would ordinarily be experienced in a community GP clinic.

101. The questionnaire for prospective patients of Eucalyptus's weight management program, for instance, currently has up to 81 questions. In addition to collecting basic patient information (such as allergies and current medications), the questionnaire seeks details about:

    a. co-morbidities related to being overweight or obese;

    b. eating disorder screening;

    c. previous weight loss interventions;

    d. any indications of mental health issues;

    e. specific absolute and relative contraindications to treatments; and

    f. lifestyle characteristics such as frequency of exercise and quality of diet.

102. The questionnaires are also dynamic and conditional, meaning that certain responses to a particular question will lead to additional questions targeted to a given patient's circumstances. This means that when it comes to a doctor's review of the patient's responses, they have the most relevant information at their disposal before they even begin asking follow-up questions.

103. In addition, in many cases the consults are not solely text-based. For example, for patients seeking skincare treatment, they are required to provide several photos of their skin (from different angles) in order to assist the doctor to make a prescribing decision. In other cases, if the doctor needs the patient to provide an up to date blood pressure result, the patient will be asked to upload a photo of their blood pressure reading (taken, eg, at a pharmacy) accompanied by a form of identification. Furthermore, doctors can send pre-recorded videos to patients during a consultation (eg, providing guidance in how to use a medication).

104. The fact that a common questionnaire is employed for all patients who seek treatment for a particular medical condition ensures consistency of data, and avoids the variability which may occur in community practice.

105. Moreover, it is unlikely that many GPs in a busy clinic would have the time to ask up to 81 questions for a new patient seeking treatment for weight loss. It may therefore be unsurprising that the most recent data from the Australian Bureau of Statistics indicates

that the rates of patients' satisfaction and belief that their doctor listens to them carefully are consistently higher in relation to telehealth as compared to in-person consultations.[49]

(e) Access and continuity issues

106. Although we appreciate that access to healthcare may be a subsidiary concern of the Board as compared to the safety and quality issues discussed above, we note that the Draft Guidelines recognise that telehealth "*provides great opportunities for access to, and delivery of, healthcare*". Similarly, section 3(2)(e) of the *Health Practitioner Regulation National Law*, which provides interpretative guidance about matters including the Board's scope of regulation, identifies as a fundamental objective to "*facilitate access to services provided by health practitioners in accordance with the public interest*".

107. We think it is important to place the issues of safety and quality within the wider context in which healthcare is (and can be) delivered in Australia. This is not to suggest that a desire to improve access to primary care should come at the expense of setting rigorous safety and quality standards; rather, it is to underline the benefits which can be achieved by telehealth when it is delivered to those standards.

108. Access to healthcare is also directly connected with continuity of care, a common flashpoint in the debate about the benefits of telehealth. The reality is that fewer Australians are obtaining primary care from a single GP, and that is a trend whose origins predate the rise of telehealth. That trend is partly (though not entirely) caused by patients' increasing struggle to obtain an appointment with the same GP.

(i) Current state of healthcare in Australia

109. The Health Minister recently described Australia's primary healthcare system as being in "*the worst shape it has been*" in 40 years and as lacking in "*digital health capability*".[50] And in its report released earlier this month, the Strengthening Medicare Taskforce referred to improving access to healthcare as its very first goal.[51] It specifically recommended heightened access to care "*in the after hours period and reduce pressure on emergency departments by increasing the availability of primary care services for urgent care needs*".[52]

110. There are many different perspectives from which to view the issue of access to primary care, because it is an outcome driven by a multiplicity of different (and often interlocking) causes, and is itself a driver of other outcomes (eg, a lack of continuity of care). While 'access' is frequently discussed only in the context of geography, in reality the concept is broader and encompasses any barriers to accessing healthcare. They also include financial

[49] Australian Bureau of Statistics, *Patient Experiences 2021-22 Report*, 18 November 2022, <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>. For instance, 81.6% of patients in telehealth consultations reported that they felt that GPs always listened to them carefully, while the equivalent figure for in-person consultations was 75.1%.

[50] L Tingle, 'Mark Butler says GP system 'in the worst shape it has been in the 40-year history of Medicare', *ABC News*, 24 January 2023, <https://www.abc.net.au/news/2023-01-17/mark-butler-says-gp-system-in-the-worst-shape-it/101865530>.

[51] Australian Government, '*Strengthening Medicare Taskforce Report*' (2022), <https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf> 3.

[52] Ibid, page 5.

barriers, supply barriers, time barriers, and others (eg, embarrassment arising from a stigmatised medical condition).

111. We note that the Draft Guidelines recommend doctors to "[b]*e aware that there is an important role for telehealth in the context of rural and regional healthcare, particularly to ensure access to specialist care and that it may be impractical for a face-to-face consultation to occur in the context of a continuing clinical relationship*".[53] But we point out that this role for telehealth equally exists on the *establishment* of a clinical relationship: the impracticality identified in the Draft Guidelines derives not from the length of the relationship but from the rural or regional location of the patient.

112. Indicators of problems with access include the following:

a. *average wait time to see a GP* — data from Australia's largest healthcare booking platform, HealthEngine, demonstrated that in 2022 patients in NSW were waiting on average 4 days between booking and attending an appointment with a GP.[54] According to the Australian Bureau of Statistics, 39.1% of people who saw a GP for urgent medical care waited for 24 hours or more.[55] In general, there was an increase in the proportion of people waiting longer than they felt acceptable for an appointment with a GP in 2021-22 compared to 2020-21, rising to 26.7% from 21.7%.[56]

b. *access in rural and remote areas* — the RACGP has reported that in 2022, the distribution of GPs between metropolitan/regional and rural/remote areas worsened over the previous 12 months.[57] In particular, 500,000 Australians have no ready access to primary health care services including GP and nurse-led clinics.[58] It will then come as no surprise that the ABS has reported that people living in outer regional remote or very remote areas are less likely to see a medical specialist than those living in major cities (35.5% compared to 38.9%) or see an after hours GP (3.4% compared to 6.3%).[59]

c. *use of a regular GP* — patients are increasingly not obtaining primary healthcare from the same doctor: one recent Australian study found that as few as 57.8% of

[53] Draft Guidelines, page 8.

[54] S Scott et al, 'GP wait times increase as Australia faces 'perfect storm' of flu, COVID and doctor shortage', *ABC News*, 5 July 2022 <https://www.abc.net.au/news/2022-07-05/gp-wait-times-getting-longer-as-doctor-shortage-grows/101205346>.

[55] Australian Bureau of Statistics, *Patient Experiences 2021-22 Report*, 18 November 2022, <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>.

[56] Ibid.

[57] Royal Australian College of General Practitioners, *General Practice Health of the Nation 2022* (Annual Report, 2022) 18. Partly as a result, Australians living in remote and very remote areas experience detrimental health workforce shortages, despite having a greater need for medical services and practitioners with a broader scope of practice: Australian Institute of Health and Welfare, *'Rural and remote health'* (Report, July 2022) <https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health#Access>.

[58] Indeed, over 65,000 Australians have no access to a GP within a 60-minute drive: Royal Flying Doctor Service, *Equitable Patient Access to Primary Healthcare in Australia* (Research Report, December 2020) 10 <https://www.flyingdoctor.org.au/news/equitable-health-access-all-australians/>.

[59] Australian Bureau of Statistics, *Patient Experiences 2021-22 Report*, 18 November 2022, <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>.

young people have a regular GP,[60] and an earlier study reported that 42% of respondents aged under 30 attended multiple GP practices and that up to 31.8% of the overall population did so.[61] The proportion of people who could not see their preferred GP on one or more occasions rose to 32.8% in 2021-22, from 25.5% in 2020-21.[62] This may be influenced by several factors: the patient's regular GP being unavailable, their relocation to a new suburb or city, or the fact that they are suffering from a stigmatised condition which they feel uncomfortable sharing with their regular GP.

d. *use of My Health Record* — while having a My Health Record is mandatory by default, using it is not. Due to its clunky usability and interface, users are reported to be interacting with only 5% of its functionality.[63] And although most GPs are reported as 'using' the platform, less than 1% of the documents uploaded to it are actually reviewed by a different health organisation.[64] This has important implications for continuity of care, because the less readily a GP can access a new patient's previous medical history, the greater likelihood there is that a detail will be missed in taking a new history.

(ii) Eucalyptus's experience

113. Clearly, the provision of telehealth has an important role to play in ameliorating issues with access to care in Australia. Asynchronous telehealth specifically — by the mere fact that it does not require a patient to schedule an appointment with a doctor — is by definition more accessible to patients who are hampered by a lack of available time during business hours.

114. Eucalyptus's internal data reflects some of the particular access issues described above.

115. First, a quarter of Eucalyptus's patients reside in non-metropolitan areas: almost 25% of all of Eucalyptus's orders have been sent to (and roughly 25% of all of Eucalyptus's patients are located in) regional areas.[65] This is illustrated in the following map, reflecting only patients' regional postcodes.

[60] M Kang et al. 'The relationship between having a regular general practitioner (GP) and the experience of healthcare barriers: a cross-sectional study among young people in NSW, Australia, with oversampling from marginalised groups', (2020) 21 *BMC Primary Care*, 220, 1 <https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-020-01294-8.>.

[61] M Wright et al, 'How common is multiple general practice attendance in Australia?', (2018) 47(5) *Australian Journal of General Practice*, <https://www1.racgp.org.au/ajgp/2018/may/how-common-is-multiple-general-practice> 289, 290.

[62] Ibid.

[63] T Burton, 'My Health Record struggles to be useful for patients', *Australian Financial Review*, 30 November 2022, <https://www.afr.com/policy/health-and-education/my-health-record-struggles-to-be-useful-for-patients-20221129-p5c218#:~:text=The%20ADHA%20is%20targeting%20a,electronic%20prescribing%20for%202022%2D23>..

[64] P Smith, 'The 2.9 million reasons why My Health Record is still wasting GP time', *AusDoc*, 12 February 2020, <https://www.ausdoc.com.au/news/29-million-reasons-why-my-health-record-still-wasting-gp-time/>. See also M Davey, 'My Health Record: after 12 years and more than $2bn, hardly anyone is using digital service', *The Guardian*, 6 June 2022, <https://www.theguardian.com/australia-news/2022/jun/06/my-health-record-after-12-years-and-more-than-2bn-hardly-anyone-is-using-digital-service>.

[65] By reference to Australia Post's definition of postcodes classified as 'metropolitan' or 'regional'.

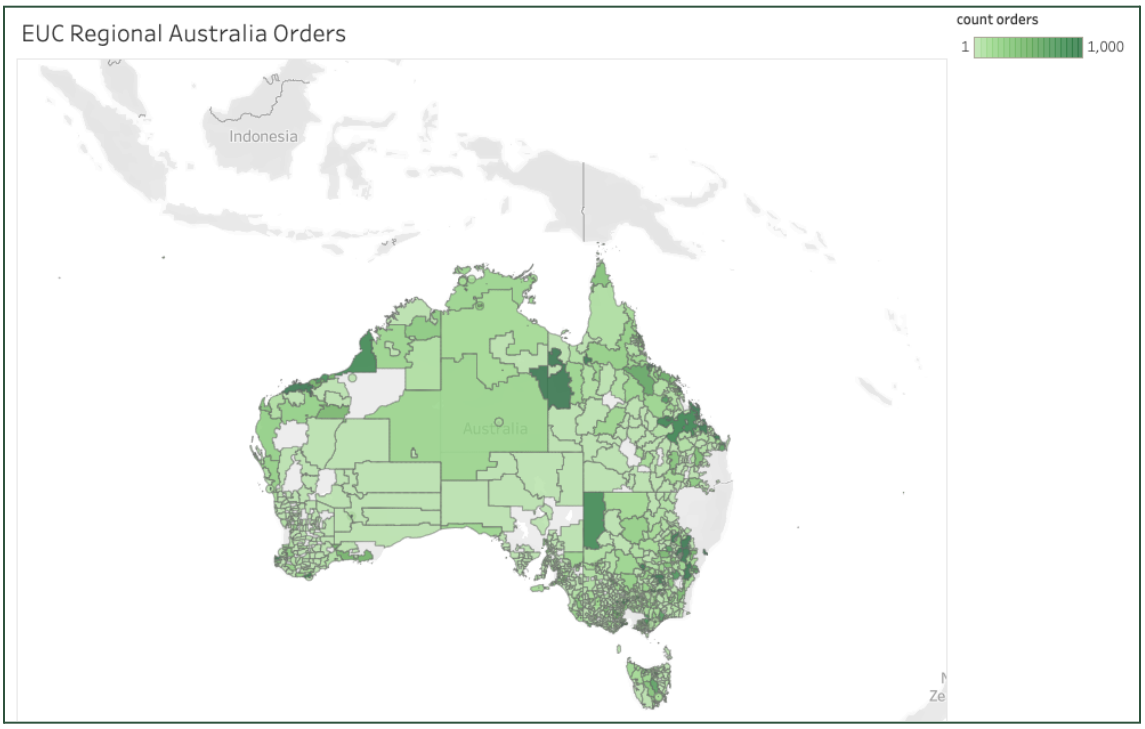

Figure 6: Concentration of orders for Eucalyptus patients sent to regional postcodes.

116. This reflects patients who, were it not for telehealth platforms such as Eucalyptus, may not have obtained care either at all or as efficiently. Increased access to expert medical care, especially in vulnerable or under-serviced populations, only serves to improve the overall health of patients and reduce the risk of adverse events, if completed safely and effectively.

117. Secondly, on average half of Eucalyptus's patients do not have a regular GP: out of over 180,000 patients of Eucalyptus's Pilot (men's health) brand who have responded to this question, 51% reported not having a regular doctor. This is illustrated in the following graph:

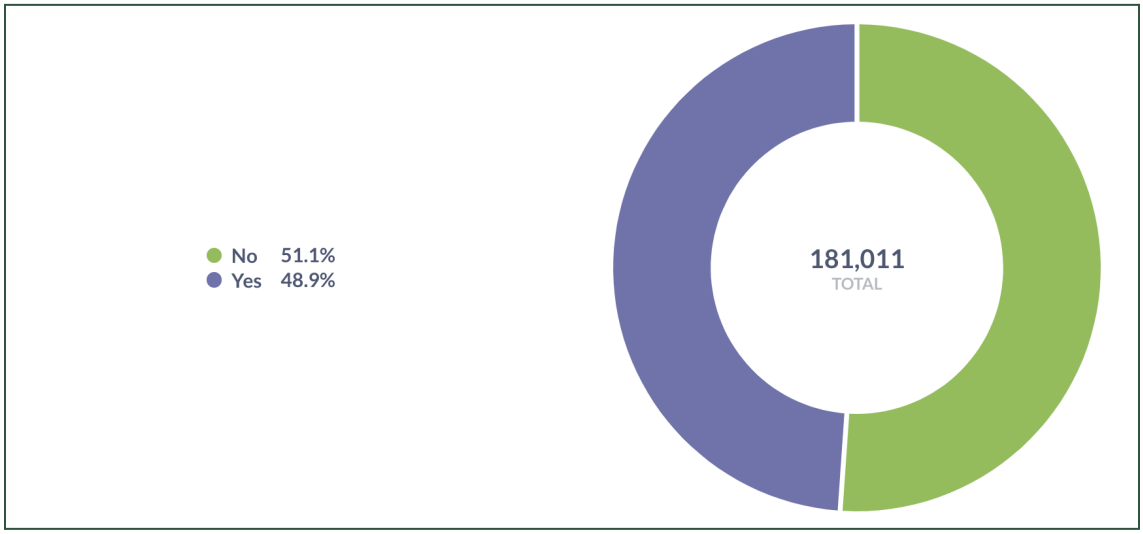

Figure 7: Proportion of Pilot patients who report not having a regular GP.

118. We appreciate that these figures do not represent a full cross-section of the population, since Pilot patients are often seeking treatment for stigmatised conditions. But such conditions form precisely a reason why Australians may avoid attending an in-person GP in the first place, and thereby constitute their own barrier to access to care.

119. More generally, for patients who attend multiple GPs, each of those GPs complements, rather than replaces, the others. So it is with asynchronous telehealth platforms like Eucalyptus. Such platforms, which do not provide 'full service' care (which would in any event be inappropriate via telehealth, as discussed in section (b) above), provide an alternative avenue to healthcare for patients in certain circumstances.

120. This only serves to alleviate the burden on GPs in community clinics who can instead focus on patients for whom telehealth is inappropriate.

III. The Draft Guidelines

121. The Draft Guidelines are largely similar to the Board's existing *Guidelines for technology-based consultations*.[66] But they depart from those guidelines in their treatment of asynchronous telehealth, by proposing for the first time to largely prohibit it in initial consultations.

122. As an apparent justification for this new prohibition, the Board has made high-level statements such as that "*prescribing is not a tick and flick exercise*"[67] and has referred to some specific concerns about asynchronous telehealth (listed in paragraph [10] above). Part II of this submission sought to describe how Eucalyptus's platform is the antithesis of a "*tick and flick exercise*" and how it does not exemplify any of the Board's other concerns.

123. More importantly, however, the Board has not explained how, by proposing to prohibit asynchronous telehealth at an initial consultation (but not in any subsequent consultations), its concerns about this modality of care would be ameliorated.

124. Part III of Eucalyptus's submission offers an analysis of this new prohibition in the Draft Guidelines. In our view, it involves the creation of a new standard which:

    a. departs from the Board's usual approach to regulating doctors, by:

        i. being overly prescriptive and thereby diminishing the discretion of doctors to determine the appropriate form of care; and

        ii. not according sufficient weight to doctors' existing obligations under *Good medical practice: a code of conduct for doctors in Australia* (**Code**);

    b. would not, in practice, satisfy the apparent goals of the Board in imposing it, since:

        i. as drafted, it is unclear how it interacts with very similar requirements in the Code; and

        ii. it does nothing to improve the safety or quality of telehealth consultations generally;

    c. does not take account of alternative, and arguably more effective, potential approaches to regulating asynchronous telehealth; and

    d. would place Australia out of step with the approach of comparable overseas jurisdictions to the regulation of telehealth.

[66] Medical Board of Australia, 'Guidelines for technology-based patient consultations', *Ahpra*, 16 January 2012, <https://www.medicalboard.gov.au/codes-guidelines-policies/technology-based-consultation-guidelines.aspx>.

[67] N Bonyhady, "Pill mills' or the future of medicine? The rise of the telehealth industry', *The Sydney Morning Herald*, 21 January 2023 <https://www.smh.com.au/technology/pill-mills-or-the-future-of-medicine-the-rise-of-the-telehealth-industry-20230117-p5cdb3.html>.

(a) Role of the Board in regulating doctors

125. Under section 35(1)(c)(iii) of the *Health Practitioner Regulation National Law*, the Board is charged with (among other things) developing and approving "*codes and guidelines that provide guidance to health practitioners registered in the profession*". This responsibility should be understood by reference to the objectives of the *National Law* (set out in s 3), which include "*facilitat*[ing] *access to services provided by health practitioners*" and "*enabl*[ing] *innovation in the … service delivery by health practitioners*".[68]

126. The primary mechanism by which the Board guides doctors working in general practice is the Code.

(i) The Board's approach to regulation

127. The Code is explicitly a high-level document. It describes itself as not being "*an exhaustive study of medical ethics*" nor as "*address*[ing] *in detail the standards of practice within particular medical disciplines*". It also points out that the "*application of the code will vary according to individual circumstances, but the principles should not be compromised*".

128. This is a recognition of the obvious reality that the practice of medicine is inherently changeable, depending on each patient's individual circumstances. It would be impossible to regulate every scenario that could arise during a doctor's consultations: instead, the purpose of this drafting style of the Code is to equip doctors with the high level tools to be able to respond to any novel situation, as a complement to their extensive medical training.

129. In other words, the Code is not intended to be prescriptive. Not only would prescriptive rules lose sight of the complexity of medical practice; they would also fail to appreciate the goal of medical training to prepare for that complexity.

130. That is no doubt why, even under the Draft Guidelines, doctors are still empowered and entrusted to decide whether a telehealth, as opposed to an in-person, consultation is appropriate for a given patient and their situation. The Draft Guidelines explicitly state that it is "*your clinical judgement, rather than* [the patient's] *preference,* [which] *will determine if the consultation occurs using telehealth or face-to-face and that this may change during the consultation*".[69]

131. The Board must, therefore, recognise that doctors are best placed to make this decision. In light of the intrinsic variability of patients' circumstances as described above, there is indeed no plausible alternative. Doctors are in a unique position of being able to marshal their professional discretion, their analysis of the nuances of a given patient's situation, their practical experience, and their ethical obligations, to determine the most appropriate modality of care. No matter how detailed its regulations and guidelines, the Board could not seriously supplant this discretion.[70]

[68] *Health Practitioner Regulation National Law 2009* (NSW) s 3(2)(e)-3(2)(f).

[69] Draft Guidelines, page 9 (point 3(e)).

[70] Of course, in the rare situation of disciplinary proceedings against a doctor, it is possible that their discretion could be supplanted by other doctors (eg, expert witnesses or a panel of a tribunal) reflecting the broad opinion of their peers.

132. If doctors (and not the Board) are best equipped to make the threshold decision of whether telehealth *generally* is appropriate for a particular patient, then it stands to reason that doctors should also be best equipped to make the *subsidiary* decision of what *form* of telehealth is or is not appropriate for a particular patient at a particular time. And yet, in proposing to require that no initial consultations be conducted asynchronously, the Draft Guidelines proceed from the assumption that it is in fact the *Board itself* which is best placed to make that latter decision.

133. This assumption, and the resulting prohibition in the Draft Guidelines, thereby constitutes a significant departure from the Board's approach to regulation. It descends into an overly prescriptive level of detail in the practice of medicine, and it diminishes doctors' capacity to determine the most appropriate modality of consultation for a given situation. Such a departure ought to be justified by clear logic and evidence, reflecting a full understanding of the sector. In our view, it is not.

(ii) <u>The current position under the Code</u>

134. The Code already contemplates the majority of the issues which can arise during telehealth consultations (including asynchronous consultations). This is a manifestation of the proposition advanced in Part I of this submission (see [1]-[7]) that all doctors' consultations, whatever technological medium (if any) they employ, share the same fundamental features.

135. We note that the consultation paper accompanying the Draft Guidelines refers to the Board having considered 'Option Two', which was to withdraw the current telehealth guidelines and to instead rely only on the Code. The Board states, in explaining its rejection of this option, that it was concerned that the Code "*does not provide specific guidance about providing technology-based medical care*", and that to rely only on it would "*place an additional burden on doctors providing telehealth as they would need to interpret it in the context of the telehealth consultation*".

136. We accept that while the Draft Guidelines largely overlap in a *substantive* sense with the Code, there are additional *procedural* recommendations which are not contained in the Code (eg, guidance to keep records of certain technical aspects of the telehealth consultation). Nonetheless, this does not provide a justification for the prohibition on asynchronous telehealth in initial consults, given the existing applicable rules in the Code.

137. In particular, the Code already contemplates the specific concerns that the Board has raised (see [10] above) about the practice of asynchronous telehealth. For example:

    a. *providing care via an inappropriate treatment modality* — if a doctor proceeded with a telehealth (rather than in-person) consultation in circumstances where it would be inappropriate for the patient, such a decision would already be in breach of, at least, the following subsections of the Code:

        i. 3.1.4 ('Referring a patient to another practitioner where this is in the patient's best interests […]');

        ii. 3.2.4 ('Considering the balance of benefit and harm in all clinical management decisions');

iii. 3.2.5 ('Communicating effectively with patients');

iv. 3.2.6 ('Providing treatment options based on the best available information');

v. 3.2.12 ('Making responsible and effective use of the resources available to you'); and

vi. 4.3.4 ('Discussing with patients their condition and the available management options, including their potential benefit and harm and material risks').

b. taking an inadequate clinical history of the patient — as outlined above in subsection (d)(iv), the questionnaires on Eucalyptus's platform which mark the beginning (and not the end) of an asynchronous consultation are highly detailed, contrary to some comments of the Board to the effect that text-based telehealth involves a "*tick and flick*" exercise. However, if a doctor were to make a prescribing decision in light of a patently inadequate patient history (eg, due to a very short questionnaire and an absence of a subsequent patient-doctor dialogue), then that conduct would already be in breach of, at least, the following subsections of the Code:

i. 3.1.1 ('Assessing the patient [etc]');

ii. 3.2.2 ('Ensuring you have adequate knowledge and skills to provide safe clinical care');

iii. 3.2.3 ('Maintaining adequate records') — see also section 10.5 and in particular subsection 10.5.4 ('Ensuring that the records are sufficient to facilitate continuity of care');

iv. 3.2.6 ('Providing treatment options based on the best available information'); and

v. the entirety of section 4.3 ('Effective communication').

c. prescribing treatment that is inappropriate in the circumstances (including prescribing by algorithm) — if a doctor on a telehealth platform prescribed a treatment to a patient which was not the most appropriate option in the circumstances (eg, because the treatment could not be prudently prescribed via telehealth, or because the doctor was influenced by commercial considerations, or because the doctor outsourced their decision to an algorithm, or for some other reason), then that would already be in breach of, at least, the following subsections of the Code:

i. 3.2.6 ('Providing treatment options based on the best available information');

ii. 3.2.7 ('Only recommending treatments when there is an identified therapeutic need and/or a clinically recognised treatment, and a reasonable expectation of clinical efficacy for the patient');

iii. 3.4.4 ('Giving priority to investigating and treating patients on the basis of clinical need and and the effectiveness of the proposed investigations or treatment'); and

iv. 7.2.1 ('Ensuring that the services you provide are necessary and likely to benefit the patient').

d. *failing to explain the side effects or contraindications of a medication* — if a doctor prescribed a medicine to a patient but then omitted to describe its possible side effects or contraindications, then that would already be in breach of, at least, the following subsections of the Code:

i. 3.2.5 ('Communicating effectively with patients');

ii. 3.2.13 ('Encouraging patients to take interest in, and responsibility for, the management of their health and supporting them in this'); and

iii. 4.3.4 ('Discussing with patients their condition and the available management options, including their potential benefit and harm and material risks").

e. *failing to explain the potential cost of a medication* — if a doctor prescribed a medicine to a patient but then omitted to explain its potential cost (including whether it may be reimbursable), then that would already be in breach of, at least, the following subsections of the Code:

i. 3.2.5 ('Communicating effectively with patients');

ii. 4.5.4 ('When referring a patient for … treatment … advising the patient that there may be additional costs, which patients may wish to clarify before proceeding'); and

iii. 4.3.4 ('Discussing with patients their condition and the available management options, including their potential benefit and harm and material risks").

138. Accordingly, it should be clear that telehealth is already adequately regulated under the Code. If the Board has concerns about the conduct of certain medical practitioners consulting on certain telehealth platforms (asynchronous or otherwise), then it already has the regulatory tools to act against that conduct. As with any regulation, the Code's rules are only as effective as their enforcement.

139. While this does not mean that there is no role for the Draft Guidelines at all (since, as noted above, they do provide some additional process-based recommendations for the practice of telehealth), it does — in our submission — suggest that that document does not need to contain additional substantive rules,

(b) Analysis of the new standard

140. Under section 41 of the *Health Practitioner Regulation National Law*,[71] a guideline approved by a National Board is admissible in disciplinary proceedings against the health practitioner as evidence of what constitutes appropriate professional conduct. While the precise legislative mechanism varies from state to state,[72] in practice this means that if a doctor contravened a guideline of the Board (particularly if the contravention was repeated), they would expose themselves to the prospect of conditions being placed on their medical registration or other punitive measures, in addition to the reputational consequences of such a process.

141. The Draft Guidelines state the following:[73]

> Prescribing or providing healthcare for a patient with whom you have never consulted, whether face-to-face, via video or telephone is not good practice and is not supported by the Board.
>
> This includes requests for medication communicated by text, email or online that do not take place in real-time and are based on the patient completing a health questionnaire but where the practitioner has never spoken with the patient.
>
> Any practitioner who prescribes for patients in these circumstances must be able to explain how the prescribing and management of the patient was appropriate and necessary in the circumstances.

142. In effect, this would mean that, for the first time the Board would require that:

a. initial consultations between a doctor and patient must not be conducted via asynchronous telehealth; and

b. by exception to the above, a doctor could undertake such a consultation if it can be shown to have been "*appropriate and necessary in the circumstances*"; but

c. all subsequent consultations (after the initial consultation) could still be conducted via asynchronous telehealth.

143. Thus, in the event that the Draft Guidelines were enacted, if a doctor were in breach of point (a) (and could not satisfy the proviso in point (b)), then they would expose themselves to disciplinary action by the Board or an equivalent regulator.

144. It is necessary to interrogate the end(s) sought to be achieved by the imposition of this new prohibition, and whether that prohibition would actually serve to achieve those ends. In our submission, as currently drafted, it suffers from the following flaws:

a. it is unclear how it interacts with existing provisions of the Code; and

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[71] See, eg, *Health Practitioner Regulation National Law 2009* (NSW) s 41.

[72] For instance, in NSW (a co-regulatory jurisdiction), the term 'unsatisfactory professional conduct' is defined in section 139B(1)(a) of the *Health Practitioner Regulation National Law (NSW)* as conduct "*that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience*"; in most other jurisdictions, the term 'unprofessional conduct' is defined in the Definitions as conduct "*that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers*".

[73] Draft Guidelines, page 11.

b. it would not have an impact on the safety or quality standards of asynchronous telehealth specifically, or telehealth generally.

(i) Interaction with existing provisions of the Code

145. As stated above, the Draft Guidelines contemplate that a doctor could justify employing asynchronous telehealth for an initial consultation where it is "*appropriate and necessary in the circumstances*". But it is unclear whether this "*appropriate and necessary*" test adds anything to the pre-existing obligations under the Code, or how that test would be applied in practice.

146. Subsection 3.2.6 of the Code already provides that doctors must only "*provid*[e] *treatment options based on the best available information*"; similarly, subsection 3.2.7 requires doctors to "*only recommend*[] *treatments when there is an identified therapeutic need and/or a clinically recognised treatment, and a reasonable expectation of clinical efficacy for the patient*". In addition, subsection 7.2.1 obliges doctors to "*ensur*[e] *that the services you provide are necessary and likely to benefit the patient*".

147. In other words, the Code already requires doctors to ensure that their treatments for patients are appropriate and necessary — and this is an obligation which applies to *all* forms of consultation, not just those via telehealth; and all consultations, not just initial consultations. If a doctor complies with those rules in any event, then is that sufficient to meet the (apparently new) standard in the Draft Guidelines, or is something more required?

148. Further, if a new standard is indeed intended by these words, what does it mean? To take the example of an initial asynchronous telehealth consultation for a patient seeking treatment for a stigmatised condition, it can be readily contemplated that such a patient would be unwilling to — and may in fact decline to — seek a synchronous consultation for such a condition. That patient may then otherwise not obtain treatment at all. Does this mean that an initial asynchronous consultation in these circumstances would therefore be considered "*necessary*"?

149. Given the potential disciplinary consequences of a doctor being in breach of this provision, it is important for this to be clarified.

(ii) Impact on telehealth consultations generally

150. More broadly, it is unclear how, by prohibiting asynchronous telehealth for initial consults (but not subsequent consults), the Board would achieve its implicit goal of improving the safety and quality of asynchronous telehealth generally, including by removing poor practices within the sector.

151. For instance, the new standard imposes no temporal limitation on the pre-existing relationship between the doctor and patient.

152. In other words, it would apparently be compliant for a doctor to conduct an initial phone consultation (which could last, say, 5 minutes) with a new patient and then to conduct all subsequent consultations, *ad infinitum*, via asynchronous means. (This is to be contrasted from the current Medicare telehealth rebate for video and phone consultations, which

requires the consulting doctor or a doctor in the same GP practice to have treated the patient in person within the previous 12 months.[74])

153. In those circumstances, it is unclear what practical risk-based benefit is actually achieved by requiring an initial synchronous consultation between the doctor and a new patient. In the example just mentioned, what substantively is added to the quality or safety of the subsequent (asynchronous) consults, or the necessity or appropriateness of the treatments thereby prescribed, by the fact that they were preceded (once, a long time earlier) by a synchronous consult (which may also have dealt with a *different* medical condition)?

154. This raises an additional concern. The new standard requiring an initial synchronous consult applies regardless of the quality of that consult (assuming that it otherwise complies with the Code). In particular, it assumes that all synchronous consultations are by definition superior in safety and quality to all asynchronous consultations.

155. As exhaustively outlined in Part II, that assumption simply does not hold true in all circumstances. If we are to compare, for a relatively simple medical condition, a 5-minute initial phone consultation with an initial 80-question questionnaire followed by a text-based dialogue between the doctor and patient, on what basis can it seriously be contended that the former option must be preferred to the exclusion of the latter, and that a regulation to that effect should be imposed?

156. Moreover, if the Board harbours concerns about the safety or quality of asynchronous telehealth generally, then why would it continue to be permitted for all consultations following the initial one? The explanation of how those concerns are ameliorated by a proposal to require synchronous care in an initial consultation (but not in any other consultation) is obscure.

157. To return to the original question, what is the end sought to be achieved by this new standard requiring all initial consultations to be synchronous? Is it —

    a. to ensure that any resulting prescriptions are appropriate and necessary? But the Code already imposes this requirement for all consultations, whether telehealth or in-person;

    b. to ensure that the doctor obtains an adequate patient history? But this can equally be obtained asynchronously; indeed, it can often be obtained *more effectively* that way (and it would constitute a breach of the Code to fail to do so in any event); or

    c. to ensure that patients are appropriately informed about the side effects of their medication? But this can also be effected asynchronously, and mandating an initial synchronous consult does nothing to produce this outcome where a medicine is prescribed at a subsequent asynchronous consult.

158. As stated earlier in this submission, the touchstone of this debate should be the quality, not the form, of the consultation. Bluntly limiting access to a particular form of consult only

[74] J Knapp, 'MBS telehealth items and the 12-month rule: FAQs for general practice', *North Western Melbourne Primary Health Network*, 10 December 2021, <https://nwmphn.org.au/news/mbs-telehealth-items-and-the-12-month-rule-faqs-for-general-practice/>.

at an initial doctor-patient interaction does not address the more substantive issues of safety and quality.

(c) Alternative approaches to regulation

159. If the Board is concerned about the conduct of certain asynchronous telehealth platforms, then imposing new and onerous rules limiting the practice of *all* medical practitioners consulting on *any* such platform — as embodied in the Draft Guidelines — is not the only solution.

160. That is particularly so where, as explained above, the imposition of those new rules would not actually have the effect of improving the safety or quality of asynchronous telehealth when it is still proposed to be permitted (ie, outside initial consultations).

161. In our submission, there are at least three alternative (and arguably more effective) approaches to regulating asynchronous telehealth which the Board should consider:

    a. better enforcing existing obligations under the Code;

    b. requiring telehealth prescribing to be undertaken by FRACGP doctors; and/or

    c. requiring telehealth platforms to obtain some form of accreditation.

(i) <u>Better enforcing existing obligations under the Code</u>

162. As outlined in detail in subsection (a)(ii), compliance with the obligations under the Code which already bind doctors would ensure high quality asynchronous telehealth consultations (where it is appropriate to provide treatment via telehealth in the first place). In particular, the specific concerns that the Board has raised about asynchronous telehealth platforms (listed at [10] above) already constitute non-compliance with those obligations.

163. We are concerned that some of those obligations have not been properly enforced. If there are asynchronous telehealth platforms committing the type of conduct that the Board is concerned about, then in our respectful view, that is not a failure of regulation; it is a failure of enforcement.

164. In our submission, much more could be done to not only identify breaches of the Code by doctors operating on those platforms, but also require rectification of those breaches (including by mandating that such doctors improve their practices, even where that may impact the operations of the platform on which they are consulting).

165. In the event that more stringent enforcement of the Code is attempted but for some reason is ineffective (eg, due to a lacuna identified in that document), then it may be appropriate to consider additional regulation. Until that time, we do not think the case has been made for the new prohibition proposed in the Draft Guidelines.

(ii) Requiring telehealth prescribing to be done by FRACGP doctors[75]

166. A further alternative method of regulation would be to focus on the level of training of the doctors who consult on asynchronous telehealth platforms. The discretion inherent in deciding whether a particular patient's circumstances are appropriate for telehealth rather than an in-person consultation (which, as we have submitted, should reside with the doctor) is no doubt more effectively undertaken by a doctor who has some practical experience. A trainee doctor who, despite being registered with AHPRA and entitled to prescribe, may not be in the best position to make that determination without further practical training.

167. One method of identifying such a higher level of training would be Fellowship of the RACGP. Fellowship "*identifies a practitioner as being capable of providing safe, specialised and high-quality general practice care. It demonstrates to governments, the general practice profession and the community that a doctor is competent to practise safely and unsupervised in any Australian general practice setting*".[76]

168. Fellowship generally takes 3 years and involves first-hand experience in a variety of healthcare settings and in a variety of locations. Supervision by an experienced clinician allows trainees to learn by osmosis and direct instruction, and to better appreciate the practical application of the principles they have learned during medical school.[77] This process also provides the training and experience for delivering care in a primary care setting (which is inherently different to a hospital-based setting), in which assessments are frequently made about the appropriateness of care delivery in that setting. That practice is, of course, transferable to the scenario of deciding on the appropriateness of telehealth as a modality of care.

169. It is reasonable to expect that, once a doctor is permitted to practise independently without supervision, they ought to be capable of making prudent decisions about the provision of telehealth services, without being governed by prescriptive rules beyond the foundational principles set out in the Code.

170. If the Board is concerned that the prescribers on some telehealth platforms are merely medical graduates or trainees, and therefore at higher risk of making poor decisions about whether and when to consult via telehealth, then it would be appropriate to consider imposing a requirement that prescribing in these circumstances must be done by a Fellowed doctor.

(iii) Requiring telehealth platforms to obtain some form of accreditation

171. Another alternative (or additional) method of regulating asynchronous telehealth would be to focus on the telehealth platforms rather than the doctors consulting on them.

[75] Or Fellows of the Australian College of Rural and Remote Medicine.

[76] Royal College of Australian General Practioners, 'Implications of restrictions, conditions and other addenda on medical registration guide', *RACGP*, <https://www.racgp.org.au/education/registrars/fellowship-pathways/policy-framework/program-handbooks-and-guides/guides/implications-of-restrictions-conditions-and-other>.

[77] See generally: Australian Government Department of Health, 'General Practice Training in Australia: The Guide', January 2020, <https://www.health.gov.au/sites/default/files/documents/2020/02/general-practice-training-in-australia-the-guide.pdf>.

172. The decision to prescribe medication or provide other forms of treatment by way of a telehealth platform is of course made by the relevant doctor, not the owner or operator of the platform. However, it should be evident from Part II of this submission that the clinical governance framework and other infrastructure provided by the platform can have a real impact on the safety and quality of the healthcare services being provided.

173. This infrastructure is capable of being accredited, just as general practices themselves can be accredited.[78] As already stated, Eucalyptus obtained EQuIP6 accreditation from the Australian Council on Healthcare Standards, the first telehealth company in the country to do so. (Another online health-related platform, Sonder, has also obtained this accreditation although it does not offer medical prescriptions.[79])

174. The Australian Commission on Safety and Quality in Health Care has not published standards on the provision of telehealth services generally, though it has prepared standards on digital mental health.[80] In the absence of applicable standards promulgated by the Commission, Eucalyptus sought EQuIP6 accreditation, which assesses the performance of the platform against almost 50 criteria across numerous categories including continuous assessment of patient need, medical records management, clinical governance framework and risk assessment.

175. Telehealth is still to some extent an emerging industry in Australia and it is clear that regulations in various areas have not yet caught up with it. While telehealth provided from a traditional GP clinic may be the indirect subject of accreditation (as part of the GP clinic's accreditation), telehealth provided by an online-only platform such as Eucalyptus presently will not. In order to assist the industry to mature, telehealth-specific accreditation standards should be developed and they should — ultimately — be made compulsory.

176. In our submission, the Board should consider a broader range of regulatory tools to define and enforce minimum standards of quality and safety in the telehealth industry than a proposal to simply prohibit a large proportion of asynchronous consultations.

(d) International comparisons

177. In proposing to regulate the specific modality used in an initial consultation (and in effect mandating a pre-existing synchronous relationship between doctor and patient before asynchronous telehealth may be employed), the Board would be departing from the practice of comparable overseas jurisdictions.

178. Some jurisdictions have chosen not to specifically regulate telehealth (no doubt because, in part, they do not see the risk involved such as to require it), while others have turned

[78] See generally See generally : mpconsulting, 'Review of general practice accreditation arrangements: Prepared for the Department of Health', 27 October 2021, <https://consultations.health.gov.au/primary-health-networks-strategy-branch/review-of-general-practice-accreditation-arrangeme/results/reviewofgeneralpracticeaccreditationarrangements-final-october2021.pdf>.

[79] R Evans, 'Why is ACHS accreditation important to us and our customers?', Sonder, 14 April 2022, <https://sonder.io/blog/achs-accreditation-sonder/>.

[80] Australian Commission on Safety and Quality on Healthcare, 'National Safety and Quality Digital Mental Health Standards', 2020, <https://www.safetyandquality.gov.au/standards/national-safety-and-quality-digital-mental-health-standards>.

their regulatory minds to telehealth-specific rules and yet have not imposed a technology-based limitation or a pre-existing relationship requirement.

179. For instance —

a. **United Kingdom:** Healthcare professionals using telecommunication are subject to the same legislative, licensing and registration obligations as they are in a face-to-face context.[81] For example, the 'Remote Prescribing High Level Principles' published by the peak health regulatory bodies in the UK recognise that telehealth via various technologies (including online) can be provided safely and do not require an established patient-doctor relationship prior to virtual care.[82]

b. **New Zealand:** There are no specific regulations on the provision of healthcare via telehealth. The Medical Council of New Zealand advises that telehealth services (defined technologically broadly) can be provided with any device, software or service which is secure, fit for purpose and preserves the quality of information or image being transmitted.[83]

c. **Canada:** There are similarly no additional requirements imposed on most Canadian doctors who deliver care using telehealth. The College of Physicians and Surgeons of Alberta,[84] Newfoundland and Labrador,[85] Ontario[86] and Saskatchewan[87] all have issued binding Standards on Telemedicine, prescribing member physicians to comply with all regulatory requirements and standards of care when practising telemedicine as they would if the patient was physically present, but without creating additional technology-specific rules.[88]

d. **United States:** Forty-six states allow both synchronous and asynchronous telehealth, with 28 having introduced additional regulations on the delivery of remote patient monitoring and other asynchronous telehealth.[89] In 47 states, a doctor is not required to establish an in-person relationship before providing telehealth services.[90] Of the remaining 3 states, 2 only require an established

[81] DLA Piper, 'Telehealth Availability and Regulation Country Insights', *DLA Piper Intelligence*, <https://www.dlapiperintelligence.com/telehealth/countries/index.html?t=08-anticipated-reforms&c=DK>.

[82] General Medical Council, 'Remote prescribing high level principles', <https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-prescribing-high-level-principles>.

[83] Medical Council of New Zealand, '*Statement on Telehealth*', October 2020 <https://www.mcnz.org.nz/assets/standards/c1a69ec6b5/Statement-on-telehealth.pdf>.

[84] The College of Physicians & Surgeons of Alberta (CPSA), 'Virtual Care - Standard of Practice, *CPSA*, 1 January 2022, <https://cpsa.ca/physicians/standards-of-practice/virtual-care/>.

[85] College of Physicians and Surgeons of Newfoundland and Labrador, 'Standard of Practice: Virtual Care', 2021 <https://cpsnl.ca/wp-content/uploads/2022/09/Virtual-Care-2021.pdf>.

[86] College of Physicians and Surgeons of Ontario (CPSO), 'Virtual Care', *CPSO*, June 2022, <https://www.cpso.on.ca/en/Physicians/Policies-Guidance/Policies/Virtual-Care>.

[87] College of Physicians and Surgeons of Saskatchewan, 'Policy: The Practice of Telemedicine', November 2019, <https://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/The_Practice_of_Telemedicine.aspx>.

[88] Europe Economics, '*Regulatory approaches to telemedicine: Report*', 1 March 2018, accessible at: <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/regulatory-approaches-to-telemedicine> 71-78.

[89] MedLink, '*Telehealth Laws Across the U.S. in 2022: How Each State Measures Up*', 2022, <https://medlinkstaffing.com/telehealth-laws-across-the-u-s-in-2022-how-each-state-measures-up>.

[90] Ibid.

in-person relationship for certain specialty providers.[91] The Federation of State Medical Boards maintains that an appropriate physician-patient relationship may be established virtually, as long as the identity of the physician is known to the patient, the patient maintains informed consent and the messaging platform is confidential and secure.[92]

e. **Denmark:** There are no additional laws applying to the provision of telehealth (although Denmark's national health authority launched a strategy for the dissemination of telemedicine back in 2012).[93] The Danish National Board of Health's 2019 *National Clinical Guidelines* specify no fixed medium by which consultations should be delivered.[94]

f. **Ireland:** No legislation or regulations specifically govern telemedicine in Ireland. Doctors' professional standards (in particular, the *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*[95]) define telehealth broadly and permit its use if "*safe and suitable*" for the patient and if the doctor follows normal "*standards of good practice*".[96]

180. While of course the practice of other jurisdictions should not necessarily bind Australia's approach to telehealth regulation, in our submission it is telling that so many other similar countries have chosen not to impose the type of prohibition that the Board is proposing to introduce by the Draft Guidelines.

[91] Ibid.

[92] Europe Economics, '*Regulatory approaches to telemedicine: Report*', 1 March 2018, accessible at: <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/regulatory-approaches-to-telemedicine> 71-78.

[93] Biolegis, 'Telemedicine: Legal Framework in EU and Israel', *Biolegis* (Report, July 2021) 4.

[94] Danish National Board of Health, 'National Clinical Guidelines - selected recommendations for use in general practice', 2019 <https://www.sst.dk/-/media/Udgivelser/2019/Nationale-kliniske-retningslinjer-Udvalgte-anbefalinger-til-brug-i-almen-praksis.ashx?sc_lang=da&hash=F5D1FE4305FE3DCA35B121FA1F797ABC>.

[95] Irish Medical Council, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (8th edition, 2019), <https://www.medicalcouncil.ie/news-and-publications/reports/guide-to-professional-conduct-and-ethics-for-registered-medical-practitioners-amended-.pdf>.

[96] Ibid, section 43.

IV. Conclusion

181. To return to a point made earlier in this submission, the touchstone of this debate should be the quality, not the form, of a doctor consultation.

182. All such consultations, by whatever medium they are undertaken, ought to be safe and effective and this goal is properly the province of the Board. The same regulatory principles should apply to all of them.

183. Asynchronous telehealth appears to be misunderstood, and in our submission that misunderstanding has affected the framing of the Draft Guidelines. It is not limited to "*tick and flick*" exercises or similar straw men; it can be an appropriate modality of healthcare in particular circumstances; it has a unique capacity for data collection, tracking and analysis; and it can ensure standards of safety and quality that are as high or higher than those provided in community GP clinics.

184. Nonetheless, asynchronous telehealth (and, indeed, any telehealth) is not appropriate for certain medical conditions or certain patients. That is hardly a controversial proposition. But the best-placed decision-maker on the question of appropriateness is not the Board but the doctor who is treating a patient.

185. The centrality of the doctor's professional discretion is a principle which suffuses the Board's entire regulatory approach (including in the *Code of Conduct*). It is the doctor who is trained to respond to the complexity of medical practice and to analyse the nuances of the particular circumstances presented.

186. The Board recognises that reality by continuing to permit doctors to decide the threshold question of whether telehealth broadly is appropriate for a given patient. And yet, it now proposes to direct doctors about which particular form of telehealth they should or should not employ at an initial consultation.

187. Ultimately, such an approach would do nothing to improve the safety and quality of asynchronous telehealth generally in Australia and it would sit awkwardly with the pre-existing rules in the *Code of Conduct* which already govern those very topics. In our submission, there are alternative and much more effective methods available to the Board to achieve its goal.

Appendix | Summary of Submission

Asynchronous telehealth can ensure high safety and quality standards		
Telehealth	• All doctor consultations contain (a) an exchange of information and (b) an exercise of discretion. Asynchronous telehealth is no different, and is not limited to a questionnaire form of consultation. • Asynchronous telehealth is not appropriate in all circumstances, but it can be appropriate in some. • Eucalyptus's platform begins with a patient questionnaire which is followed by further online communication between the doctor and the patient (which is not limited to text).	**8-15**
Safety	• Asynchronous telehealth is uniquely capable of collecting and tracking all data associated with the care given. • Eucalyptus implements stringent safety thresholds throughout its platform while various teams digest, review and act on data related to those thresholds. • Doctors on the platform are required to refer patients to physical consultations where deemed appropriate. This occurs for around 50% of Eucalyptus's prospective patients for certain conditions. • Eucalyptus has teams of registered health practitioners and other technology to manage patients' clinical inquiries, in addition to review and follow-up consultations with doctors.	**16-21**
Quality	• Doctors on Eucalyptus's platform are rigorously credentialled and their performance continually assessed. • Those doctors have clinical independence and are not incentivised to prescribe. • Consultations are thorough and include questionnaires of up to 80 questions for certain medical conditions.	**21-26**
Access	• Telehealth presents an obvious partial solution to the problem of access to primary healthcare in Australia. • Almost 25% of Eucalyptus's patients live in regional areas, and around 50% report not having a regular GP.	**27-31**

The Draft Guidelines are overly prescriptive and would be ineffective		
Approach to regulation	• The Draft Guidelines would require that initial consultations between a doctor and a new patient must not be conducted asynchronously, unless the doctor can justify it as being "*appropriate and necessary*". • Doctors are entrusted and empowered to decide whether telehealth (as a threshold issue) is suitable for a given patient, and yet the Board now proposes to tell them what *form* of telehealth to employ. This diminishes their discretion to determine the most appropriate form of consultation for a particular patient. • The Board's *Code of Conduct for Doctors* already sufficiently regulates doctor consultations, and in particular already regulates the Board's apparent concerns about the safety and quality of asynchronous consultations.	**32-36**
The new standard	• It is unclear how the wording of the new prohibition on asynchronous telehealth in initial consultations would interact with very similar existing obligations under the *Code of Conduct*. • That prohibition would be ineffective in improving the safety or quality of asynchronous telehealth generally, including because it would continue to be permitted in all non-initial consultations.	**36-40**
Alternative approaches	• The existing rules under the *Code of Conduct*, which already prohibit poor practices via telehealth, could be enforced more stringently. • Telehealth could be required to be undertaken only by doctors who are Fellows of the RACGP or equivalent. • Accreditation standards for telehealth platforms could be developed, and made mandatory.	**40-42**
International comparisons	• Numerous comparable overseas jurisdictions have either not seen the need to regulate telehealth specifically at all or have promulgated technology-agnostic guidelines which do not impose a requirement of any form of pre-existing relationship before a doctor is permitted to provide care to a patient asynchronously. • Jurisdictions in this category include the United Kingdom, Canada, the United States, Ireland, New Zealand and Denmark.	**42-44**