Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
February 2023

Feedback on the Medical Board of Australia's Revised Telehealth Guidelines

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage local specialist and allied health services.

ACRRM has more than 6000 rural doctor members including 1000 doctors in training, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

The College welcomes the opportunity to provide further feedback on the Medical Board's draft revised *Guidelines: Telehealth consultations with patients*, having initially provided feedback in June 2022.

It is imperative that the revised Guidelines take cognisance of the unique distinctions of telehealth in rural and remote practice, particularly the issues surrounding connectivity and access to adequate voice and data services.

Digital technologies can never replace in-person services, however, when backed by appropriate staff, resources, systems, and training, they can substantively improve the quality of medical care that our doctors provide to rural and remote communities.

It is perverse to suggest that the standard of care provided in a telehealth consultation should meet the same standard of care provided in an in-person consultation. Whilst there are similarities between both models, in relation to professional standards and levels of expertise provided, the telehealth model will always be limited by the lack of person-to-person interaction. It is important that the Guidelines recognise these limitations, rather than simply attempting to equate telehealth with in-person care.

The Guidelines need to reflect a clear distinction between the standard of professionalism and expertise the practitioner brings to the consultation which should always be maintained, and the standard of care that is achieved in the consultation. This distinction must recognise the fundamentally different circumstances of virtual care and key aspects of the experience which may be significantly impaired by issues beyond the control of the practitioner. These include connectivity and technology issues, the digital literacy of the patient, and the patient's access to an appropriate physical space for the consultation

General Comments

1. Is the content and structure of the draft revised Guidelines: Telehealth consultations with patients helpful, clear, relevant and workable?

Generally, the College considers the draft revised Guidelines are helpful, clear, and useful in so far as they are a very succinct and universally applicable set of Guidelines. However, ACRRM considers that best-practice telehealth would benefit from examination of a more detailed range of considerations which could be included in the guidelines as adjunct information.

The Guidelines are simple and user friendly, but we see value in directing users to where they may find some further information about what each of the sixteen steps outlined in the Guidelines entails such as resources provided by their College or other expert standards providers.

The Medical Board may wish to consider the use of the terminology "*in person*" in place of "*face to face*" and "*remote consultations using telehealth*" in place of "*telehealth*" (the latter where appropriate) throughout the guidelines.

2. Is there anything missing that needs to be added to the draft revised guidelines?

Amendments/additions/comments in relation to the section headed "*Before a telehealth consultation you should*:" on page 9 of the Public Consultation document:

Recommended amendments to Item 2c

Amend this item to include reference to the storage of video as well as photographic images as part of the medical record.

Recommended amendments to Item 3

Include a step ensuring that the patient knows and understands how to connect to the telehealth consult.

Amendments/additions/comments in relation to the section headed "*During the consultation you should*:" on page 10 of the Public Consultation document:

Recommended amendments to Item 7

This Item should include reference to the steps the medical practitioner/patient will/should take if the connection is lost at any stage during the consultation.

There may be value in mentioning to the patient upfront, the value in moving from one technology to another during the consultation. For example, in some circumstances it might be useful to move from telephone to video when more visual information is required, or to move from video to telephone when connectivity issues are impacting audio. The explanatory notes mentioned in our response to Question 1 and detailed in our response to Question 3 could outline “best practice strategies” in those circumstances or scenarios.

Recommended amendment to Item 10

A telehealth consultation should not proceed unless it is the best possible way to provide healthcare to the patient in the circumstances. Likewise, standards should not prevent a consultation provided by a competent practitioner if it is indeed able to substantively improve a patient’s access to care and where it can be connected to a continuous care relationship. This is especially important for patients living in remote locations.

ACRRM agrees that the standard of professionalism and expertise provided by the medical practitioner in a telehealth consultation should be the same standard as provided in an in-person consultation, but the Guidelines must recognise the nature and limitations of the telehealth delivery model. There are many circumstances in which it will simply not be possible to deliver the same standard of care as an in-person consultation could deliver.

The Guidelines should consider the competency and expertise of the medical practitioner and their capacity (within the restrictions of the telehealth model) to provide an acceptable standard of care to the patient. It is imperative to draw a distinction between the standard of care delivered, including the expertise and professionalism of the practitioner, and the standard of care ultimately received by the patient. As outlined above, best practice virtual care may not look like best practice in person care and quality outcomes may be determined by many factors beyond the control of the practitioner.

Definitions of what constitutes an acceptable standard of care should differ for telehealth and face to face consultations.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.