RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

RACP Submission to the Medical Board of Australia's draft revised Guidelines for Telehealth consultations with patients

February 2023

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Foreword

The RACP welcomes the second round of consultations of the Medical Board of Australia's (the Board) daft revised *Guidelines for telehealth consultations with patients*. As requested by the Board, a confidential RACP submission was made to the preliminary consultation in 2022; we thank the Board for considering and broadly adopting a number of themes highlighted in our previous submission.

Telehealth has become a permanent feature of Australia's health care. While the majority of health care has transitioned back to face-to-face post-lockdowns, the use of telehealth remains strong. In the third quarter of 2022, telehealth consultations accounted for 22 per cent of Medicare Benefit Schedule (MBS) services delivered, representing 11.1 million consultations[1]. The expansion of telehealth has broadened access to much-needed care, especially in regional and remote areas, and relieved pressure on hospitals. More importantly, telehealth has substantive potential to advance health equity. This renders the safety of and access to telehealth consultations critical.

The recent ANAO performance audit report on expansion of telehealth services during the pandemic reports on the lack of performance monitoring and evaluation of temporary or permanent telehealth as well as on the shortfalls in the governance and risk management of this expansion. This highlights the key importance of active surveillance and research into utilisation and impacts of telehealth modalities to inform telehealth policy and services in the future.

In the absence of the monitoring and evaluation of telehealth services to date, the draft revised Guidelines will play an especially important role in setting the standard for telehealth best practice in Australia and in helping to realise its potential to improve access to care, advance health equity, and ensure continuity of care.

This brief submission contains feedback from the RACP, the Australian and New Zealand Society of Palliative Medicine (ANZSPM) and the Australian Rheumatology Association (ARA). We look forward to the release of the final *Guidelines for telehealth consultations with patients* to support medical practitioners in delivery of safe, effective telehealth consultations.

Comments

The RACP considers the current draft clear, well-structured, fit-for-purpose and practical for use by medical practitioners across Australia.

While appreciating the Board's adoption of our previous comments in relation to the appropriate use of telehealth, the expected standard of care, the need for medical judgement and consideration of patient-specific factors and the need for access to interpreters, the RACP remains of the view that the guidance provided in the current version is high level. To better delineate telehealth best practice, the final Guidelines would benefit from more detail on specific care circumstances and special considerations that practitioners might face as well as from examples of potential exemptions that might apply to the Guidelines.

Telehealth consultations consist of a wide array of clinical services and specialties. Listing all the practice points in a high-level manner may pose the risks of misinterpretation, unintended application and of not addressing the special needs of certain populations. The final Guidelines should therefore provide a more detailed understanding of telehealth best practice so as to better assist medical practitioners in decision making, attending to issues important to their patients, and focusing on the right outcomes.

[1] University of Queensland. Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia. Key Statistics for Quarter 3 2022. Available from https://coh.centre.uq.edu.au/telehealth-and-coronavirus-medicare-benefits-schedule-mbs-activity-australia

In light of this, the RACP maintains that the following themes be further specified or explained in the final Guidelines:

- **Appropriate access to interpreters –** we note this theme has been included as a footnote. Considering that the use of interpreters is a complex area which can impact patient health and wellbeing outcomes as well as the physician-patient relationship and may involve medicolegal risks associated with poor interpreting, we maintain that clarification of these issues should be made in the final Guidelines. Further, the importance of access to Aboriginal and Torres Strait Islander Health workers to support culturally safe and appropriate care should also be mentioned.

- **Patient preference for telehealth modality such as phone call or video** – we note this theme is implicitly stated in 'What do I need to?' section. Patient-specific circumstances such as older age, fragility, some disabilities, less advanced technology skills, low bandwidth, geographical barriers and inability to access in-person care can be decisive factors for the patient preference. Therefore, details on varying patient circumstances and preferences should be provided in the final Guidelines to better inform medical practitioners' understanding of this matter.

- **Patient-centred care needs of priority groups –** we welcome the strong focus on Aboriginal and Torres Strait Islander people in the draft revised Guidelines. However, this focus should also extend to other priority groups including patients with disability, those from culturally and linguistically diverse (CALD) backgrounds, those living in supported accommodation settings (disability; out of home care) or residential aged care settings. Some of these priority groups are often excluded from telehealth consultations yet clarifying issues important to the priority groups are critical to achieving equity. Additionally, the definition of 'vulnerable members of the community' in the context of these Guidelines should be clarified.

- **Prescribing without having consulted with the patient –** while we agree that prescribing without having consulted with patients should be avoided, there are circumstances that warrant exceptions. We note these exceptional circumstances may be covered in the 'In emergency situations' section". However, due to the high-level framing of this section, it is unclear what the exceptional prescribing situations are. It would be beneficial to provide some examples of these situations in the final Guidelines – such as that in the context of 24-hour community or hospital phone support for palliative and geriatric care, essential medications are allowed to be prescribed by medical practitioners for patients known to their service or practice rather than to themselves, based on information provided by registered nurses. We also suggest that the naming of this section could be more specific and be changed to 'Prescribing without having personally consulted with the patient, either face-to-face or by telehealth'.

The RACP is pleased to see the emphasis on the appropriate use of telehealth as an adjunct to face-to-face consultations and on the safety standard of care as comparable to face-to-face consultations in the revised Guidelines. We also note the Board's view that '*telehealth is generally most appropriate in the context of a continuing clinical relationship with a patient that also involves face-to-face consultations'.* We recommend that any statements on appropriate use of telehealth in the provision of care be inclusive of the principle 'that *telehealth should be used as an adjunct to face-to-face consultation to assist and facilitate ongoing care in a therapeutic relationship'.* However, it is noteworthy that in many remote or rural areas the severe shortages of certain medical specialist can prevent regular face-to-face consultations and that Telehealth consultations are a literal lifesaver in these circumstances.

Additional feedback points for the Board's consideration:

- There should be specific mention of paediatric patients/children in relation to telehealth best practice; a point should be included in the revised Guidelines along the lines of 'in the *case of paediatric patients, telehealth consultation should include the patient and caregiver being present*

in the consultation, in particular for children <16 years old and that it is not usually appropriate for a paediatric consultation to not have the parent present. However, both the patient and the caregiver might, under some circumstances, be offered the opportunity to speak privately with the physician/paediatrician. Under certain circumstances, young people aged between 12 and 16 years should be offered the opportunity for confidential discussion without the caregiver present. A brief discussion of such circumstances could be included in the Guidelines.

- With regard to point 3E in relation to clinical judgement and patient preference, an opposite scenario should also be covered that '*a medical practitioner should not force the use of telehealth where a patient is not comfortable.'*
- Telehealth consultations are valuable for sensitive and stigmatised health conditions such as sexual and reproductive health, which could be considered including in point 4 of the revised Guidelines
- An additional point stating that the patient's regular treating doctor must be informed by the alternate practitioner if sourced via telehealth, including requests for any investigations or prescribing of any medications. could also be added.

The RACP appreciates this opportunity to comment on the draft Guidelines. We are looking forward to further engagement on this and related matters.