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| Medico-legal aspects of virtual care services for Victorian Public Health Services |
| April 2022 |
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This document is provided as a resource only. Nothing in this document should be taken to be legal advice or direction from the Department of Health. Health practitioners, health service providers and health services should seek independent legal advice about any medico-legal matters relating to virtual care.

The original version of this document was written by DLA Piper and published in 2015. The version presented is a revision of the original document titled *Medico-legal aspects of telehealth for Victorian Public Health Services.*

To receive this document in another format, email the Health Services Improvement team <telehealth@health.vic.gov.au>.

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# BACKGROUND

## INTRODUCTION

1. **Emergence of telehealth**
   1. Telehealth has undergone a significant transformation from a novel innovative model for the provision of health and medical services, to one that is widely understood and used by a large number of Victorian health providers.

*The term 'telehealth' is used universally to describe the provision of health care and medical services to patients, or between health practitioners, who are not located in the same physical space as each other. This includes, but is not limited to, health services provided by video consulting or telephone but does not include the use of technology during face-to-face consultations.*

* 1. Telehealth has been used to provide patients in rural and remote communities with greater access to, and greater choice of, health and medical service providers for a number of years. Delivery of health services via telehealth can reduce the expense and disruption of travel for patients, while also supporting the rural health workforce to provide high-quality care. Telehealth has facilitated the sharing of knowledge between health service providers in different geographical locations, as well as across areas of speciality. Health practitioners across rural and regional Victoria have benefited from the increased peer support, training and education options which have been made possible by telehealth.
  2. Recently, telehealth has emerged as a viable and advantageous model for the provision of health and medical services beyond rural and remote locations. The COVID-19 pandemic has fast-tracked several changes in the health service sector, including in relation to the physical infrastructure required to provide telehealth services, community awareness of and preparedness to adopt telehealth, and the regulatory and professional guidance required to support widespread utilisation.

1. **Legal framework for telehealth**
   1. There is no specific legal framework for telehealth services at the national level, or in any state or territory. Historically, this can be construed as a barrier to widespread uptake of telehealth, due to the range of medico-legal uncertainties which are unique to health services delivered via telehealth rather than face-to-face. However, the legal framework for health services in Australia does not require that services be delivered face-to-face. The majority of the relevant legal requirements are flexible in their application to health and medical services delivered by different modes, including by telehealth.
   2. To complement this, some professional bodies have published guidelines regarding the expectations of their members when engaging in telehealth. These guidelines revolve around the general principle that health and medical services provided by telehealth should meet the same standards of care as services delivered in person but also address some of the benefits and challenges which are unique to telehealth. These are discussed in more detail later in this document.

*…the legal framework for health services in Australia does not require that services be delivered face-to-face. The majority of the relevant legal requirements are flexible in their application to health and medical services delivered by different modes, including by telehealth.*

* 1. This document outlines the medico-legal aspects of using telehealth to provide health and medical advice and related services from various settings where healthcare services are provided and received, such as, but not limited to, hospitals, specialist medical clinics, local medical centres and even patient homes.
  2. This document is limited to the discussion of the Victorian laws and relevant national legislation that also applies to Victorian health services. It is beyond the scope of this document to more fully consider the legal frameworks of other jurisdictions. Health services that have entered into arrangements with hospital and health service providers in other states and territories or internationally should seek legal advice as to the laws that apply to the specific circumstances.
  3. This document recognises that there are challenges associated with telehealth, but that if those challenges are understood and managed, any associated risks can be controlled. Registered health practitioners and other health practitioners who provide services using telehealth are already skilled and capable of providing care of an appropriate standard. The provision of training, clinical guidelines and support for GPs, nurses, hospitals and health services to collaborate and agree on their roles and how they will manage the delivery of health services using telehealth are all expected to assist significantly with the management of the challenges which are unique to telehealth services. For example, improved documentation and communication are key risk management tools.
  4. This document is provided as a resource only and is general in its discussion of telehealth challenges and risk management approaches. **Nothing in this document should be taken to be legal advice** from the Victorian Department of Health (**Department**), or a direction or recommendation from the Department. The Department and the State of Victoria each disclaim all liability for reliance on any information in this document. Health practitioners and health service providers should seek independent legal advice about any medico-legal matters relating to telehealth as it applies in their specific circumstances.

## SCENARIOS

1. **Introduction**
   1. There is no question that telehealth services may be beneficially utilised in a myriad of circumstances and to deal with varying health issues. For example, some of the services for which telehealth may be appropriate include:
      1. practitioner-patient consultations via video or telephone,
      2. practitioner collaborations using multi-point video consulting with or without the patient present;
      3. online prescription requests, or requests for tests (eg routine blood tests, pregnancy tests and tests for sexually transmitted diseases);
      4. the electronic delivery of test results and other clinical information and health education.
   2. For the purposes of this document, four scenarios have been identified in which telehealth might commonly be used. These scenarios are referred to throughout this guide and are used to better explain the legal framework and differing responsibilities and obligations of each of the health services and individuals involved in the delivery of a healthcare via telehealth.

*The scenarios included in this section are:*

* *A practitioner(s) in a public health service provides a virtual real-time consultation to a patient in their home*
* *A practitioner in a public health service specialist clinic provides a virtual real-time consultation to a patient located at another health service, at their GP, community health setting, or a location other than the patient’s home*
* *A practitioner(s) in a public health service provides advice virtually to another health service*
* *A public health service emergency department provides a virtual real-time consultation to a patient located at another health service.*
  1. In all of the scenarios, the public health service could be a hospital or community health facility. Similarly, the practitioners described could be registered health practitioners of any kind (eg, medical practitioners, nurses, midwives, psychologists). The examples are intended to highlight the different relationships which may arise from a risk and liability perspective, rather than factual circumstances.

1. **Scenario A: A practitioner(s) in a public health service provides a virtual real-time consultation to a patient in their home**
   1. A patient is referred to a public health service or practitioner for a disease, injury or condition. The treating practitioner decides that consulting with the patient virtually is clinically appropriate.
   2. The treating practitioner contacts the patient directly using a telephone or video consulting platform to undertake the consultation. The patient is located at their home during the consultation.
   3. In this scenario, the treating practitioner is the health service provider and the patient is the recipient.
2. **Scenario B: A practitioner in a public health service specialist clinic provides a virtual real-time consultation to a patient located at another health service, at their GP, community health setting, or a location other than the patient’s home** 
   1. A patient is referred to a public health service or practitioner for a disease, injury or condition. The treating practitioner decides that consulting with the patient virtually is clinically appropriate.
   2. The treating practitioner contacts the patient directly using a telephone or video consulting platform to undertake the consultation. At the time of the consultation, the patient is located at a health or community setting other than that of where the treating practitioner is located. The setting where the patient is located may be considered a ‘host organisation.’
   3. In this scenario, the treating practitioner is the health service provider and the patient is the recipient.
3. **Scenario C – A practitioner(s)** in **a public health service provides advice virtually to another health service**
   1. A patient attends a public health service with a disease, injury or condition. After initial inquires, the treating practitioner considers that they require another practitioner's advice in order to treat the patient. There is no such practitioner at the health service.
   2. In the patient's absence, the treating practitioner contacts another health service ('tertiary health service') and shares the patient's x-ray. The tertiary health service identifies an available specialist practitioner who arranges a telephone call with the treating practitioner to discuss the best course of treatment.
   3. In this scenario, the tertiary health service is the provider and the health service is the recipient. The patient does not participate in the telehealth service and therefore is not the recipient of the service. The patient may be an inpatient or an outpatient.
4. **Scenario D – A public health service emergency department provides a virtual real-time consultation to a patient located at another health service.**
   1. A patient attends an urgent care centre or another emergency department or a residential aged care facility or a correctional facility with a disease, injury or condition. After initial inquiries, the treating practitioner considers that they require the advice of an emergency practitioner from another health service in order to treat the patient.
   2. The attending practitioner contacts another health service’s emergency department via telephone or video consult and shares the patient case to discuss the best course of treatment. The patient is present during the consultation
   3. In this scenario, the contacted health service’s emergency department is the provider. The health service where the patient has attended, and the patient, may both be considered recipients.

## LEGAL FRAMEWORK AND REGULATORY BODIES

**Key Points**

Health practitioners have legal obligations arising under legislation and case law.

All health practitioners in Australia must have a current registration with AHPRA and comply with the National Law, as well as all relevant professional standards, codes and guidelines published by their National Board.

There is no "Telehealth Board of Australia". All health practitioners who provide telehealth services continue to be subject to regulation by AHPRA and their relevant national board.

Some National Boards have published guidance specifically relating to telehealth.

The Health Complaints Commissioner is a Victorian statutory authority responsible for dealing with complaints about health service providers (including health services provided by telehealth) and the handling of health information.

1. **Legal system in Australia**
   1. The legal system in Australia is based on legislation and common law.
   2. Generally speaking, legislation takes precedence over the common law. Legislation includes statutes ('Acts') made by parliament at the National and State level, as well as delegated or subordinate legislation, made under the Acts (e.g. regulations, rules) made by individuals or bodies authorised to do so by Parliament.
   3. Common law is essentially judge-made law (case law) and is used to interpret common legal principles as well as legislation. Case law creates a legal precedent such that subsequent judges are bound or influenced by the reasoning of judges in previous, similar cases. Case law from outside of Victoria or Australia may have bearing on a similar Victorian case.
   4. Some of the legislation and case law that is relevant to health practitioners will be mentioned in this document. However, the state of the law is never constant. Particularly in the field of health and medical law, where the law changes in response to scientific and socio-political developments. This document focusses on well-established legal principles which relate to the conduct of health and medical professionals, good clinical practice and the law of negligence. When understood in the telehealth context, these principles can provide a sound basis for managing the corresponding medico-legal risks.
2. **Legal framework for health practitioners**
   1. The laws, regulations and regulatory bodies governing health practitioners who practice via telehealth are the same as those who do not practice via telehealth.
   2. In summary:
      1. health practitioners' practising in Victoria are registered under and required to comply with the *Health Practitioner Regulation National Law (Victoria) Act 2009* (**National Law**);
      2. all registered health practitioners must also practice in accordance with their registration standards, codes and guidelines, specifically:
         1. in accordance with the expectations set out in their profession’s code of conduct or equivalent in relation to confidentiality and privacy, informed consent, good care, communication, health records and culturally safe practice;
         2. by ensuring that they have appropriate professional indemnity insurance arrangements in place for all aspects of their practice, including telehealth consultations;
         3. all health practitioners and public health services comply with the *Health Records Act 2001* (Vic) and any other state legislative requirements relating to heath records, including digital health records; and
         4. all public health services comply with the *Health Services Act 1988* (Vic), which includes obligations of confidentiality.
3. **Regulatory bodies for health practitioners**
   1. The role and responsibilities of AHPRA and the other key regulatory bodies which are relevant to Victorian health practitioners are summarised below.

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| **AHPRA** | All health practitioners are required to be registered under the National Law to practise in Australia. The registration process is administered and overseen by the Australian Health Practitioner Regulation Agency (**AHPRA**).  AHPRA also manages investigations into the professional conduct, performance, or health of registered health practitioners in all Australian jurisdictions except New South Wales (where this is undertaken by the Health Practitioner Councils Authority and the Health Care Complaints Commission) and Queensland (where this is undertaken by the Queensland Health Ombudsman, as of 1 July 2014).  AHPRA's operations are governed by the National Law.  AHPRA does not impose registration or renewal requirements upon telehealth providers that are any different or more rigorous than those requirements for practitioners not wishing to practice via telehealth. |
| **National Boards** | There are 14 national boards that are responsible for regulating the 14 health professions within the scope of the National Law. The national boards issue registration standards, codes and guidelines for members of their relevant profession. Compliance with the standards, codes and guidelines of each national board is mandatory.  Telehealth providers remain subject to regulation by AHPRA and their relevant national board. For example, a psychologist consulting a patient via telehealth will remain subject to regulation by the Psychology Board of Australia. The complaints procedure in relation to complaints about the provision of telehealth services will be the same as that for complaints about the provision of any other health service. |
| **Health Care Complaints Commissioner** | The Health Complaints Commissioner (**HCC**) is an independent Victorian statutory authority that is responsible for dealing with complaints made about health service providers and the handling of health information in Victoria in accordance with the *Health Complaints Act 2016* (Vic).  The HCC has jurisdiction to deal with complaints about doctors, hospitals, dentists, pharmacists, physiotherapists and other providers of health services, or any person or organisation that collects, holds or discloses health information. As such, complaints made against a telehealth provider will be dealt with by the HCC in the same manner as if the practitioner or health service provider was providing the health service in a traditional, face-to-face consultation.  The HCC has jurisdiction to hear complaints about any treatment that was received by a patient in Victoria. In other words, the HCC will be able to hear any complaint about treatment provided via telehealth so long as those services were received in Victoria. This will be the case whether or not the telehealth provider was providing the services from Victoria, interstate or internationally.  AHPRA and the HCC both play crucial roles in regulating all registered health practitioners and the conduct of all regulated health professions. They operate hand-in-hand while having distinct roles. |
| **Office of the Victorian Information Commissioner** | The Office of the Victorian Information Commissioner (**OVIC**) is the regulator for dealings with personal information by public sector entities in Victoria. |
| **Office of the Australian Information Commissioner** | The Office of the Australian Information Commissioner (**OAIC**) is the regulator for dealings with personal information by Commonwealth agencies and private sector organisations, including private health care providers. |
| **Australian Digital Health Agency** | The Australian Digital Health Agency is the system operator for the My Health Record system. The Australian Digital Health Agency and the OAIC have statutory functions in relation to the My Health Record. |

1. **Telehealth guidance and standards for health practitioners**
   1. Each national board publishes registration standards, codes and guidelines for the members of their profession. The national boards and AHPRA jointly published *Telehealth guidance for practitioners* on 27 July 2020 which applies to all registered health practitioners. The Medical Board of Australia has also published specific guidelines for all registered medical practitioners. Generally speaking, these guidance documents provide that health services provided by telehealth should meet the same standards of care as services delivered in person but also address some specific challenges and expectations relating to telehealth.[[1]](#footnote-2)
   2. The Medical Board of Australia's *Guidelines for technology-based patient consultations* provide that medical practitioners who engage in telehealth services should:
      1. apply the usual principles for obtaining their patient’s informed consent, protecting their patient’s privacy and protecting their patient’s rights to confidentially;
      2. make a judgement about the appropriateness of a technology-based patient consultation and in particular, whether a direct physical examination is necessary;
      3. make their identity known to the patient;
      4. confirm to their satisfaction the identity of the patient at each consultation;
      5. provide an explanation to the patient of the particular process involved in the technology-based patient consultation;
      6. assess the patient’s condition, based on the history and clinical signs and appropriate examination;
      7. ensure they communicate with the patient to:
         1. establish the patient’s current medical condition and past medical history, and current or recent use of medications, including non-prescription medications;
         2. identify the likely cause of the patient’s condition;
         3. ensure that there is sufficient clinical justification for the proposed treatment
         4. ensure that the proposed treatment is not contra-indicated;
      8. accept ultimate responsibility for evaluating information used in assessment and treatment, irrespective of its source;
      9. make appropriate arrangements to follow the progress of the patient and inform the patient’s general practitioner or other relevant practitioners;
      10. keep an appropriate record of the consultation; and
      11. keep colleagues well informed when sharing the care of patients.[[2]](#footnote-3)
   3. Given the interdependent relationship between actual practice and the availability of practice standards, codes and guidelines within each of the regulated health professions, if the demand for telehealth services continues to grow, it is likely that more national boards will publish guidance on their expectations of practitioners in the telehealth space.

# MEDICO-LEGAL ASPECTS AND RISKS OF TELEHEALTH

**Key Points**

There are always risks related to the delivery of health services. These include risks for the health services providers, health practitioners and patients involved.

Some of these risks may be increased in the context of telehealth due to, for example, the restrictions on the type and extent of examinations which can occur, adequacy and appropriateness of the patient-practitioner relationship and communication or limitations of the equipment or technology used.

The most prominent risk associated with the use of telehealth is misdiagnosis.

## IDENTIFYING THE RISKS

1. **Introduction**
   1. Whenever a health service is provided there, are risks involved. The parties which are affected by those risks include the health practitioner(s) and patient(s) directly involved in any particular health service, as well as the health service provider who is responsible for arranging and/or facilitating the health service.
2. **Risks for health practitioners**
   1. The risks for health practitioners engaging in telehealth are most likely to fall into the categories of litigation risk or reputational risk.
   2. Litigation risks may arise from shortcomings in a health practitioner's clinical or professional conduct leading to misdiagnosis, inappropriate reassurance about symptoms of a condition or a failure to properly refer a patient to another health care provider. These risks are present for all health practitioners when providing health services by any means. However, some risks may be exacerbated in the telehealth context.
   3. For example, the risks of misdiagnosis may be higher because of the restrictions of telehealth on the type and extent of examinations which a practitioner can conduct remotely. The inability to perform a hands-on examination can make some diagnoses more difficult (for example, the inability to palpate lymph nodes). In these instances, a health practitioner can only provide information and advice within the limits of the equipment and/or resources available to them at the time but must take reasonable steps to ensure the patient is not provided with inaccurate or incomplete diagnostic information. This would likely involve arranging a face-to-face consultation so that the patient can be physically examined.
   4. Depending on the nature and extent of the conduct, litigation may occur in the form of civil proceedings, a coronial inquiry or criminal proceedings.
   5. Reputational risks may be secondary to litigation and include risks related to disciplinary consequences of inadequate or inappropriate clinical or professional conduct. As for litigation risks, reputational risks are ever present for health practitioners however, telehealth can present unique challenges (compared to face-to-face services) with respect to ensuring clear and reliable communication with patients, ensuring adequate privacy and confidentiality measures are in place and maintaining a close but professional relationship with patients.
   6. Provided that appropriate procedures are followed, and the telehealth provider engages in best practice, as would be required in a face-to-face consultation (for example, that all practitioners are appropriately credentialed and only provide services within their approved scope of practice), the litigation and reputational risks which may be specifically attributed to health services delivered by telehealth can be minimised.
3. **Risks for patients**
   1. Risks for patients are likely to arise with respect to the quality of the care they receive via telehealth. This may or may not be a reflection of the competence or capabilities of the medical practitioner or other health practitioner providing telehealth services. It is more likely that risks for patients arise out of the limitations in technology, especially in the early stages of the implementation of telehealth and the limitations assessment (especially, for example, in the context of email-only or telephone-only consultations).
   2. The hardware and software used for telehealth services can create risks related to privacy and information security, as well as in relation to clinical suitability and accuracy. The information security risks are discussed in section 22 of this document, 'Managing privacy, confidentiality and health records'. The clinical risks are related to the quality of information which can be transmitted by selected telehealth software or hardware, and the reliability of a connection.
   3. A cooperative approach to telehealth by health practitioners and patients, involving a commitment to attend follow-up or substitute face-to-face consultations when a physical examination or other intervention is clinically appropriate, is critical to minimising risks.
4. **Risks for health services**
   1. All health services owe a duty of care to patients that reasonable skill and care will be exercised in arranging and/or facilitating their health service(s). In the context of telehealth services, a health service may supply physical premises for telehealth services (for example, a health service may supply adequately equipped consulting rooms from which health practitioners can provide telehealth services) or they may supply software or online services to health practitioners so that they can connect with patients by telehealth from home or another location.
   2. The duty of care owed by a health service in a telehealth arrangement will vary depending on their legal and contractual responsibilities. This will directly influence the health service's risks of being involved in that telehealth arrangement. Managing these risks will largely revolve around minimising the risks of the health practitioners and patients who will be involved (as discussed above) but will also include ensuring that all of the facilities, equipment, platform and/or support services provided by a health service provider are appropriate, adequate and fit for their purpose.

## RISK MANAGEMENT FOR TELEHEALTH

1. **Introduction**
   1. There are a number of ways in which health practitioners and health services involved in the provision of telehealth services can reduce their risks.
   2. The following risk management strategies are discussed in the remainder of this document:
      1. Open disclosure
      2. Incident reporting
      3. Credentialing and defining the scope of clinical practice
      4. Maintaining good clinical practice in the telehealth context
      5. Managing privacy, confidentiality and health records
2. **Open disclosure**

**Key Points**

Health service providers can manage telehealth-related risks by implementing open disclosure procedures which comply with the Australian Open Disclosure Framework.

* 1. The National Safety and Quality Health Service Standards (**NSQHS** **Standards**) recommend that health service organisations should implement open disclosure policies. The essential elements of open disclosure are outlined in the Australian Open Disclosure Framework, created by the Australian Commission on Safety and Quality in Health Care (**ACSQHC**).
  2. According to the Open Disclosure Framework, "open disclosure" is the open discussion with the patient, their family and carers of adverse events that result in harm to a patient while receiving health care. An adverse event is any unplanned event resulting in, or having the potential to result in, injury to a patient or an otherwise unintended outcome. For an event to be classified as an "adverse event", it is not necessary that any harm actually occurred or that there was any mistake or error.
  3. The elements of open disclosure are:
     1. an apology or expression of regret, which should include the words "I am sorry" or "we are sorry". "We are sorry this happened to you" is often an appropriate expression;
     2. a factual explanation of what happened;
     3. an opportunity for the patient, their family and carers to relate their experience;
     4. a discussion of the potential consequences of the adverse event; and
     5. an explanation of the steps being taken to manage the adverse event and prevent recurrence.
  4. Open disclosure should occur as a process of discussion, not a one-way provision of information from a health practitioner to the patient, their family and carers.
  5. Where a telehealth service triggers the need to report an adverse patient, the ordinary expectations and procedures for open disclosure should apply. The level of involvement of the telehealth provider should be proportionate to the role they played in the patient's treatment prior to the adverse event in question, or the role their treatment had in triggering the adverse event. For example, in Scenario C, it may be normal for the telehealth provider to have little input in the process of open disclosure if their involvement in the patient's treatment did not directly relate to the occurrence of the adverse event. However, in Scenarios A, B and D, the telehealth provider is more likely to be directly involved in any adverse event related to the patient's treatment and therefore, should be more heavily involved in the open disclosure process,
  6. Further, providers of community health care services should be aware that, prior to any grant, subsidised or financial assistance being given, the Department will consider what arrangements are in place for:
     1. ensuring the community health service provider makes efficient use of its resources;
     2. monitoring and improving the quality of health services provided;
     3. making its services accessible to minority groups and disadvantaged people;
     4. enabling users of its services to make informed decisions about health care; and
     5. enabling its employees to participate in decisions about their work environment.

1. **Incident reporting**
   1. All Victorian publicly funded health service providers are required to comply with the Department's incident reporting policies.
   2. Clinical, occupational health and safety incidents, near misses, hazards and consumer feedback from Victorian public health services are managed through the Victorian Health Incident Management System (**VHIMS**). The VHIMS is administered by the Victorian Agency for Health Information (**VAHI**) and Safer Care Victoria (**SCV**). SCV specifically oversees reported adverse patient safety events including sentinel events.
   3. Health service providers who report sentinel events are also required to conduct a root cause analysis (**RCA**) to detect failures in the current system and to find solutions to address these failures and prevent similar adverse events re-occurring.
   4. Common sentinel events which may occur as a result of telehealth services are:
      1. "medication error resulting in serious harm or death"; or
      2. any "other adverse patient safety event resulting in serious harm or death".
   5. The risk of these events may be greater in a telehealth context than in a face-to-face context because the health practitioner has limited ability to physically examine a patient or the communication between the practitioner and patient is adversely affected by the mode of telehealth being used (possibly being due to the capability of the practitioner involved or the quality of the equipment being used).
   6. Where the requirement to conduct a RCA arises out of a telehealth service, all of the health practitioners involved and the health service should work collaboratively to complete the RCA.
2. **Credentialing and scope of practice**

**Key Points**

All Victorian public health services must comply with the Safer Care Victoria (SCV) credentialing policy for senior medical practitioners.

Where patients of health services receive advice by telehealth from health practitioners who are not employees of the health service, the health service should ensure the telehealth service provider is appropriately credentialed.

It is not necessary that a health service undertake the task of credentialing all telehealth providers it might use but must be satisfied that the telehealth service provider has been appropriately credentialed by either a credentialing committee or a similar health service in Victoria.

* 1. Credentialing is the formal process of checking that medical practitioners and dentists are appropriately qualified, registered and experienced to deliver safe, high-quality care.
  2. ACSQHC requires health services to implement a credentialing system which complies with NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations (Actions 1.10.1–1.10.5). It is also a condition of the insurance arrangements of Victorian public health services that the health service credential practitioners who have individual responsibility for patient care.
  3. Accordingly, all senior medical practitioners in Victorian health services must be appropriately credentialed and have their scope of clinical practice defined in accordance with their level of skill and experience, and the capability and need of the health service in which they work. The approved processes for verification, appointment, review, reappointment and changing the scope of clinical practice are specified in the SCV Credentialing Policy.[[3]](#footnote-4)
  4. These requirements apply equally to public health services providing telehealth services as they do to face-to-face services. Nonetheless, when credentialing a practitioner, it is recommended that it be mentioned whether the scope of practice extends to delivering services via telehealth.
  5. Credentialing of telehealth practitioners may be more difficult than face-to-face practitioners because it may be unclear who is responsible for credentialing the practitioners. For example, in Scenario A and B, it is clear that the health service of the treating practitioner is responsible for ensuring that practitioner is properly credentialled to provide telehealth services of the kind in question. However, in Scenarios C and D:
     1. if the secondary practitioner is a public health service practitioner, the treating practitioner may reasonably expect the secondary practitioner to be appropriately credentialed by their relevant health service / employer; but
     2. if the secondary practitioner is a private practitioner, the health service of the treating practitioner is likely to be responsible for credentialing the private practitioner prior to permitting him/her to consult the patient by telehealth.
  6. There is no legal requirement that a health service undertake the task of credentialing all telehealth providers it might use. Provided that the health service is satisfied that a practitioner (whether a health service practitioner or private practitioner) has been appropriately credentialed, either by a credentialing committee or by a similar health service in Victoria, it will be acceptable to rely on that credentialing.
  7. The process of credentialing may be undertaken at a local, sub-regional, regional or state level by way of a regional or sub-regional committee. Defining the scope of clinical practice, however, may only be undertaken by an individual health service. Therefore:
     1. a single health service in Victoria could establish a committee comprised by a group of the health service's staff to undertake both credentialing and defining the scope of clinical practice for both the health practitioners working at the health service and the telehealth practitioners the health service engages; or
     2. that health service in Victoria could join other health services in the same geographical region to establish a regional or sub-regional committee to undertake credentialing for all member health services. However, if the original health service wished to limit a practitioner's scope of clinical practice at its particular health service, beyond the limits of the scope of practice imposed by the committee, it would be required to do so itself. Each health service needs to bear in mind that credentialing a practitioner and determining their scope of practice is not dictated solely by the practitioner's experience and expertise, but also by the facilities and resources of the particular health service to support the scope of practice being considered.
  8. For telehealth practitioners (as for all practitioners), credentialing must be:
     1. undertaken prior to appointment to the health service;
     2. reviewed at least every three years; and
     3. reviewed upon request by either the individual practitioner or by an authorised person within the health service.

1. **Maintaining good clinical practice in the telehealth context**

**Key Points**

*Duty of care*

It is not essential that the health practitioner have a direct relationship with a patient to owe the patient a duty of care. When providing treatment to or advice to or about a patient, the health practitioner has a duty of care to the patient and will be liable for their negligent acts.

In some circumstances the health provider is liable not only for their own acts or omissions but those of the telehealth provider also.

*Informed consent*

In a telehealth arrangement, a health practitioner must obtain the patient's informed consent before performing any physical test or procedure and before providing the patient's health information to the telehealth provider. Consent for telehealth should be obtained in the same manner as it would be for face-to-face consultations and treatments and will follow the same rules for obtaining consent for adults who lack capacity, children and in emergencies.

*Referrals*

Some, but not all, telehealth arrangements constitute a referral. For those that do, the legislative requirements can be met by the host provider completing a referral form and electronically transmitting it via the telehealth system.

*E-Prescribing*

Subject to specific criteria, prescriptions can be sent electronically to patients or pharmacies across Victoria.

There are limitations, most notably in the context of telehealth, a medical practitioner is not permitted to prescribe medications other than for the treatment of a patient under that practitioner's care. In some telehealth scenarios a patient may not be considered to be under the care of the telehealth provider. These circumstances may require the telehealth consultation to be modified such that the patient is in attendance.

* 1. Duty of care
     1. Health services and their employees and independent health practitioners owe a duty to exercise reasonable skill and care when providing health services to their patients. It is no different when providing services via telehealth.
     2. In respect of the telehealth scenarios, the relevant duties of care owed are as follows (assuming the non-delegable duty of care the law imposes on hospitals equally applies to the health services referred to in the scenarios):

|  |  |
| --- | --- |
| **Scenario A**  *A practitioner(s) in a public health service provides a virtual real-time consultation to a patient in their home* | The health service will owe the patient a duty of care for the health care provided by the health service practitioner. |
| **Scenario B**  *A practitioner in a public health service specialist clinic provides a virtual real-time consultation to a patient located at another health service, at their GP, community health setting, or a location other than the patient’s home* | The health service will owe the patient a duty of care for the health care provided by the health service practitioner.  The host provider may owe the patient a duty of care to provide a private and appropriate setting for the patient to participate in their consultation. This may include ensuring any equipment used in the consultation is of an acceptable quality. |
| **Scenario C**  *A practitioner(s) in a public health service provides advice virtually to another health service* | The health service of the treating practitioner will owe the patient a duty of care for the health care provided by the treating practitioner.  Under the principles of non-delegable duty, the health service will also likely owe a duty of care to the patient for the health care provided by the telehealth provider, namely the secondary practitioner.  The secondary practitioner and the relevant health service, also owe/s the patient a duty of care because it is apparent that the secondary practitioner's opinion will influence the management of the patient.  Therefore, the treating practitioner and their health service are liable to the patient for not only their own acts and omissions but for the acts and omissions of the secondary practitioner also. The secondary practitioner and their health service is/are liable to the patient for (only) their own acts and omissions. |
| **Scenario D**  *A public health service emergency department provides a virtual real-time consultation to a patient located at another health service.* | In this scenario, the treating practitioner has referred the patient to the secondary practitioner. In these circumstances, the duty of care of the treating practitioner and their health service does not extend to the acts and omissions of the secondary practitioner and the secondary practitioner's health service. The treating practitioner and their health service are liable only for their own acts and omissions. This includes tasks the treating practitioner performs at the request of the secondary practitioner to assist with the assessment or treatment of the patient.  The secondary practitioner and their health service, provide/s a service directly to the patient and therefore, owe the patient a duty of care.  If the treating practitioner or their health service competently perform a task at the request of the secondary practitioner, but the request is deemed negligent, the secondary practitioner may be liable for any resultant injury to the patient. The treating practitioner or their health service will not be liable, unless they ought to have known that the task requested was contraindicated. For example, if the secondary practitioner requests the treating practitioner to administer an injection of a common medication at a dose far in excess of the safe limit, the secondary practitioner (for negligently directing an excessive dose be given) and the treating practitioner (for administering the excessive dose when it ought to have known it was excessive) will both be liable to the patient.  Therefore, the treating practitioner and their health service are liable to the patient for their own acts and omissions and, likewise, the secondary practitioner and their health service are liable to the patient for their own negligent acts and omissions. The secondary practitioner might also be liable to the patient for tasks it requests the treating practitioner (or others) to perform, and which are performed negligently. |

* 1. Informed consent
     1. Obtaining valid consent to provide medical treatment is a standard component of good clinical practice in all forms of health services. Clear and comprehensive guidelines and policies for obtaining patient consent can be a valuable management tool for health services.
     2. In order to be valid, consent must be informed, relevant, free and voluntarily given. This means that sufficient information has been given to the patient to enable the patient to decide whether to undergo the procedure or treatment and following this the patient has consented to it.
     3. Consent may be oral or written. Signed consent forms are not of themselves conclusive proof that a patient has given informed consent to a procedure or for their information being provided to another person.
     4. In a telehealth arrangement, a health provider is required to obtain the patient's informed consent before:
        1. performing any physical test or procedure on the patient; and
        2. providing the patient's health information to a telehealth provider.
     5. It would be appropriate and reasonable for a host provider to require a patient to sign a form confirming that they consent to their health information being provided to the telehealth provider for the purposes of their further treatment.
     6. In some circumstances, it may be difficult, or impracticable, to obtain informed consent from a patient. For example, where an adult patient does not have capacity to give consent, in the case of an emergency or where the patient is a minor (under 18 years old). The ordinary legal and professional rules for obtaining consent in these situations should be applied equally in a telehealth context as to face-to-face interactions.
     7. Further guidance on the informed consent requirements for Victorian public health facilities has been published at <https://www.health.vic.gov.au/practice-and-service-quality/informed-consent>.
  2. Referrals
     1. Not all telehealth arrangements amount to a referral. Scenario D is an example of a telehealth arrangement which is likely to constitute a referral.
     2. If the professional service provided by telehealth is listed on the MBS, the referral requirements in the *Health Insurance Regulations 2018* (Cth) are met, and the patient is entitled to a Medicare benefit (having regard to the restrictions on access to Medicare benefits for public patients and requirements of the National Health Reform Agreement), the patient will be entitled to a Medicare benefit for the telehealth service.
     3. Provided that it is signed and dated in accordance with the legal requirements for electronic signatures, a referral may be issued by telehealth, for example, by email.
  3. E-prescribing
     1. Electronic prescribing (e-prescribing) is a mechanism that enables all stages of the prescribing and supply of medicine, and the claiming process to be completed electronically. E-prescribing is a fundamental tool for the implementation of telehealth. It ensures that telehealth consultations to result in action and treatment, rather than merely un-actionable advice. In turn, e-prescribing will help to align the capabilities of telehealth closer to that of a face-to-face consultation.
     2. In Victoria, all prescriptions must comply with the requirements of the *Drugs, Poisons and Controlled Substances Act 1981* (Vic), the *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) and the relevant approvals of the Secretary.
     3. Further guidance on e-prescribing has been published by the Department at <https://www.health.vic.gov.au/quality-safety-service/digital-health-standards-and-guidelines>.

1. **Managing privacy, confidentiality and health records**

**Key Points**

The *Privacy Act 1988* (Cth), *Health Records Act 2001* (Vic), *Privacy and Data Protection Act 2014* (Vic) and *Health Service Act 1998* (Vic) protect a patient's right to privacy and confidentiality.

They contain the Australian Privacy Principles and the Health Privacy Principles regulating the collection, use, disclosure and storage of health information. All health service providers and health practitioners, whether providing services via face-to-face consultation or via telehealth, must comply with the relevant principles.

Who has responsibility for managing an individual's records in telehealth is less clear than in the traditional provision of health services. Where there is doubt, all involved parties should keep accurate and contemporaneous records.

Victorian public health services are required to retain records for varying periods prescribed by the *Public Records Act 1973* (Vic).

* 1. A patient's right to privacy is protected in the private and public health care sectors by the following legislation:
     1. *Privacy Act 1988* (Cth) at the national level;
     2. *Health Services Act 1988* (Vic), *Privacy and Data Protection Act 2014* (Vic) and the *Health Records Act 2001* (Vic) at the State level.
  2. The management, use and disclosure, and storage of records / documents which contain personal (including health) information are also subject to legislation, for example:
     1. the *Health Records Act 2001* (Vic) regulates the production, handling and storage of records which contain health information, including telehealth records, through the Health Privacy Principles; and
     2. the *Public Records Act 1973* (Vic) regulates for how long public health services must keep original records, when copies can be made and for how long records (original or copies) must be kept.
     3. the *Health Services Act 1988* (Vic) provides the legislative authority for health service entities to share confidential information about an individual within the health system for quality and safety purposes.
  3. The confidentiality and record management requirements contained within these legislations apply to all health service providers equally in respect of face-to-face and telehealth services. Generally speaking, they require health service providers to deal with patients' personal (including health) information in a manner that will preserve the patient's privacy and confidentiality.
  4. The way in which records are made and kept in a face-to-face consultation, written or typed notes are likely to be sufficient in the telehealth context. It is unlikely that host providers of telehealth and telehealth providers will be required to keep video or audio recordings of telehealth consultations.
  5. The provision of telehealth services is unlikely to cause issues in relation to use and disclosure of patient information between host providers, telehealth providers and/or other practitioners because the necessary disclosures are likely to be expressly consented to by the patient (e.g. by an initial consent form) or be required to be shared to provide care to the patient. In Scenarios C and D for example, the treating practitioner should not disclose health information about the patient to the telehealth provider unless the patient has first consented to it. There are exceptions provided for in the *Health Records Act 2001* (Vic) where the patient is incapable of giving consent, and it is not reasonably practicable to obtain the consent of an authorised representative, or the patient does not have such a representative.
  6. However, the management of records produced from telehealth services present some unique challenges in respect of privacy and security against unauthorised third parties. These may be related to:
     1. the security of the video consulting software and/or hardware used a particular practitioner or practice;
     2. the security of the patient information created and/or shared during a telehealth service (eg encryption and use of secure messaging);
     3. the security of the storage mechanism(s) used for any video recordings or still images created or shared during a telehealth service; and/or
     4. the visual and audio privacy of the premises where a telehealth services occurs (including the locations of both the patient and the practitioner).
  7. In light of this, what constitutes 'reasonable steps' to protect health information from misuse, interference, loss, unauthorised access, modification or disclosure may be more onerous in respect of telehealth records than health records created from face-to-face interactions.
  8. Some risk management strategies include:
     1. ensuring the rooms in which the patient and the telehealth provider(s) are exchanging information have restricted access for the duration of a telehealth consultation;
     2. ensure the transmission systems used for telehealth consultations are secure and reviewed on a regular basis; and
     3. having internal procedures to ensure a patient's contact details are correct and accessible by them before sharing any information to those details.
  9. In Victoria, the Health Privacy Principles (**HPPs**) provide that health service organisations and individual practitioners must keep medical records for their patients for at least 7 years after the last occasion on which it provided a health service to the patient. In other words, a health service organisation or individual practitioner that provides medical services to a patient must keep records of the services provided and will be responsible for the appropriate management of those records.
  10. Under the *Public Records Act*, the Public Records Office of Victoria (**PROV**) is responsible for issuing guidance and direction in relation to the retention and destruction of records held by State Government agencies. It does this by issuing Retention and Disposal Authorities (**RDAs**). The RDAs specify various retention periods for various classes of documents.
  11. The question of who is responsible for the management of an individual's medical records in the provision of telehealth is less clear than in the traditional provision of health services. In the traditional arrangement, one health service provider provides a single service to an individual. A patient may be referred from one provider to another for different services, for example, from a general practitioner to a radiologist. The general practitioner and the radiologist in that arrangement are providing different medical services to the patient. In that case, each provider is obliged to keep accurate records of their respective consultations.
  12. In the context of telehealth, who is responsible for the management of a patient's health records depends upon the nature of the telehealth arrangement. In Scenario A, the treating practitioner is solely responsible for making and maintaining the patient's clinical record. In Scenario C, the treating practitioner and the secondary practitioner / telehealth provider should keep records of their discussion. The treating practitioner will need to rely on these notes in order to treat the patient and the telehealth provider may need to rely on them if it is later alleged that the advice given was inappropriate. Similarly, in Scenario D, both the treating practitioner and the secondary practitioner / telehealth provider should take accurate and contemporaneous notes and enter into an arrangement to share the notes and records which are relevant to the patient's ongoing care. Alternatively, the telehealth provider may choose to post a record to a common repository or a shared care plan.
  13. Since 2012, patients have had the opportunity to register for a personally controlled electronic health record, now known as the My Health Record. This is a separate record from a patient's electronic medical record. The fact that a patient has a My Health Record does not affect a medical practitioner's obligation to keep accurate records for the patient. Access to a patient's records through the patient's My Health Record may be useful in the provision of telehealth services.
  14. Complaints regarding breaches of the *Health Records Act 2001* (Vic) can be made to the Health Complaints Commissioner. Any issues with the My Health Record system are referred to the Australian Digital Health Agency.

# INSURANCE AND INDEMNIFICATION

1. **Insurance for Victorian public health service providers**
   1. Under an insurance policy issued by Victorian Managed Insurance Authority (**VMIA**), Victorian public health services are indemnified for claims arising directly out of health care services, which includes telehealth.
   2. Subject to one exception, employees of Victorian public health services are indemnified by VMIA when:
      1. providing advice, care or treatment to patients of their employer health service or patients of another Victorian public health service; and
      2. providing advice to another healthcare facility, whether or not a Victorian public health services.
   3. The exception is employee medical practitioners who provide treatment (as distinct from advice) to private patients of another Victorian public health service or to patients of a healthcare facility which is not a Victorian public health service. Those medical practitioners are indemnified by VMIA for advice so given, but not any treatment or care. In those circumstances, the medical practitioner will need to turn to their own insurance.
   4. For those medical practitioners requiring cover for their private patients, most of the policies of the major medical indemnity providers in Australia are broad enough such that telehealth services would fall within the ambit of cover. Nevertheless, there are variances and medical practitioners (in telehealth) ought to check their indemnity arrangements.
   5. All Victorian public health services and their employees would be, under indemnity arrangements with VMIA, entitled to indemnity for claims for injury arising out of the provision of telehealth services in each of the scenarios set out in the example scenarios. Health practitioners providing services not covered under those arrangements would be indemnified under their own insurance assuming they have taken it out such as required as a condition of their registration with AHPRA.
   6. In particular:
      1. Scenarios A and B
         1. The health service is entitled to indemnity from VMIA pursuant to the terms of the health service's insurance policy with VMIA.
         2. The treating practitioner is entitled to indemnity from VMIA pursuant to the terms of the health service's insurance policy with VMIA.
      2. Scenario C
         1. The treating practitioner and the health service of the treating practitioner are entitled to indemnity from VMIA pursuant to the terms of the health service's insurance policy with VMIA.
         2. As a public health service practitioner, the secondary practitioner and the health service of the secondary practitioner are entitled to indemnity from VMIA pursuant to the terms of that health service's insurance policy with VMIA.
      3. Scenario D
         1. The treating practitioner and the health service of the treating practitioner are entitled to indemnity from VMIA pursuant to the terms of the health service's insurance policy with VMIA.
         2. As a public health service practitioner, the secondary practitioner and the health service of the secondary practitioner are entitled to indemnity from VMIA pursuant to the terms of that health service's insurance policy with VMIA.

# Glossary

## Defined Terms

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| Credentialling | means the formal process of checking that medical practitioners and dentists are appropriately qualified, registered and experienced to deliver safe, high-quality care. |
| Department | means the Department of Health Victoria. |
| National Boards | means the 14 national boards established under the National Law for each health profession thereunder, for example, the Medical Board of Australia and the Psychology Board of Australia |
| National Law | means the *Health Practitioner Regulation National Law (Victoria) Act 2009* |
| NSQHS Standards | National Safety and Quality Health Service Standards |
| Telehealth | means the provision of health care and medical services to patients, or between health professionals, who are not located in the same physical space as each other. This includes, but is not limited to, health services provided by video consulting or telephone but does not include the use of technology during face-to-face consultations. |

Acronyms

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| --- | --- |
| ACSQHC | Australian Commission on Safety and Quality in Health Care |
| AHPRA | Australian Health Practitioner Regulation Agency |
| HCC | Health Complaints Commissioner |
| MBS | Medicare Benefits Schedule |
| NSQHS | National Safety and Quality Health Service |
| OAIC | Office of the Australian Information Commissioner |
| RCA | Root Cause Analysis |
| SCV | Safer Care Victoria |
| VAHI | Victorian Agency for Health Information |
| VHIMS | Victorian Health Incident Management System |
| VMIA | Victorian Managed Insurance Authority |

1. Available here: <https://www.ahpra.gov.au/News/COVID-19/Workforce-resources/Telehealth-guidance-for-practitioners.aspx>. [↑](#footnote-ref-2)
2. Available here: <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Technology-based-consultation-guidelines.aspx>. [↑](#footnote-ref-3)
3. Available here: <https://www.bettersafercare.vic.gov.au/sites/default/files/2020-05/Credentialing%20and%20scope%20of%20clinical%20practice%20final.pdf>. [↑](#footnote-ref-4)