Webinar, 7 April 2020

Q&As: Remote consulting

Please note, the answers to these questions are general in nature, provided for guidance and may change depending on the facts. They do not replace the need to seek comprehensive advice from Medical Protection in the advent of consent issues arising in your practice.

1. **Can you please state what platforms MPS are recommending?**

   MPS do not make recommendations regarding platforms. We strongly suggest you contact your IT provider or College for advice about which platforms are secure and fit for purpose. You might also like to look at www.telehealth.org.nz for further information.

2. **Will you insure us if we use a specific platform?**

   MPS will insure you for the practice of telehealth if you are working within your scope of practice and which takes place in New Zealand, i.e. the complaint must arise in the New Zealand jurisdiction. The Medical Council (MCNZ) has just released an update regarding scopes of practice, which has been broadened until 30 November 2020. If you work within MCNZ guidelines you will be covered.

3. **Clarification regarding the Psychologists Board's guidance on telepsychology.**

   Some psychologists gained the impression from the webinar that the Psychologists Board are against telepsychology. This is not the case. I have obtained this statement from the Board:

   "The following guideline and further updated information regarding telepsychology from the New Zealand Psychologists Board may be helpful when considering offering this service. The links are below:
   http://www.psychologistsboard.org.nz/cms_show_download.php?id=244
   http://www.psychologistsboard.org.nz/questions-about-covid19
   As always, the Board's expectation is that psychologists are working within their scope of practice and adhering to the Code of Ethics and the HPCA Act."

4. **What is MPS' advice for patients requesting for their regular meds during the pandemic (where these patients are from overseas, stuck in NZ during the lockdown, has never been seen in clinic), but the patient has emailed through the medications they need.**

   We suggest you speak with the patient on either the phone or video. Consider the following questions:

   - Have you verified the person's identity?
   - What is the medical history of the patient and do I need to obtain clinical notes? Use your clinical judgement. The degree of seriousness of the patient's medical problems increases the importance needing the notes. You might wish to obtain the patient's clinical noes from their usual health provider.
   - Does the patient require an examination? Is there critical information that can only be obtained by an examination?

- Is it safe to prescribe the medication by only seeing a photo of the medication bottles?
- Does any monitoring (e.g. blood tests) need to take place?
- Am I complying with The Medical Council's statement Good Prescribing?

5. If you cannot speak the same first language as your patient what cautions should you consider.

Consider the need for a translator. Often a family member or friend of the patient can interpret or contact your local translation service for health providers.

6. The DHBs are mandating virtual/phone consults or defer consults. We are under enormous pressure NOT to see patients but defer them. Our choice seems very limited.

The primary consideration is patient safety. In the event of a complaint, you will be held responsible for the decisions you make, although consideration will be given regarding the current environment. The clinical decision is yours as to who needs to be seen for an in-person consultation and the timing of it. If you are uncertain about the decision consult with a senior colleague to spread your risk. It is important to document your rationale for the decision you make.
It is also prudent to put your concerns about patient safety in writing to management and ask for them to confirm that despite your concerns they are instructing you to not see patients.
If you are a member of ASMS, you may wish to contact your local representative.

7. Could you provide a sentence that could be copied and pasted to cover "reason for remote consult" due to COVID-19?

What is important is to state your rationale as to why you believe that patient can be seen safely remotely. This will vary from patient to patient. For patients who are known to you, are stable and just wanting repeat prescriptions or have minor conditions, a simple sentence is all that is required. It should be evident from your clinical notes that the patient did not need to be seen. The more difficult the decision, the more you should document, especially if the patient disagrees with you regarding an in-person consultation.

8. When doing virtual video medical death/cremation certification for rest home patients, if we have sighted fixed dilated pupils, no respiration in a known end-of-life patient is live video satisfactory?

The Minister of Health has issued an authorisation for cremation certificates to be completed remotely for rest home patients where there is a perceived increased risk of Covid 19. This relates mostly to the form AB regarding pacemakers etc. where the requirement was previously to have examined the body. Form B requires you to have 'seen and identified' the deceased which we believe can be by video rather than needing in-person attendance.

9. Are we not covered for prescribing for our long-term patients who live on remote islands like Solomon's with no satisfactory care available who do come back to NZ for exam regularly?

MPS will cover you for providing care for your enrolled patients who are seen in New Zealand, so long as the complaint is made in the New Zealand jurisdiction.

10. What were the general prescribing guidelines Dr King was referring to?

Good prescribing practice is a Medical Council statement which we are measured by. It can be found here: https://www.mcnz.org.nz/our-standards/current-standards/medical-care-and-prescribing/good-prescribing-practice/

11. We conduct phone clinics and often prescribe meds without examining the patient. Unfortunately it's the only way. How is that legally?

However you consult with the patient, the Medical Council holds you to the same standards. Please see the answer to question 4.

12. Please would you mind showing the record keeping slide again?

- Note that is not in-person consultation and why.
- Does the patient understand why remote consultation undertaken?
- History.
- Any examination/observations which were possible.
- Plan/advice/follow up/safety net.
- If referral or in-person is required.

13. When scripts are sent to the patient or pharmacy, do we need to confirm the patient/pharmacy actually received it? Is it mandatory to post the script?

I suggest you pass the responsibility to the patient to contact you if the prescription has not arrived in the expected time frame. For phone and fax prescriptions, the signed original must be sent to the pharmacy. ePrescriptions no longer require a signature (unless it is for controlled drugs), therefore no paper copy needs to be sent.

14. What support is provided to doctors in DHBs being threatened with being stood down if they wear PPE for close patient contact? (Patients not Covid positive or symptomatic but concern that staff or patient could be asymptomatic carrier)?

The DHB has health and safety obligations to its workers and patients. It has to make decisions based on the Ministry of Health Guidelines amongst others. If they fail to adhere to their obligations, this could result in prosecution.

Doctors also have health and safety obligations for themselves and others. If they consider that their or others' health and safety is being or could be compromised, they have an obligation to raise this with the DHB, including how their concerns can be resolved.

If the DHB's instruction is reasonable, notwithstanding the concerns expressed by doctors, then a failure to follow that instruction would be a failure to follow a reasonable instruction and could result in disciplinary action being taken. If the DHB's instruction is not reasonable, then it need not be followed and/or the doctor may refuse to work. Any action taken by the DHB in this context against the doctor concerned could be a criminal offence and/or give rise to civil liability.

The difficulty is determining “reasonableness”. This will be determined at a later date by a court or other body. In this context, the DHB and doctors should work together to find a way forward that works for both.

It is recommended that legal advice be sought in relation to the specific circumstances of a particular situation before embarking on any course of action and/or refusing to comply with any instructions.

15. In our practice, the nurses generate all repeat prescriptions, and they are all ePrescriptions. Does this mean the pharmacist can dispense the medication before the doctor has even seen the prescription?

The Pharmacist will understandably make the assumption that prescription has been approved by the doctor. It is important to develop a robust system to ensure that patients only receive appropriate medications as prescribed by a qualified prescriber.

16. What is the legal advice about doing phone consultations in GP settings where there are no visual examination options especially prescribing for rashes which might be clinically obvious as per history taking but obviously not personally seen? Do you recommend video consults rather than phone consults legally as well?

There are some rashes where it may be possible make a presumptive diagnose over the phone, however a video consultation will always offer you more information, not just for a limited examination, but also for non-verbal communication. If a video consultation is not possible, you might ask the patient to take photos of the rash (depending on the site of the rash) and send it to you.
Use your clinical judgement regarding the safety of prescribing over the phone. Ask yourself, what is the risk of prescribing that particular medication to that particular patient? This will hopefully guide your decision.

17. How about prescribing SSRIs for a new patient with anxiety/depression via telehealth who is under a counsellor during these unprecedented times?

Video consultation will provide much more information than phone consultation in this situation. The counsellor/psychologist may be able to provide valuable collateral information. Family and friends may also be able to provide you with information. You might want to speak with the patient’s regular GP if they have one. It is prudent to ensure you perform a risk assessment for self-harm. If the condition is severe, an in-person consultation may be needed. Be very detailed in your safety netting advice, plan for follow up in a timely manner. Document the consultation well. If you have doubts about the patient’s safety consider a referral to acute mental health services (if you are a GP).

18. What is meant by "safeguarding concerns"?

This refers to patients at risk of harm, e.g. children, victims of domestic abuse.

19. Regarding telepsychiatry - so we are discouraged from assessing new patients? Is there a statement or other source of information I can refer to?

The decision is yours to make regarding which patients are safe to see using telehealth. It is best to consider the specific patient in front of you. Be aware of the limits of telehealth. Consider whether the risks to the patient of using telehealth outweigh the risks of coming into the clinic. For acutely unwell patients who are being assessed under the early sections of the Mental Health Act it is helpful to refer to the Ministry of Health COVID 19 guidelines and your local DHB protocols. If you are uncertain about how to proceed consulting senior colleagues is often helpful.

20. We are currently doing telephone consulting. What happens if the patient is still a little confused from recent hospital discharge and his carer answers the call? What if the carer/emergency contact is able to provide some insight into his current problem? Do we continue a brief history or just disconnect the call?

If the patient lacks competence it is appropriate to gather information from a caregiver. If there is no Enduring Power of Attorney or welfare guardian appointed, it is appropriate to release enough information to a carer to enable them to provide day to day care for the patient.

21. What if the patient develops potential but expected side effects due to medication I have advocated? What are the softer implications (as opposed to harder implications like HDC or enquiry)?

When we prescribe medications the patient must be provided enough information to make an informed decision. Part of this is detailing the potential side effects to the medication and to give advice about what the patient should do in that situation. If you have done this you are unlikely to be criticised. I recommend you review the Medical Council's statement Good prescribing practice found here: https://www.mcnz.org.nz/our-standards/current-standards/medical-care-and-prescribing/good-prescribing-practice/

22. Phone consultation consent is implied if they have booked for one?

Patients may not realise the limits of a phone consultation, so it is advisable to speak to the patient regarding this. The decision is yours as to whether to offer a phone consultation. The patient can make an informed decision whether to accept the offer.

23. Our department has adopted verbal consenting during COVID19 pandemic, we document it on our medical records as verbal consent taken. Is this enough?

Verbal consent is fine so long as you document this in the notes. The more serious the procedure, the more important it is to have evidence of consent. You might ask the patient for a photo of a signed form, or you might record them stating their consent. When procedures do not go as planned some patients will claim that they did not consent. Remember consent is a process.

24. What steps should we take to verify a patients identity, is self-identification enough?

You are best to 'satisfy yourself' that you have verified their identity. This may mean seeing a passport, birth certificate or driver's license.

25. What about patients who have seen the Naturopath who have been told to see us to prescribe, very commonly this is progesterone creams.

You cannot be forced to prescribe if you do not consider that the item is indicated or you do not consider you have enough experience with the 'medication' to safely prescribe. I suggest you review the Council's Good prescribing statement: https://www.mcnz.org.nz/our-standards/current-standards/medical-care-and-prescribing/good-prescribing-practice/

26. How do we deal with patients who deliberately do not disclose COVID-19 symptoms?

If they are breaching lockdown rules you may wish to consider calling the Medical Officer of Health for advice, without disclosing the patient's name. Then follow the advice given, which may include revealing the name of your patient.
If they deliberately lie to you, this breached the trust in the therapeutic relationship and you have grounds for disenrolling or not seeing the patient again. There is a process to follow and I suggest you call MPS around how best to do this.

27. If there is Doctor triage doesn't it often morph into Doctor consultation? Do triage Doctors charge for triage?

As I understand it there are no hard and fast rules on whether to do a full remote consult at the time of triage or schedule a later consult. The latter would enable you to manage the triage time better. Some practices charge for triage, others do not.

28. Is there a position on a situation where a doctor and patient disagree on the need for an in-person consult?

If you strongly believe an in-person consult is needed you need to make this clear to your patient and try to find out why they do not agree to come in. There may be something you can do to reassure a patient who is worried about the possibility of Covid 19 infection if they do attend. If they still decline, document carefully and follow up more closely than you might otherwise do.

29. What about involving trainees in remote consultations (med student or registrar)?

No problem, just ensure that you have consent from the patient before proceeding.

30. Surely the patient accepting your Zoom invite or picking up their phones at their designated appointment times implies consent? Or is there a quick way to obtain consent?

Patients may not understand the limitations of the video platform and informing your patient about this is wise. It does not need to take long to consent your patient. You could also email out the information ahead of your appointment.

31. If you are asked to intubate a COVID-19 patient and there is no PPE available, do you have the right to refuse?

Hopefully with the current low prevalence and availability of PPE this will not happen. In the unlikely event it did occur, as per Medical Council guidance, you are not obliged to put yourself at significant risk to provide care.

32. Does ePrescribing apply to private specialist

The Ministry of Health have guidance on ePrescribing. The new rules are here: https://www.health.govt.nz/system/files/documents/pages/covid-19-new_rules_for_electronic_prescriptions-3apr20.pdf

33. Is the e-consultation a paid job? How is funding calculated and who pays?

Most doctors charge remote consults as per a normal consultation, ACC will also fund these.

34. As a specialist can I request the GP to prescribe patient medication I would have recommended after an initial FSA via telehealth.

Yes, but you might want to contact the GP directly to confirm they are happy to do this.

35. Does that mean psychiatrists cannot assess new patients via telemedicine?

Use your clinical judgement regarding the safety of providing telehealth consultation, whether they are new patients or not. For the **acutely** unwell patient the risks can be higher. If you work in a DHB I suggest you review their protocols/guidelines, as well as the MOH guidance.

36. In Obstetrics we have been told by our med director that we must put PPE on first with a COVID patient prior to delivery. Even if the delivery is urgent/category 1 CS for example. We must make ourselves safe first. Would MPS agree?

Your employer has a responsibility to provide a safe working environment. Therefore this is a reasonable requirement, particularly as the only additional protection you would need is the eyeshield and a bit more time to get the PPE on and off correctly.

37. How will HDC cope with the fact we cannot examine patients?

This remains unknown, but in the current scenario where remote consultations are the norm rather than the exception, then any expert opinion would need to take this into account. If it was clear from the history that an in-person assessment was needed, then failure to recommend this would be criticised.

38. Many practices are working in teams for 1/2 the week now so there will be challenges with continuity of care.

With most consults being done remotely it should be possible to maintain reasonable continuity except when in-person consults are needed. The best way to ensure continuity of care is to write comprehensive clinical notes, including your rationale for working diagnosis and detailed plan moving forward.

39. Hi, how do we access the recorded talk later, thanks?

It is available through PRISM.

40. What to do if a patient's Covid status is unknown? Do we treat that person as Covid negative or potentially positive considering that pre-clinical cases/asymptomatic cases are still infectious?

This is a clinical decision based on current prevalence in the population and the kind of care that needs to be provided. Most NZ patients Covid 19 status will be unknown.

41. What if I am an asymptomatic Covid case and infect someone inadvertently because current guidance does not permit mask use unless patient is a known Covid positive?

There is unlikely to be medicolegal risk for a health professional who infects someone else while asymptomatic. If you follow MoH and DHB guidelines it would be difficult to be criticised. If you are symptomatic and continued to work and later proved to be positive and had infected others then it might be a question of professionalism for the Medical Council.

42. Could the DHB take action against a doctor for wearing a mask saying it is making other people anxious?

A DHB could take action depending on whether:

a) It had requested that a mask not be worn.
b) That instruction is reasonable.

Reasonableness in this circumstance will include whether the wearing of a mask is recommended or required according to any guidelines issued by the Ministry of Health etc. We again recommend that legal advice be taken should a situation like this arise.

43. Is it too risky to advise an operation to a patient one has not actually seen in person on the basis of a phone call?

Clearly an in-person consult would be needed before any surgery is done, but a phone call could be sufficient to advise someone they needed to be assessed.

44. What is the medicolegal position of specialists in the DHBs when the DHB determines that all clinics are telehealth by default, leaving a tail however, when they say that "doctors have ability of bringing the patient in if felt appropriate" to protect the DHB. For the individual doctors (e.g. for us cardiology), clinical examination which is missing in telehealth at times give us unexpected findings that change management. In some ways, we actually have to examine everyone to ensure that we are not missing things that we would otherwise pick up if we saw the patient in person. The DHB's default position disadvantages the individual doctor's ability to provide the usual care, but yet DHB is protected medicolegally?

The bottom line is still that if you feel you cannot get sufficient information from a remote consultation to provide safe care, then an in-person consultation is required. For some specialties, many consults may be safely done remotely, while for others it will be relatively few.

45. About ePrescriptions: I am uncomfortable with the fact that prescriptions could be printed off and sent without the doctor even having known that it was prescribed. Will this be tightened up after the COVID period?

The clinic needs robust systems to ensure that prescriptions cannot be sent from the practice, whether electronically or by fax etc., without the doctor having seen and OK'd them. It is not acceptable for nurses to do this without the doctor checking first.

46. Any comment on instances where the patient may choose to record the consult themselves - either overtly or covertly?

Patients should ask for consent before recording a consult. However, we would not know if a consult is covertly recorded, so it is safer to proceed knowing that it is a possibility. Knowing this may influence your behaviour during the remote consult!

47. Do you have advice as what to include in information sheet for virtual consult please?

You are welcome to use material from the webinar to assist you with preparing an information sheet that suits your practice and your patients. Other resources are found here:

- https://www.ranzcp.org/practice-education/telehealth-in-psychiatry
- https://www.telehealth.org.nz
- https://www.telehealth.org.nz/regulations-and-policies/regulations-and-standards/
- https://www.healthcarehome.org.nz
- https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians
- https://www.mentalhealthonline.org.au/Assets/A%20Practical%20Guide%20to%20Video%20Mental%20Health%20Consultation.pdf

48. Should patients expect to pay the same fee for a teleconsult rather than in-person, and how should we respond if they challenge a fee charged for remote consults?

It is reasonable to charge a fee and patients need to know this, and the likely amount, prior to any consult. The fee level is up to individual doctors or practices to determine.

49. The problems I have encountered in doing a partial physical examination: I ask the patient what is their temperature? They told me they have no thermometer, I asked what is your weight, they told me they no scales. How to work out those physical examination? Thanks.

As with any remote consultation you will need to determine whether you have enough information to safely manage the patient. This will obviously be an individual decision for each consultation.

50. What if a patient from overseas is in lock down asking for medicine not available here in NZ?

Provided there is something similar available in NZ, and you are able to get enough information to determine that it is safer to prescribe something than it is for the patient to be left with no medication, then it would be reasonable to prescribe. Document carefully.