

ASF STANDARDS · TELEMEDICINE · STANDARD 9

Standard 9 — Sustainable Care

5 criteria · 0 core · 5 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 6, 6th Edition

CRITERIA IN THIS STANDARD

- 9.1 — Digital Infrastructure
Impact Is Genuinely Assessed,
Not Assumed Negligible
- 9.2 — Hosting and Technology
Procurement Genuinely
Considers Environmental
Impact
- 9.3 — The Provider Genuinely
Considers Its Real Reduction of
Patient Travel Impact
- 9.4 — Staff Are Genuinely
Engaged in Sustainability
Practice
- 9.5 — Sustainability
Commitments Are Genuinely
Reviewed, Not Static

Digital Infrastructure Impact Is

9.1 Genuinely Assessed, Not Assumed Negligible

STANDARD

The provider genuinely assesses the environmental impact of its own digital infrastructure — server hosting, data storage, device energy use — not assumed negligible simply because the service has no physical patient-facing facility.

In plain terms: Having no physical clinic doesn't mean no environmental footprint — servers, data storage, and devices all genuinely use real energy, and the provider has actually looked at this.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A telemedicine provider's absence of a physical building can create a genuine, mistaken sense that there is no real environmental footprint to consider — but server infrastructure, data centers, and the cumulative device energy use of a distributed clinical workforce all carry real, measurable impact. Digital services aren't impact-free; their impact is simply less visible.

WHAT GOOD LOOKS LIKE

- A genuine assessment of hosting and infrastructure impact exists.
- Cloud or hosting provider environmental practice has been genuinely reviewed.
- This assessment is genuinely revisited periodically.

COMMON FAILURE MODES

- No assessment has ever been conducted, on the assumption a digital service has no real footprint.

WORKED EXAMPLE

IN PRACTICE	
<i>A telemedicine provider that had never considered its hosting footprint.</i>	
BEFORE	The provider used a major cloud hosting service with no review of that provider's own energy sourcing or environmental commitments.
ACTION	The hosting provider's published sustainability report was reviewed and documented as part of the assessment.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review your hosting provider’s own published environmental practice.

The most common mistake: Assuming a digital-only service has no real environmental footprint worth assessing.

SELF-ASSESSMENT QUESTIONS

1. Has the provider genuinely assessed its hosting and data infrastructure footprint? — *A real, documented assessment.*

Evidence: Infrastructure assessment document
2. Where cloud or hosting services are used, has their provider’s own environmental practice been genuinely reviewed? — *A real, specific check.*

Evidence: Hosting provider review
3. Is this assessment genuinely revisited periodically? — *Real, periodic review.*

Evidence: Review schedule

COMMON REASONS FOR A PARTIAL ANSWER

- **Hosting is used but the provider’s own environmental practice was never checked.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Review hosting provider’s environmental practice and document.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Assessment review	Reviews the documented infrastructure assessment.

- **Ask directly whether anyone has looked at the hosting provider's own sustainability record.**

EVIDENCE BASE

World Health Organization. WHO Guidance for Climate-Resilient and Environmentally Sustainable Health Care Facilities. Geneva: WHO; 2020.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Hosting and Technology Procurement

9.2 Genuinely Considers Environmental Impact

STANDARD

Decisions about cloud hosting providers, servers, and core technology infrastructure genuinely factor in environmental impact alongside cost and performance — not sustainability treated as irrelevant to a purely digital service.

In plain terms: When the provider picks a hosting company or technology vendor, it actually considers environmental impact — not purely cost and speed.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Technology procurement decisions — which hosting provider, how data is stored and retained — compound across a provider's entire operation, and genuine environmental consideration here is where a digital provider's real sustainability commitment is actually tested, not in a general policy statement.

WHAT GOOD LOOKS LIKE

- Hosting decisions genuinely weigh environmental impact.
- A real instance shows this influencing a choice.

COMMON FAILURE MODES

- Hosting is chosen purely on cost and performance.

WORKED EXAMPLE

IN PRACTICE

A provider reviewing its data retention practice.

BEFORE

All patient data was retained indefinitely by default, with no review of what was genuinely necessary to keep versus what could be archived or deleted per regulatory requirements.

ACTION

A data retention policy was introduced aligned with actual regulatory requirements, reducing unnecessary long-term storage.

AFTER

The Monitor reviewed the retention policy. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Review current data retention practice against actual regulatory requirements.

The most common mistake: Data retained indefinitely by default with no genuine review of what's actually necessary.

SELF-ASSESSMENT QUESTIONS

1. Does hosting provider selection genuinely weigh environmental impact? — *Real, documented consideration.*

Evidence: Procurement criteria

2. Is there a real, documented instance of this genuinely influencing a choice? — *A concrete, real example.*

Evidence: Procurement decision record

3. Is data storage genuinely reviewed for efficiency? — *A real, ongoing review.*

Evidence: Retention policy

- **A retention policy exists but hasn't actually been applied to reduce storage.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Review and document a data retention policy.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Procurement review	Reviews procurement criteria and retention policy.

SUPERVISOR TIPS

- **Ask about the current data retention policy specifically.**

EVIDENCE BASE

NHS England. Delivering a Net Zero National Health Service. London: NHS England; 2022.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.3 The Provider Genuinely Considers Its Real Reduction of Patient Travel Impact

STANDARD

The provider genuinely recognises and, where meaningful, documents the real environmental benefit telemedicine delivers by reducing patient travel — not an unexamined assumption of benefit with no real attention to whether this is actually communicated or substantiated.

In plain terms: The provider has actually thought about the real environmental benefit of patients not having to travel for care, not just assumed it exists without ever really considering it.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Telemedicine’s genuine environmental benefit — avoided patient travel — is real and substantial, but it’s also easy to assume without ever actually examining or substantiating it. A provider that genuinely considers this benefit is better positioned to make real, informed decisions about which services should remain available remotely versus which genuinely require in-person delivery.

WHAT GOOD LOOKS LIKE

- The real travel-reduction benefit is genuinely recognised.
- This benefit is genuinely communicated where appropriate.
- This recognition genuinely informs scope decisions.

COMMON FAILURE MODES

- The benefit is assumed but never actually examined or communicated.

WORKED EXAMPLE

IN PRACTICE	
<i>A provider that had never actually examined its travel-reduction impact.</i>	
BEFORE	The provider’s marketing mentioned convenience but never genuinely considered or communicated the environmental dimension of avoided travel.
ACTION	A brief internal review documented the genuine travel-reduction benefit, which informed a decision to keep a specific follow-up service remote rather than reverting to in-person.
AFTER	The Monitor reviewed the documented consideration and its connection to the scope decision. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

The most common mistake: Assuming the travel-reduction benefit without ever actually examining or documenting it.

SELF-ASSESSMENT QUESTIONS

1. Does the provider genuinely recognise telemedicine's real travel-reduction benefit? — *A real, considered recognition.*

Evidence: Documented consideration

2. Is this benefit genuinely communicated to patients where appropriate? — *Real, visible communication.*

Evidence: Patient-facing communication

3. Does this recognition genuinely inform scope decisions? — *A real, considered connection.*

Evidence: Scope decision record

COMMON REASONS FOR A PARTIAL ANSWER

- **The benefit is mentioned in marketing but never genuinely examined internally.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Document a genuine consideration of travel-reduction benefit.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Consideration review	Reviews the documented consideration and any resulting decision.

SUPERVISOR TIPS

- **Ask whether this has ever actually informed a real service-scope decision.**

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.4 Staff Are Genuinely Engaged in Sustainability Practice

STANDARD

Staff genuinely understand and participate in the provider’s sustainability practices — not a policy known only to leadership with no real staff awareness or input.

In plain terms: Staff actually know what the provider is doing to be more sustainable — including staff who rarely or never meet colleagues in person.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A genuinely distributed, remote workforce can easily miss internal communication that would naturally reach an in-person team through a noticeboard or hallway conversation — genuine sustainability engagement here requires deliberate, functioning communication appropriate to this provider’s actual structure.

WHAT GOOD LOOKS LIKE

- Staff can genuinely describe a real practice.
- Staff input is genuinely sought.
- Communication genuinely reaches remote staff.

COMMON FAILURE MODES

- Communication happens only at head office, missing remote staff entirely.

WORKED EXAMPLE

IN PRACTICE

A provider whose sustainability updates never reached remote clinicians.

PHIG	BEFORE	Sustainability updates were posted on an office noticeboard that remote clinicians never saw.
GILS · Labour Studies	ACTION	Updates were moved to the provider’s standard internal digital communication channel, genuinely reaching all staff.
GMJ · Journal	AFTER	The Monitor interviewed a remote clinician who could describe a recent update. Verified.
GMJ News		
GMJ Academy		

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

- 1. Check whether current communication genuinely reaches remote staff, not just those at a central office.

The most common mistake: Internal communication methods designed around an in-person office that a genuinely remote workforce never sees.

SELF-ASSESSMENT QUESTIONS

- 1. Can staff describe a genuine sustainability practice? — *Real, demonstrated awareness.*
Evidence: Staff interview
- 2. Is staff input genuinely sought? — *Real, two-way engagement.*
Evidence: Staff suggestion record
- 3. Does communication genuinely reach remote or distributed staff? — *Real, functioning communication.*
Evidence: Remote staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Office-based staff are aware but remote staff genuinely are not.

IMPLEMENTATION PLAN

When	What
Week 1	Move communication to a channel that genuinely reaches remote staff.

Method	What	Detail
ASK	Staff interview	Asks a remote staff member to describe a specific practice.

SUPERVISOR TIPS

- Interview a genuinely remote staff member, not only office-based staff.

EVIDENCE BASE

Health Care Without Harm. Global Green and Healthy Hospitals Agenda. Reston: HCWH; 2020.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

9.5

Sustainability Commitments Are Genuinely Reviewed, Not Static

STANDARD

The provider’s sustainability goals and practices are genuinely reviewed and updated as circumstances change — not a document written once and never genuinely examined for whether it still reflects actual practice.

In plain terms: The provider’s sustainability goals actually get revisited — not written once and left to go stale.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A document written once stops genuinely reflecting current practice as hosting providers, data practices, and the provider’s own scale change. Real, periodic review is what keeps the commitment meaningful.

WHAT GOOD LOOKS LIKE

- Goals are genuinely reviewed.

COMMON FAILURE MODES

- A document was written once and never revisited.

WORKED EXAMPLE

IN PRACTICE

A provider whose sustainability statement predated a hosting provider switch.

BEFORE	The statement referenced a hosting provider no longer used.
ACTION	A named person was assigned annual review responsibility.
AFTER	The Monitor reviewed the updated, dated document. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Assign named review responsibility.

The most common mistake: A document nobody is specifically responsible for revisiting.

SELF-ASSESSMENT QUESTIONS

1. Are goals genuinely reviewed? — *A real, periodic review.*

Evidence: Review schedule

2. Is there a real revision instance? — *A concrete example.*

Evidence: Revision history

3. Is responsibility genuinely assigned? — *A real, named accountability.*

Evidence: Assigned responsibility documentation

COMMON REASONS FOR A PARTIAL ANSWER

- A schedule exists but hasn't been followed consistently.

When	What
Week 1	Assign review responsibility and conduct the first review.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Revision history review	Reviews the document's revision history.

SUPERVISOR TIPS

- Ask who is specifically responsible for review.

EVIDENCE BASE

United Nations Environment Programme. Sustainable Healthcare Facilities Guidance. Nairobi: UNEP; 2022.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

- ← **Telemedicine Standards**
— all standards
- Self-assess against these criteria →**
- Standard 10 — Artificial Intelligence Systems →**

ASF STANDARDS · TELEMEDICINE · STANDARD 10

Standard 10 — Artificial Intelligence Systems for Care

5 criteria · 2 core · 3 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 7, 6th Edition

Platform reliability, security, and data privacy are governed by Standards 1 and 6. This standard addresses the additional governance layer specific to artificial intelligence tools used within the telemedicine service.

CRITERIA IN THIS STANDARD

10.1 — The Service Never Disadvantages a Patient Who Cannot Access It Digitally

10.2 — AI Systems Are Introduced in Line With Law and Best-Practice Guidance

10.3 — AI Systems Are Genuinely Monitored for Unintended Consequences

10.4 — Clinicians Are Genuinely Consulted Before an AI System Is Introduced

10.5 — Accountability for AI-Assisted Care Is Explicitly Defined

10.6 — Patients Are Genuinely Informed When Their Care Involves AI

10.1 The Service Never Disadvantages a Patient Who Cannot Access It Digitally CORE

A genuine process exists so that a patient who cannot access the telemedicine platform — no reliable internet, no suitable device, limited digital literacy — is never simply left without care, but is genuinely referred or redirected to an appropriate alternative, not told the service is unavailable to them with no real next step.

In plain terms: A patient who can't actually use the platform still gets genuinely connected to care somehow — not just turned away with nothing offered instead.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because telemedicine's entire service model depends on digital access, meaning a patient who genuinely cannot access the platform isn't facing a minor inconvenience — they face a real, complete barrier to this provider's care. A genuine, functioning referral or alternative pathway is what prevents digital access itself from becoming the thing that determines whether someone receives care at all.

WHAT GOOD LOOKS LIKE

- A genuine, defined pathway exists for patients who cannot access the platform.
- Staff are genuinely trained to recognise this specific need.
- A real, documented instance shows a patient genuinely redirected.

COMMON FAILURE MODES

- A patient who can't use the platform is simply told the service isn't for them.

IN PRACTICE

A telemedicine provider with no defined response for digitally excluded patients.

BEFORE

A patient without reliable internet access called the booking line and was simply told the service required a stable connection, with no alternative offered.

ACTION

A referral pathway was established to connect such patients with a partner in-person clinic, and staff were trained to offer this proactively.

AFTER

The Monitor reviewed a documented referral and confirmed the patient genuinely received appropriate care. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Establish a referral relationship with an in-person alternative for digitally excluded patients.
2. Train staff to proactively offer this, not just state the digital requirement.

The most common mistake: Treating “requires a stable internet connection” as an acceptable final answer with no genuine alternative offered.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, defined pathway for a patient who cannot access the platform digitally? — *A real, usable referral or alternative pathway.*

Evidence: Referral pathway documentation

2. Are staff genuinely trained to recognise and respond to digital access difficulty? — *Real, specific staff awareness.*

Evidence: Training record

3. Is there a real, documented instance of a patient genuinely redirected to an appropriate alternative? — *A real, concrete example.*

COMMON REASONS FOR A PARTIAL ANSWER

- A referral pathway exists on paper but staff don’t actually know to offer it proactively.

IMPLEMENTATION PLAN

When	What
Week 1-2	Establish a referral pathway and train staff.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Referral record review	Reviews a real instance of a patient genuinely redirected.

SUPERVISOR TIPS

- Ask a booking staff member what they’d actually do for a patient with no internet access.

EVIDENCE BASE

World Health Organization. Global Strategy on Digital Health 2020-2025. Geneva: WHO; 2021.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.2

AI Systems Are Introduced in Line With Law and Best-Practice Guidance

STANDARD

Any artificial intelligence tool used to support triage, diagnosis, or clinical documentation is introduced in accordance with applicable law, or where none exists, with available best-practice guidance such as WHO’s AI ethics and governance guidance — not adopted with no reference to any external standard of responsible use.

In plain terms: Before using an AI tool, the provider has actually checked what the law requires — including across every jurisdiction it actually operates in.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Telemedicine providers often genuinely operate across multiple jurisdictions, and AI regulation varies meaningfully between them — a governance basis that was genuinely checked for one jurisdiction may not actually apply in another where the provider also delivers care. Real, jurisdiction-specific verification is what this criterion is actually protecting against: an assumed basis that doesn't genuinely hold everywhere the provider operates.

WHAT GOOD LOOKS LIKE

- AI systems are genuinely introduced in line with applicable law.
- Where no law exists, introduction is genuinely informed by recognized guidance.
- The governance basis is genuinely checked per relevant jurisdiction.

COMMON FAILURE MODES

- A single governance basis is assumed to apply uniformly across all jurisdictions served.

WORKED EXAMPLE

IN PRACTICE	
A provider operating across three countries with an AI triage tool.	
BEFORE	A single governance review had been conducted for the provider's home jurisdiction, with no check of whether the same basis genuinely applied in the two other countries served.
ACTION	A jurisdiction-specific review was conducted for each country, revealing one jurisdiction had a specific AI medical device requirement the provider had not previously met.

The Monitor reviewed the jurisdiction-specific governance documentation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List every jurisdiction where your telemedicine service is genuinely delivered.
2. Check AI-specific regulation for each one individually.

The most common mistake: Assuming one jurisdiction’s governance basis automatically applies across every other jurisdiction served.

SELF-ASSESSMENT QUESTIONS

1. Is any AI system genuinely introduced in line with applicable law?
— *Real, verified compliance.*
Evidence: Regulatory check record
2. Where no law exists, is introduction genuinely informed by recognized guidance? — *A real, referenced source.*
Evidence: Documented guidance reference
3. Has the governance basis been genuinely checked against each relevant jurisdiction? — *A real, jurisdiction-specific check.*
Evidence: Multi-jurisdiction review record

COMMON REASONS FOR A PARTIAL ANSWER

- A review covers the provider’s primary jurisdiction only.

IMPLEMENTATION PLAN

When	What
Week 1-2	Conduct jurisdiction-specific regulatory reviews.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Multi-jurisdiction review	Reviews the governance basis for each jurisdiction served.

- **Ask about governance in a jurisdiction other than the provider’s home base.**

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.3

AI Systems Are Genuinely Monitored for Unintended Consequences

STANDARD

The provider genuinely monitors any AI-assisted triage or diagnostic tool for over-diagnosis, missed diagnosis, and other unintended consequences — a genuinely heightened concern in a remote setting where an AI tool may be compensating for the absence of physical examination — not deploying a tool and assuming it works as intended with no real, ongoing scrutiny.

In plain terms: The provider actually keeps checking whether its AI tools work well — this matters even more here, since there’s no physical exam to catch what the AI might miss.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A remote consultation already lacks the real information a physical examination provides, and an AI tool used to help compensate for this gap carries genuinely elevated stakes — if the tool itself has accuracy problems, there is no physical exam acting as a natural backstop to catch what it misses. Monitoring here needs to genuinely account for this compounded risk, not treat it identically to an AI tool used alongside in-person examination.

WHAT GOOD LOOKS LIKE

- AI output is genuinely audited.
- Monitoring genuinely reflects remote assessment's specific limitations.
- A documented instance shows monitoring catching a real issue.

COMMON FAILURE MODES

- Monitoring treats the remote AI tool identically to an in-person equivalent, missing the compounded risk.

WORKED EXAMPLE

IN PRACTICE	
A provider using an AI-assisted symptom triage tool.	
BEFORE	The tool's accuracy was audited using the same generic process as an in-house AI tool, without specific attention to cases where the absence of physical examination might compound an AI error.
ACTION	The audit was revised to specifically flag and review cases where the AI recommendation diverged significantly from what a subsequent in-person assessment later found.
AFTER	The Monitor reviewed the revised audit methodology. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a specific comparison between AI-assisted remote assessments and any later in-person findings.

The most common mistake: Auditing a remote AI tool the same way as an in-person one, missing the genuinely elevated risk of no physical exam as a backstop.

1. Is AI-assisted output genuinely audited? — *Real, ongoing audit.*

Evidence: Audit record

2. Does monitoring genuinely reflect remote assessment's specific limitations? — *A real, setting-specific consideration.*

Evidence: Audit methodology

3. Is there a documented instance of monitoring identifying a genuine issue? — *A real, concrete example.*

Evidence: Issue response record

COMMON REASONS FOR A PARTIAL ANSWER

- Audits happen but don't specifically track divergence from subsequent in-person findings.

IMPLEMENTATION PLAN

When	What
Week 1-2	Build a remote-specific audit comparing AI output to later in-person findings where available.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Audit methodology review	Reviews the audit for genuine, remote-specific consideration.

SUPERVISOR TIPS

- Ask whether the audit specifically accounts for the absence of physical examination.

EVIDENCE BASE

US Food and Drug Administration. Artificial Intelligence and Machine Learning in Software as a Medical Device. Silver Spring: FDA; 2023.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.4

Clinicians Are Genuinely Consulted Before an AI System Is Introduced

STANDARD

Clinicians who will actually use a new AI tool are genuinely consulted before its introduction, with real training needs identified and addressed — not a tool rolled out to a genuinely distributed, often remote clinical workforce with no engagement beyond a brief notification.

In plain terms: Before a new AI tool goes live, clinicians — including those working remotely, not just those at a central office — have had a real say.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A genuinely distributed clinical workforce is easy to under-consult simply because convening them is logistically harder than gathering an in-person team — but their real, practical experience with the AI tool's actual use in remote consultations is exactly the knowledge genuine consultation is meant to surface.

WHAT GOOD LOOKS LIKE

- Clinicians are genuinely consulted before introduction.
- Consultation genuinely reaches remote clinicians across time zones.
- Clinicians can describe genuine consultation.

COMMON FAILURE MODES

- Consultation happens only with clinicians easiest to convene, missing remote staff.

WORKED EXAMPLE

IN PRACTICE

A provider introducing an AI documentation tool across time zones.

BEFORE

A single consultation call was scheduled at a time convenient for the provider's home time zone,

which several remote clinicians in other time zones could not attend.

ACTION

A second session was scheduled, and a written feedback option was added for anyone still unable to attend either.

AFTER

The Monitor confirmed clinicians across multiple time zones had genuinely participated. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Schedule consultation sessions that genuinely accommodate your clinicians' real time zones.

The most common mistake: Scheduling a single consultation session at a time that genuinely excludes part of a distributed workforce.

SELF-ASSESSMENT QUESTIONS

1. Are clinicians genuinely consulted before introduction? — *Real, prior consultation.*

Evidence: Consultation record

2. Does consultation genuinely reach remote clinicians across time zones? — *Real, functioning consultation.*

Evidence: Participation record across time zones

3. Can clinicians describe having been genuinely consulted? —

Tests whether consultation actually registered.

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A single session was held, genuinely excluding part of the workforce.

IMPLEMENTATION PLAN

When	What
Before any launch	Schedule consultation genuinely accommodating all clinician time zones.

Method	What	Detail
ASK	Remote staff interview	Asks a remote clinician whether they felt genuinely consulted.

SUPERVISOR TIPS

- Specifically interview a clinician in a different time zone from the provider’s base.

EVIDENCE BASE

Topol EJ. High-Performance Medicine: The Convergence of Human and Artificial Intelligence. Nature Medicine. 2019;25(1):44-56.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.5

Accountability for AI-Assisted Care Is Explicitly Defined

CORE

The provider has genuinely considered and documented accountability for care decisions made with AI support — who is responsible when an AI-assisted decision is wrong — not leaving this as an unexamined question until it actually matters, a question with genuinely added complexity when the clinician, the platform, and the AI vendor may all sit in different jurisdictions.

In plain terms: Everyone knows, in advance, who’s actually responsible if an AI-supported decision is wrong — even with a clinician, a platform, and an AI vendor potentially all in different countries.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

This is marked Core because the cross-border nature of many telemedicine operations adds a genuinely real layer of complexity to accountability that doesn’t exist in a single-site facility — the clinician,

the platform operator, and the AI tool's vendor, may each sit in different jurisdictions with different legal frameworks. Without explicit, documented accountability, a safety incident risks becoming a genuinely tangled jurisdictional dispute exactly when the patient needs a clear answer.

WHAT GOOD LOOKS LIKE

- Clinical accountability is explicitly documented.
- Clinicians genuinely understand accountability, including across jurisdictional lines.
- A defined process exists for reviewing accountability in an incident.

COMMON FAILURE MODES

- Accountability has never been examined in light of the provider's genuine cross-border structure.

WORKED EXAMPLE

IN PRACTICE	
A provider with clinicians, a platform operator, and an AI vendor in three different countries.	
BEFORE	Accountability for AI-assisted decisions had never been explicitly documented with this genuine cross-border structure in mind.
ACTION	A clear policy was developed with legal input, explicitly confirming the treating clinician retains clinical accountability regardless of where the AI vendor or platform is based.
AFTER	The Monitor reviewed the policy and interviewed a clinician who could clearly describe their own accountability. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Map every jurisdiction involved in your AI tool's use — clinician, platform, vendor.

The most common mistake: Documenting accountability as if the provider operated from a single jurisdiction, missing the genuine cross-border complexity.

SELF-ASSESSMENT QUESTIONS

1. Is clinical accountability explicitly documented? — *A real, clear answer.*

Evidence: Documented accountability policy

2. Do clinicians genuinely understand accountability across jurisdictional lines? — *Real, demonstrated understanding.*

Evidence: Staff interview

3. Is there a defined process for reviewing accountability in a safety incident? — *A real, usable process.*

Evidence: Incident review protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **A policy exists but was never reviewed against the provider's genuine cross-border structure.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Map jurisdictions and document accountability with legal input.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a clinician to describe their accountability, including cross-border considerations.

SUPERVISOR TIPS

- **Ask specifically how jurisdiction affects accountability, not just the general policy.**

EVIDENCE BASE

European Commission. Ethics Guidelines for Trustworthy Artificial Intelligence. Brussels: European Commission; 2019.

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

10.6 Patients Are Genuinely Informed When Their Care Involves AI

STANDARD

A patient whose care involves an aspect delivered with AI system support is genuinely informed of this — not left to assume every decision was made by the remote clinician alone, with disclosure treated as optional rather than a genuine, standard part of informed telemedicine care.

In plain terms: If AI is actually involved in part of a patient's remote consultation, they're genuinely told — not left to assume a human clinician made every decision alone.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient's genuine right to understand their own care includes knowing, in plain terms, when a triage or interpretation decision affecting them was shaped by an AI system rather than the remote clinician's judgement alone. This matters especially in telemedicine, where a patient genuinely cannot see the clinician's workflow the way they might observe cues in an in-person visit, making explicit disclosure the only real way they would know.

WHAT GOOD LOOKS LIKE

- Patients are genuinely informed when AI is involved in their care.
- Disclosure is genuinely understandable, in plain language.

COMMON FAILURE MODES

- AI disclosure is buried in a general platform terms-of-use document, technically present but never genuinely read or understood.

WORKED EXAMPLE

IN PRACTICE

A telemedicine service using an AI-assisted symptom triage tool.

BEFORE

AI's role was mentioned only in the platform's general terms of use, which patients accepted without genuine awareness that an AI tool had actually been involved in their specific triage.

ACTION

A brief, plain-language note was added during the consultation itself: "An AI-assisted tool helped prioritise your case; your clinician reviewed it directly."

AFTER

The Monitor interviewed a patient who could genuinely confirm they understood AI had been involved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a brief, plain-language disclosure point at the moment AI-assisted care is actually discussed with the patient during the remote consultation.

The most common mistake: Treating a line buried in platform terms of use as genuine disclosure, when the patient never actually registers it.

SELF-ASSESSMENT QUESTIONS

1. Is a patient genuinely informed when AI is involved in their care?

— *Real, standard disclosure.*

Evidence: Disclosure protocol

2. Is this disclosure genuinely understandable, not buried in platform terms? — *A real, plain-language explanation.*

Evidence: Disclosure wording sample

3. Can a patient asked directly confirm they were genuinely told?

A real, concrete confirmation.

Evidence: Patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- **Disclosure exists in platform terms but patients genuinely cannot recall or explain it when asked directly.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Draft plain-language disclosure wording for AI-assisted consultation points and train clinicians to deliver it.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Asks a patient whether they were genuinely told AI was involved in their care.

SUPERVISOR TIPS

- **Ask a patient directly rather than relying on the platform terms' existence alone.**

EVIDENCE BASE

World Health Organization. Ethics and Governance of Artificial Intelligence for Health: Guidance on Large Multi-Modal Models. Geneva: WHO; 2024.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← Telemedicine Standards
— all standards

Self-assess against these criteria →

← Standard 9 — Sustainable Care

Standard 11 — Supporting the Care Workforce →

ASF STANDARDS · TELEMEDICINE · STANDARD 11

Standard 11 — Supporting the Care Workforce

5 criteria · 1 core · 4 standard-level · Version 1.0 · Aligned to ISQua EEA
Principle 8, 6th Edition

Credentialing and governance of individual providers are addressed in Standard 7. This standard addresses the additional workforce-support dimensions genuinely distinct to a remote, often geographically distributed clinical workforce.

CRITERIA IN THIS STANDARD

- 11.1 — Ongoing Competency Is Genuinely, Regularly Evaluated
- 11.2 — Providers Have Genuine Access to Ongoing Education and Peer Connection
- 11.3 — Clinician Wellbeing and Isolation Risk Are Genuinely Monitored
- 11.4 — Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved
- 11.5 — Workforce Feedback Is Genuinely Gathered and Acted On
- 11.6 — Equality, Diversity and Inclusion Across the Workforce Are Genuinely Monitored

11.1

Ongoing Competency Is Genuinely, Regularly Evaluated

CORE

The continued clinical competency of every provider is genuinely, regularly evaluated, including competency

specific to remote assessment technique, not assumed to remain adequate indefinitely once initial credentialing under Standard 7 is complete.

In plain terms: Clinical competency keeps getting genuinely checked — including the specific skill of assessing a patient remotely, which is genuinely different from in-person examination.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Remote clinical assessment is a genuinely distinct skill from in-person examination — reading visual cues through a camera, compensating for the absence of physical touch, knowing when remote limitations mean a case needs escalation. This is marked Core because a provider whose credentialing confirmed general clinical competency years ago, but whose remote-specific assessment skill has never been separately, ongoingly evaluated, carries real, direct patient safety risk.

WHAT GOOD LOOKS LIKE

- Competency is genuinely evaluated on a real schedule.
- Evaluation genuinely includes remote-specific assessment skill.
- A genuine gap triggers a real response.

COMMON FAILURE MODES

- Evaluation checks general clinical competency but never remote assessment skill specifically.

WORKED EXAMPLE

IN PRACTICE

A provider whose evaluation never covered remote-specific skill.

BEFORE

Annual competency reviews confirmed general clinical knowledge but never actually evaluated how well a clinician conducted remote visual assessment or recognised when a case exceeded remote assessment’s real limits.

BEFORE A remote assessment-specific evaluation component was added, including review of a recorded (with consent) sample consultation.	
AFTER	The Monitor reviewed a recent evaluation including the remote-specific component. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Add a remote-assessment-specific component to your existing competency evaluation.

The most common mistake: Evaluating general clinical knowledge while never actually assessing remote-specific examination skill.

SELF-ASSESSMENT QUESTIONS

1. Is ongoing competency genuinely evaluated on a real schedule?

— *A real, periodic evaluation.*

Evidence: Evaluation records

2. Does this genuinely include remote-specific assessment competency? — *A specific, setting-relevant evaluation.*

Evidence: Remote-specific evaluation criteria

3. When a genuine gap is identified, is there a real, defined response? — *A genuine corrective process.*

Evidence: Correction record

COMMON REASONS FOR A PARTIAL ANSWER

- **Evaluation exists but relies on self-report rather than observed remote consultation.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Build a remote-assessment-specific evaluation component.

Method	What	Detail
DOCUMENT	Evaluation review	Reviews evaluation for genuine, remote-specific substance.

SUPERVISOR TIPS

- **Ask specifically whether remote assessment skill is evaluated separately from general clinical knowledge.**

EVIDENCE BASE

Institute of Medicine. Health Professions Education: A Bridge to Quality. Washington DC: National Academies Press; 2003.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.2 Providers Have Genuine Access to Ongoing Education and Peer Connection

STANDARD

Every provider has genuine access to ongoing education and, specifically, genuine opportunities for peer connection and consultation — which a geographically distributed, remote workforce can easily lack compared to colleagues who work alongside each other daily in a shared physical space.

In plain terms: Providers can actually keep learning and genuinely connecting with peers — something that doesn't happen naturally when everyone works remotely and never crosses paths.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Clinicians in a shared physical setting naturally consult colleagues informally — a quick question in a hallway, a case discussed over lunch — and this genuine peer learning simply doesn't happen on its

own in a remote setting unless it's deliberately, structurally built in. A BIG GILS Labour Studies GMJ Journal GMJ News GMJ Academy provider that treats education purely as individual, self-directed courses misses this genuinely distinct, real need.

WHAT GOOD LOOKS LIKE

- Genuine, ongoing access to education beyond onboarding.
- Real, structured peer consultation opportunities exist.
- A provider can describe a real opportunity taken.

COMMON FAILURE MODES

- Education is purely individual online courses, with no genuine peer connection.

WORKED EXAMPLE

IN PRACTICE

A provider whose clinicians had no genuine peer connection.

BEFORE	Education consisted entirely of individual online modules, with clinicians having no structured way to discuss cases with colleagues.
ACTION	A monthly virtual case discussion session was introduced, genuinely scheduled across time zones to maximize attendance.
AFTER	The Monitor interviewed a clinician who described genuine value from a recent session. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular, structured peer case discussion session.

The most common mistake: Treating individual online courses as a complete substitute for genuine peer connection.

SELF-ASSESSMENT QUESTIONS

- 1. Does every provider have genuine, ongoing access to education?**
— *Real, continuing access.*

2. Are genuine peer consultation opportunities offered? — *Real, structured peer connection.*

Evidence: Case discussion schedule

3. Can a provider describe a genuine opportunity taken in the past year? — *A real, specific example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- A peer session exists but attendance is genuinely low due to scheduling exclusion.

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a regular, time-zone-accommodating peer session.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Staff interview	Asks a provider to describe a genuine peer connection opportunity.

SUPERVISOR TIPS

- Ask about actual attendance at peer sessions, not just their existence.

EVIDENCE BASE

World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030. Geneva: WHO; 2016.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.3 Clinician Wellbeing and Isolation Risk Are Genuinely Monitored

STANDARD

The provider genuinely monitors for the real wellbeing and professional isolation risk distinct to remote clinical practice

In plain terms: The provider actually pays attention to the real loneliness and isolation risk of working remotely — not treating remote wellbeing the same as an in-person team’s.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Professional isolation is a genuine, documented occupational wellbeing risk for remote clinicians — the absence of daily in-person colleague contact, the lack of a natural debrief after a difficult consultation, can genuinely accumulate without ever being formally recognised. A generic wellbeing policy copied from an in-person clinical setting misses this real, distinct risk.

WHAT GOOD LOOKS LIKE

- Isolation risk is genuinely, specifically considered.
- Real, regular check-ins happen beyond clinical/administrative matters.
- A clinician can describe a real instance where this made a difference.

COMMON FAILURE MODES

- Wellbeing check-ins, if they happen, cover only clinical caseload, never genuine personal wellbeing.

WORKED EXAMPLE

IN PRACTICE

A provider with no genuine wellbeing check-in process.

BEFORE

Manager check-ins covered only caseload and administrative matters, with no real space for a clinician to raise genuine isolation or wellbeing concerns.

ACTION

A separate, explicitly wellbeing-focused check-in

was introduced quarterly, distinct from administrative reviews.

AFTER

The Monitor interviewed a clinician who described the quarterly check-in as genuinely valuable. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a wellbeing-specific check-in, separate from administrative review.

The most common mistake: Treating a caseload review as equivalent to genuine attention to isolation and wellbeing.

SELF-ASSESSMENT QUESTIONS

1. Does the provider genuinely consider isolation risk specific to remote practice? — *A real, setting-specific consideration.*

Evidence: Wellbeing policy

2. Are genuine, regular check-ins conducted beyond clinical or administrative matters? — *Real, human contact.*

Evidence: Check-in schedule

3. Can a clinician describe a real instance where this genuinely made a difference? — *A real, concrete example.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- Check-ins happen but genuinely never move beyond caseload discussion.

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a wellbeing-specific check-in.

Method	What	Detail
ASK	Staff interview	Asks a clinician about genuine wellbeing check-in content.

SUPERVISOR TIPS

- Ask whether check-ins ever actually move beyond caseload and administration.

EVIDENCE BASE

World Health Organization. Health Worker Safety Charter. Geneva: WHO; 2020.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.4

Workplace Issues Raised by Staff Are Genuinely Investigated and Resolved

STANDARD

A genuine process exists for investigating and resolving workplace issues raised by staff — including whistleblowing concerns — with real protection from adverse treatment, not a grievance process that exists on paper with no real follow-through, which a remote workforce may have genuinely less visibility into than colleagues physically present at a shared site.

In plain terms: When staff raise a concern, it actually gets looked into, and they’re genuinely protected — this needs to work just as well for a remote workforce as a co-located one.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A remote workforce genuinely has less visibility into workplace processes than colleagues who see posters, overhear conversations, or simply absorb information by being physically present — a reporting

WHAT GOOD LOOKS LIKE

- A genuine, accessible process exists, reaching remote staff.
- Real evidence of genuine resolution.
- Genuine protection from adverse treatment.

COMMON FAILURE MODES

- The process exists but remote staff were never actually told about it.

WORKED EXAMPLE

IN PRACTICE

A provider whose grievance process was undocumented for remote staff.

BEFORE

The grievance process was outlined in a printed handbook given to office-based staff at onboarding, but remote clinicians onboarded virtually had never received it.

ACTION

The process was added to the digital onboarding materials every clinician genuinely receives, regardless of location.

AFTER

The Monitor interviewed a remote clinician who could correctly describe the process. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether remote staff genuinely received information about the reporting process.

The most common mistake: A process documented in materials that genuinely never reach remotely onboarded staff.

SELF-ASSESSMENT QUESTIONS

1. Is there a genuine, accessible process reaching remote staff? —
A real, known process.

2. Is there real evidence of genuine resolution? — *Genuine follow-through.*

Evidence: Resolution log

3. Are staff genuinely protected from adverse treatment? — *Real, demonstrated protection.*

Evidence: Staff interview

COMMON REASONS FOR A PARTIAL ANSWER

- The process exists in materials that remote staff genuinely never saw.

IMPLEMENTATION PLAN

When	What
Week 1	Confirm remote onboarding materials genuinely include the reporting process.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Remote staff interview	Asks a remote clinician to describe the reporting process.

SUPERVISOR TIPS

- Specifically interview a remotely onboarded clinician.

EVIDENCE BASE

International Labour Organization. Violence and Harassment Convention, 2019 (No. 190). Geneva: ILO; 2019.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

11.5 Workforce Feedback Is Genuinely Gathered and Acted On

STANDARD

The provider has a genuine, systematic approach to gathering feedback from its remote workforce, with real analysis and a genuine, implemented response — not

feedback collected occasionally with no real pattern of actual improvement, particularly important given the genuine absence of informal, in-person feedback moments a remote workforce naturally lacks.

In plain terms: Remote staff get genuinely asked how working here actually is, and real changes happen as a result — this can't rely on hallway conversations that simply don't happen remotely.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

An in-person workplace naturally generates informal feedback moments — a manager noticing frustration, a casual comment overheard — that simply don't occur in a remote setting. A provider relying on these informal signals alone, without a genuine, structured feedback process, is effectively collecting no real feedback from its remote workforce at all.

WHAT GOOD LOOKS LIKE

- Feedback is genuinely gathered systematically.
- Feedback is genuinely analysed.
- A documented instance shows a genuine, implemented change.

COMMON FAILURE MODES

- The provider relies on informal signals that simply don't exist in a remote setting.

WORKED EXAMPLE

IN PRACTICE

A provider with no structured feedback process for its remote clinicians.

BEFORE

Leadership believed they had a good sense of staff sentiment, based on informal interactions that, in a fully remote team, essentially never occurred.

PHIG	GILS · Labour Studies · GMS · Journal · GMS News · GMS Academy	ACTION	A quarterly structured survey was introduced, revealing genuine concerns about scheduling flexibility that had never previously surfaced.
		AFTER	The Monitor reviewed the survey results and the resulting scheduling policy change. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

- 1. Introduce a structured, quarterly feedback survey.

The most common mistake: Assuming informal awareness of staff sentiment that, in a genuinely remote setting, doesn't actually exist.

SELF-ASSESSMENT QUESTIONS

- 1. Is feedback genuinely gathered on a systematic, recurring basis?
— *Real, ongoing collection.*
Evidence: Survey records
- 2. Is collected feedback genuinely analysed? — *A real, documented analysis.*
Evidence: Analysis notes
- 3. Is there a documented instance of feedback genuinely leading to a change? — *A real, concrete example.*
Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- A survey exists but results are never actually shared back or acted on.

IMPLEMENTATION PLAN

When	What
Week 1-2	Design and launch a structured feedback survey.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Survey review	Reviews survey results and resulting changes.

- **Ask for a specific example of a change made because of feedback.**

EVIDENCE BASE

NHS England. NHS Staff Survey National Results. Leeds: NHS England; 2023.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

Equality, Diversity and Inclusion

11.6 Across the Workforce Are Genuinely Monitored STANDARD

The provider genuinely monitors and responds to real patterns of equity across recruitment, work allocation, scheduling, and promotion — including across a genuinely distributed, remote clinical workforce — not an assumption that fair treatment exists simply because no formal complaint has been raised.

In plain terms: The provider actually looks at real patterns — who gets hired, which cases or hours people get, who gets promoted — not just assuming things are fair because nobody has formally complained.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Inequity in recruitment, case assignment, or promotion can genuinely persist for years without a single formal complaint — people often don't report a pattern they can't fully see themselves, or don't trust reporting to change anything. This genuinely matters more, not less, for a remote clinical workforce that already has less natural visibility into organisational patterns than a co-located team. Genuine, proactive monitoring of real workforce data is what actually surfaces a pattern that individual complaints alone would likely never reveal.

WHAT GOOD LOOKS LIKE

- Workforce data is genuinely monitored for patterns.
- A genuine pattern triggers a real response.
- A real instance shows monitoring informing a change.

COMMON FAILURE MODES

- No formal complaint has been raised, so the provider genuinely assumes no issue exists, with no actual data ever reviewed.

WORKED EXAMPLE

IN PRACTICE

A provider that had never reviewed its own case-assignment data across remote clinicians.

BEFORE

Case assignment was managed informally with no genuine review of whether certain clinicians consistently received lower-volume or less desirable case types.

ACTION

A quarterly equity review was introduced, which identified and corrected a genuine, unintentional pattern.

AFTER

The Monitor reviewed the review documentation and the resulting correction. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Introduce a regular review of recruitment, case assignment, and promotion data across the full remote workforce.

The most common mistake: Assuming fairness exists because no one has formally complained, with no actual data ever reviewed.

SELF-ASSESSMENT QUESTIONS

1. Is workforce data genuinely monitored for patterns of inequity? —
A real, documented monitoring process.

2. Where a genuine pattern is identified, is there a real, defined response? — *A genuine corrective process.*

Evidence: Response record

3. Is there a real, documented instance of this genuinely informing a change? — *A concrete, real example.*

Evidence: Change record

COMMON REASONS FOR A PARTIAL ANSWER

- **Data exists but has genuinely never been reviewed specifically for equity patterns across the remote workforce.**

IMPLEMENTATION PLAN

When	What
Week 1-2	Introduce a quarterly equity review of recruitment, case assignment, and promotion data.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Equity review record	Reviews the monitoring data and any resulting corrective action.

SUPERVISOR TIPS

- **Ask to see the actual data behind the last equity review, including remote clinicians specifically.**

EVIDENCE BASE

World Health Organization. Gender Equity and Human Rights in the Health Workforce. Geneva: WHO; 2019.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Telemedicine Standards**
— **all standards**

Self-assess against these criteria →

