RPCPE
ISSN 2613-943X (print)
ISSN 2620-5572 (online)
Journal Homepage:
https://jurnal.ugm.ac.id/rpcpe
Review of Primary Care Practice and Education
(Kajian Praktik dan Pendidikan Layanan Primer)

Webinar Panelist RPCPE Serial Response to Pandemic COVID-19

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Presented at the webinar organized by the collaboration between the Indonesian Family Medicine College, the Indonesian Family Doctors Association, the Indonesian Society of Teachers in Family Medicine, the Journal of Review on Primary Care Practice and Education, and the Center for Policy Management, Department of Family and Community Medicine, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada on May 16, 2020.

To cite this article:
Kusnanto H, Vidiawati D, Setiawati EP, Fadilah M, Nurdin A, Syarhan, Gunawan S, Claramita M. Webinar panelist RPCPE serial response to pandemic COVID-19. Rev Prim Care Prac and Educ. 2022; 5(2): 45-51.

Relaxation of PSBB Policy from the Perspective of Community Medicine and Epidemiology in Indonesia

When the government will do something meaningful and full of uncertainty, such as relaxation of the PSBB, it needs to be done based on a plan with uncertainty, namely scenario planning. In scenario development, four stages must be carried out, namely identifying the driving forces and critical uncertainties. Some scenarios then create a path for how a plan will travel[1]. In identifying driving forces, the government should think about the disease and the burden on people's lives. Not working for more than one month will undoubtedly be burdensome for the community, especially for non-formal workers. Currently, many people carry out risky activities with the possibility of contracting COVID-19. If the severity is high, it will cause stress in the family and become a more significant life burden. Not only that, but it will also cause stress in the community and health system. Therefore, it must also examine the critical uncertainties, namely: (1) high transmission rate and low severity; (2) Low transmission rate and high severity; and (3) Transmission rate and severity are low. It is expected, but the opposite may be true; (4) Transmission rate and severity are high. There are so many predictions that post-Eid al-Fitr will have a high level of transmission and severity so that the health system will be overwhelmed in handling the spike in cases that may occur. After the critical uncertainties are formulated, a scenario will be obtained. They are namely: (1) Transmission continues to occur in people who are not susceptible, but the virus's virulence decreases. Based on the results of many viral mutation studies, some have shown that the virus's virulence has decreased[2]. There are many causes, but not severe. So, this is a concern of primary care because they can be handled in primary care, not severe means, and not referred. (2) Transmission is reduced, but the severity is high; the hospital still serves high cases and fatalities. (3) The society is disciplined, and the transmission is reduced, the virulence of the virus is also reduced, so the burden of disease is small, so this is an ideal situation. (4) The high transmission also includes vulnerable, many deaths, hospitals handle severe cases and high fatality. It is what we did not expect. Thus, several possible pathways can be taken to end the pandemic, namely tracing, testing, positive tight isolation, and tracking to prevent transmission. It is done if the transmission rate and severity are high. If the transmission is low, this can be done by communicating risks, monitoring mask use, and distancing. It is more or less what happened. In Yogyakarta, sanctions have been imposed for anyone who does not wear a mask because even though the number of deaths has remained low since weeks ago, the transmission rate is still very high. Another path that can be taken is to limit social mixing by doing some public activities online at home. It has been done, but in reality, the transmission rate is still very high, so this is not enough. Then, we tried easing public activities, and strengthening the health service system and referrals. It is done if the transmission rate is low, but the disease severity

is high, so that the health care system must be sound. However, because the level of transmission is low, public activities can be relaxed. However, the President said to make peace with the virus. A new habit must be designed in the new standard era, namely applying physical distancing and wearing a mask. Currently, masks have even become a fashion trend among the community. Besides, because this is a new standard, washing hands with soap in all public facilities must be available. It assumes that transmission is still occurring, perhaps increasing, but that the disease is not severe. If the disease is severe, then the health care and referral system must be strengthened. Then, efforts to detect (tracing, testing, tracking) must also be strengthened. The path to ending this pandemic can be chosen when the situation changes, in the sense that it is adjusted to the situation and conditions that occur.

The Importance of Public Health Services Based on Telemedicine and Tele-education

Telemedicine or online services can be considered to reduce face-to-face contact. It has broader coverage and is cheaper for Indonesia. Telemedicine has been around since the 1970s. In the 1970s, the meaning of telemedicine was healing at a distance. Then, in 2007 - a study found that there were 107 definitions of telemedicine. In 2010, the World Health Organization (WHO) concluded that telemedicine is the online delivery of health services. There is a distance factor by all health workers using information and communication technology in exchange for valid information for the diagnosis, treatment, and prevention of disease and trauma can also be used for research and evaluation. It can be used as continued medical education for health service providers, all in order to improve individual and community health[3]. Overall, these are the four main aspects to remember in using telemedicine.

Moreover, according to the WHO can the purpose of telemedicine be to provide clinical support? Telemedicine is intended to overcome geographic barriers by connecting users. Furthermore, who says they are not in the same location? Telemedicine involves the use of various kinds of information and communication technologies. Moreover, it has the purpose of telemedicine to improve outcomes from better health[3]. Then, the AAFP differentiated between telemedicine and telehealth. Telehealth differs from telemedicine. It refers to broader coverage of long-distance health services than telemedicine. Telemedicine refers explicitly to remote clinical services, whereas telehealth can refer to remote non-clinical services[4]. So, as WHO mentions for CME and so on, webinars on health, including telehealth.

In the face of the COVID-19 pandemic, through the Ministry of Health, the government has issued Circular HK.02.01 / MENKES / 303/2020 concerning the Implementation of Health Services through the Use of Information and Communication Technology to Prevent the Spread of COVID-19, dated 29 April 2020. In a Circular Letter, it is explained that health services are provided through telemedicine[5]. However, in reality, telemedicine in Indonesia has been on the rise since the end of March 2020. Nevertheless, with the circular letter that has been issued, this has become a support for health service providers in providing health services through telemedicine. The doctor has the authority to provide telemedicine services. That is including anamnesis and specific physical examinations carried out via audiovisual media. It is providing the necessary recommendations based on the results of specific supporting examinations or physical examination results, establishing a diagnosis, managing and treating patients, writing prescriptions for drugs or medical devices, issuing referral letters for further examination or action at the laboratory or health service facility according to the results of patient management[5]. On April 30, 2020, it was promulgated in the State Gazette of the Republic of Indonesia, KKI Regulation (Perkonsil) Number 74 of 2020 concerning Clinical Authority and Medical Practice through Telemedicine Pandemic Corona Virus Disease 2019 (COVID-19) in Indonesia. Based on the content of Article 2, this Perkonsil aims to provide additional clinical authority for doctors and dentists to carry out professional work, and this Perkonsil also aims to improve the quality of services[6]. Then, doctors and dentists who carry out medical practice through telemedicine are required to make medical records. It is following the content of Article 76. Then Article 8 states that doctors and dentists can carry out diagnosis and procedures for supporting examinations, prescribe drugs and medical devices, sick letters, and so on through telemedicine. The prescriptions for narcotics and psychotropic substances are exempted[6]. Likewise, what was done by PDKI, PDKI in the COVID-19 response program outside the hospital has prepared a telemedicine program to be able to reach a wider community and also faster reporting.

For telemedicine in Indonesia, Indonesia currently has 12 digital health service companies that are members of the Indonesian Telemedicine Alliance (Atensi), united in helping to tackle COVID-19 in Indonesia, with around 300,000 users. Of course, this figure is still very small compared to Indonesia's 260 million population.

AMARI-COVID-19 (Coronavirus Disease 2019 Introspective Application)

Amari's vision is to develop an application-based individual and collective community empowerment system model integrated with the regional health system response in the COVID-19 pandemic situation. The goal is to help people subjectively assess their health, especially those related to COVID-19 infection, help people control concerns by understanding their potential vulnerability to COVID-19 infection, helping people gain understanding and practical action according to their health conditions, and provide media. Liaisons have been formed between individuals/ families and the health care system in the COVID-19[7,8,9] pandemic situation. So, apart from being an introspective application for COVID-19, Amari was also developed to empower the community.

Amari was developed initially not as a diagnostic tool or a substitute for face-to-face services but rather as a digital information media to provide education or information to

the public about practical matters in preventing COVID-19 transmission, which is very much needed by the community particularly because of the accuracy of the information. During its development, Amari, previously only for UNPAD, developed into the public platforms, then adopted by ITB and Sumedang. Then, in conducting the analysis, there was also health personnel who were filling in, so it was felt that there was a need for a particular treatment for these health workers. Moreover, it turns out that in its development, those who access Amari seem to need follow-up, in the sense that it is not just for educational information.

Amari's current implementation starts with Tele verification. So, it can conduct verification of matters that are filled in by the community[7,8]. Next is telescreens, which is screening whether the patients are healthy, ODP, or OTG[7,8]. For those who are in need, then Tele-education is carried out[7,8]. Telemedicine was also developed by the Faculty of Medicine, which is currently in the trial phase. The Faculty of Nursing developed telenursing, and the Faculty of Psychology developed counseling. Currently, some develop Tele-Hypnosis, which is already running but not yet incorporated in Amari. Later, we will try to include this Tele-Hypnosis so that all become one unit.

Important aspects that need to be considered in developing applications for communication or services via applications are determining the target of this application, whether open or closed. If it is closed, for example, for a Puskesmas, then the target is only people in the working area of the Puskesmas. Nevertheless, if it is open like what UNPAD has done, then the accessees are people who live in Bandung and people who live in other cities. Then, in application development, people are needed to manage the application. Moreover, when the application is running, it is informed that the target is open or closed. There must be a follow-up on the data collected through the application, both individual and population-based. Therefore, it takes a team to follow-up. When talking about the team to follow-up, a workload needs to be considered, so it is necessary to recruit volunteers to carry out this or stick with the Puskesmas staff alone. Then, every follow-up that is done through filling out the Amari requires a standardized process, requires training and monitoring in its implementation. Why are standardization, training, and monitoring needed? Because it turns out that as of April 30, 2020, there were 84,000 hits. A total of 6,779 agreed to be contacted, and 1,300 were successfully contacted for verification. From this group, there were 58 health workers. Because there were so many hits and it was impossible if only done by the development team, recruitment was held. In the recruitment process, standardization of volunteer HR recruitment was developed based on the type of service because there are various kinds of services. The standardization of recruitment for tele-education is health students, willing to attend training, willing to work according to contracts, willing to fill out a statement letter, and willing to change the profile photo on the cellphone according to the stipulated conditions[7,8]. Then, the standardization of telemedicine recruitment is almost the same as the standardization of recruitment for tele-education. It is just that the volunteer must be a doctor who already has STR[9]. In addition to standardization of recruitment, standardization for service processes is also set.

Even though only Tele verification or tele-screening, training, and standardization are still carried out for volunteers, Televerification, telescreens, and tele-education training are carried out by lecturers of FK, Fikom, and Psychology[7,8]. Meanwhile, the telemedicine training was conducted by Amari's Project Manager, Internal Medicine Specialists, Clinical Nutrition Specialists, managers of the Primary Service Medical Study Program, and Programmer Redcap[9]. This standardization is made in writing so that there are Tele verification, tele-screening, tele-education, and telemedicine protocols. The telemedicine protocol is still being updated according to conditions in the field. They also set the workflow standardization how to respond to users who fill out the Amari application[7,8,9]. If nursing is needed in the telemedicine workflow, it will be coordinated with the nursing team and will be carried out / followed-up by telenursing[9].

www.amari-unpad.ac.id is Amari UNPAD's website, which can be accessed by the public, and it will be followed-up. An important note here is that if it has not reached a low level based on WHO standards, then there should be no loosening. If the easing is still carried out, then the implication is that many people will be OTG and ODP. It requires good record keeping, which can follow-up on all of these aspects so that those with problems can be handled and followed-up properly to break the chain of transmission.

Community Empowerment Through Online Education

Online education for community empowerment can be done through various social media, using WhatsApp. The selection of WhatsApp is based on initial research that has been carried out on several social media, and it is agreed that the social media that is needed at this time for COVID-19 is WhatsApp. It is not without theory. The theory is taken from the Source, Message, Channel, and Receiver (SMCR) Communication Model[10] and the Hiebert, Ungurait, and Bohn (HUB) Communication Model[11].

In the implementation of online education, some principles must be adhered to namely, an implementation must adhere to principles, especially concerning time. Online education providers must have a responsibility with a predetermined theme. Participant identity must be exact, and off-topic questions must be sorted/selected. The moderator must understand the "language of the community." and all that is done is returned to the moderator. The most important part and what the participants expect is the take-home message. So, do not forget to take home the message here. Then, online education providers must also understand all the social media language because participants can come from various groups, including the millennial generation. In online education, several missions must be achieved, so good planning is needed, even from topic to target. Then how is the implementation, what should be used?

Another aspect that is no less important is the preparation of evaluation, and an assessment must be prepared and so on so that it can be seen what has been done.

The online education titled WhatsApp seminar has gone through a field trial divided into several groups, with a total number of participants being 5,822 participants. The WhatsApp seminar was held within ten days from April 20 to 30, 2020. Based on gender, education level, and religion, most participants were women, high school, and Muslim, respectively. Then, based on profession, most participants who took part in this WhatsApp seminar were jobless, as many as 47%. So, this is an opportunity to provide information to the participants. The participants' responses were also excellent, and even a lot of participants wanted an extension of the time for a seminar. This spirit must be exploited. Before and after the seminar, participants were asked to fill out a questionnaire. The result was that the participants' knowledge increased from 16.38% to 84.57%, both regarding the participants' knowledge and perceptions.

Online education is the right choice for now when offline education is not possible. Then, WhatsApp's choice for online education was chosen because of several advantages, including WhatsApp is safe, has no age limit for users, is very easy to use, low cost, and the features offered are also various allowing interactive dialogue to occur.

Post-COVID-19 New Civilization Scenarios of Medicine

The current COVID-19 pandemic will create a new civilization in the world of Medicine. Thus, several scenarios will occur, namely the decoupling of medical education and disruption of health services. Decoupling education and health services is a disconnection between the current medical education and future health service needs. So, students who are being taught at this time, in the next ten years, will experience confusion because they do not get an education as their future assignments at the hospital or the Puskesmas. Then, in the future, the Puskesmas will disappear because the functions of the Puskesmas will be replaced by artificial intelligence. So, the Puskesmas are missing, and the lecturer is preparing to replace the Puskesmas with something new following the Industrial Revolution 4.0, which is getting faster. Currently, the Medical Education System is still using face to face meetings, and CSL is still in close contact. However, in the future, faculty-student face-to-face meetings no longer occur, there are no more classroom walls, the classroom/ campus is wherever students are in the world. Then, the current health service is still in close contact.

One day everything will be replaced by the Internet of Things and artificial intelligence. Physical examinations, medical skills, and supporting examinations using expensive tools will be reduced or lost to be replaced by artificial intelligence. So, health services in the future will be cheaper. MRI, CT-scan, and so on are no longer needed. In handling COVID-19, many doctors and health workers have died due to COVID-19, so in the future after COVID-19, medical personnel will be replaced by machines to reduce direct boxes. Thus, medical and health research must change drastically. Future diagnosis is only to diagnose using DNA, no longer PCR, but Google to diagnose. So, viruses, bacteria, parasites, and so on can be seen directly through DNA. Chronic diseases such as cancer, diabetes, and so on can be predicted. Even before pre-diabetics, it can be diagnosed by DNA that has been recorded in big data, let alone early pre-diabetics.

What must be done to overcome decoupling and disruption can be started by reviewing the current Medical Education curriculum. Then, equip students with courses in artificial intelligence, IoT in medicine, and medical engineering. Then, what is important in making students understand artificial intelligence is to provide courses on artificial intelligence in medicine with specific learning outcomes; for example, students can make artificial-intelligence-based medical applications and make various artificial intelligence-based medical products. The achievement for the Internet of Things in medicine courses is that students can do Internet-based microcontroller programming for data mining needs. So, all patient data will be recorded on the Internet of Things.

For example, in artificial intelligence in medicine, there are four study materials, namely applications of artificial intelligence, genetic algorithms, fuzzy systems, and artificial neural networks[12]. Then, in sub-subject learning outcomes, there are topics that are not familiar, for example, first-order logic. First-order logic is a formal language in computer science, also called predicate calculus, which is the logic used to represent problems that cannot be represented using propositions. So, many problems can be solved using propositions. Then fuzzy logic or fuzzy logic is aimed to reach the truth[13]. So, these are program languages, which are skilled in solving Goal Stack Planning (GSP) problems. So, billions of information from a patient will be entered into the Internet of Things to find the diagnosis quickly. This diagnosis is obtained by artificial intelligence. Then, they are skilled at making the Artificial Neural Network (ANN), which is a model of information computing systems similar to how neural networks work[14]. It will create an artificial nerve, an artificial brain, which will be much more intelligent than a doctor. All references from all over the world, from 10 UN languages into the Internet of Things, are processed very fast. If the doctor wants a product, it will produce that. For example, a doctor wants to perform surgery. Then he will quickly give directions on what to do—however, all of this without leaving the principle of person-centered care, especially in family medicine.

The Role of Rural Health in Facing COVID-19

Currently, Indonesia is facing the threat of the spread of COVID-19. It is well-known that this definitely and significantly affects Indonesian people's lives, including rural communities' lives. The Indonesian rural context is built by various strengths, demographic, geographic, educational, and political forces. Four essential parts distinguish rural and urban areas today. The first is in terms of geography. So, the rural landscape is dominated by mountains, rice fields, fields, and oceans. The second is livelihood; rural communities are more engaged in

agriculture and fisheries. The third difference is that in rural areas, they still maintain heritage, which binds rural communities socially and in life. Then the last aspect which is of course, the current access to health services is very different, which has to do with geography. Of course, the countryside's strengths shape the values and principles that are upheld by the doctors working in the villages. One of the most important values that are still developing today is kinship. The health principles that rural doctors have developed are the principle of primary care or family medicine principles. Almost the whole world operates the primary care approach because peers run 99% of rural health in the world from GP and Family Medicine.

The main reason why rural health is so important is because 43% of Indonesians live in rural areas or around 116.5 million. Currently, rural agriculture and fisheries are the backbones of Indonesia's food sovereignty. Then, the rural health response is also significant, first, because of vulnerability. Currently, rural communities have a very high vulnerability due to several aspects, including the exodus of migrants. Non-formal workers who previously lived in urban areas then returned to rural areas, feeling that in the village it is safer, and it is easier to do social and physical distancing. Then the second aspect is that chronic disease in rural areas is the same as in urban areas. If you look at the prevalence of diseases, such as hypertension, diabetes, and then the age of 20 million people in rural areas, this population is very vulnerable to the current COVID-19 pandemic. If rural areas are affected by a pervasive COVID-19 infection, it will be perilous because they have low response and resources.

Indonesia should be better prepared to face the current COVID-19 pandemic. On December 31, 2019, this virus was first detected in Wuhan when viewed from the timeline. Then, on January 30, 2020, this virus began to spread in Europe. After that, several countries in Asia started to contract COVID-19. Prof. Marc Lipsitch from Harvard University warned that there should have already been at least 5 cases in February in Indonesia[15]. However, it turns out that the government's framing and figures in Indonesia have not led the public always to be vigilant and prepare themselves to face COVID-19. Doctors in rural areas who are members of Indonesian Rural and Remote Doctor Association (IRRDA) have prepared several means to understand doctors throughout Indonesia who work in rural areas through webinars in collaboration with Equity. The committee presented a speaker from Universitas Gadjah Mada, Dr. Abu Tholib Aman to explain how this virus develops and how to deal with it, both from the aspect of rural health and from the aspect of virology, which is currently developing so rapidly.

So, look at the timeline. It should also provide a more extraordinary ability to handle COVID-19 in rural areas because what should be being developed is to build the right mindset for the community towards this COVID-19 pandemic. The mindset that COVID-19 is very dangerous and spreads very quickly if people do not prepare themselves through physical distancing, wearing masks that should be worn in public, and reducing group activities, or activities that involve large numbers of people. The first challenge for doctors in rural areas is, of course, poor education / literacy. Then the second is that the quality of health services is not yet optimal. If this virus spread widely in rural areas, of course, it would use up all available resources, which are limited in rural areas. The third challenge is the rural public health infrastructure. Hospitals are still limited, and doctors are limited; nurses and midwives are also still limited. Funding in rural areas has not been so attractive to build as an investment to develop Indonesia as a whole. The fourth is the inability to fully involve the community, including providing a complete understanding of COVID-19 to migrants who should not be returning to their respective areas at this time. Nevertheless, what happened is that everything has happened; 2 million Indonesians who used to work in Jakarta eventually spread all over Indonesia. Finally, there is no adequate comprehensive preparedness, which should have started before the government and organizations carried out the COVID-19 pandemic restrictions and policies.

To deal with the COVID-19 pandemic, IRRDA is doing several approaches: epidemic preparedness and epidemic response. In epidemic preparedness, planning for a pandemic response is carried out through meetings with peers in the organization, while making contact with the COVID-19 clusters in each region. Then, efforts were made to build a correct and honest mindset against COVID-19 online so that everyone feels they have a strong obligation and have the same conscience to prevent the spread of COVID-19, not only in cities but also in rural areas. Then, it is imperative to build links with several community members in education, health, and several community leaders in their respective areas. In the epidemic response, webinars in collaboration with Docquity were conducted several times, which were attended by tens of thousands of doctors throughout Indonesia. Thus, there are three essential roles for doctors in rural areas. First, rural doctors are educators who must build literacy about COVID-19 honestly and correctly so that all can face and have optimism that this pandemic will quickly pass. Second, as collaborators, rural doctors must collaborate with various stakeholders, both government and community leaders, to jointly build strength to prepare for COVID-19 and prepare for what will be faced in the next life. Then the last role is that rural doctors become providers. It is hoped that doctors will not see an exodus from the villages to the cities. So that if COVID-19 spreads in rural areas, doctors in rural areas can still provide services or at least be able to direct the community if doctors cannot be directed to better or higher quality services.

Telemedicine in an Ethical and Legal Perspective

The primary service or primary health care facility has a much wider variety of practice scope than the secondary one. Doctors in secondary health care facilities are now more comfortable because they focus on handling COVID-19 and non-COVID-19 patients. Meanwhile, doctors who work in primary health care facilities (family doctors), apart from dealing with COVID-19 and non-COVID-19 patients, also participate in dealing with

patients' psychological and socio-economic problems. It will further add to the complexity of the problem. Each has a different scope of practice. Some doctors work at the Puskesmas, and some also work in practice as private family doctors. Of course, the scope is very different. Therefore, after two months, each doctor is expected to determine where and what the current and future work scope will look like because the changes brought about by COVID-19 are genuinely extraordinary. In general, before the COVID-19 pandemic, there were quite many patients seeing doctors, and the doctor's work was burdened. During the COVID-19 pandemic, the problems became complex.

The first is the difficulty doctors in primary care have in dealing with patients. If the patient concerned is a COVID-19 or non-COVID-19 patient? Has the doctor used the complete PPE? Did doctors separate COVID-19 and non-COVID-19 patients? Is the service methodology different between COVID-19 and non-COVID-19? There are so many considerations that must be made. Then, because of the existence of COVID-19, there are also so many non-COVID-19 patients who have come for treatment so much less. Of course, these patients did not recover, or did their illnesses got lighter. It is also necessary to think about patients with chronic diseases whose disease may get worse. Then, how do you reach them? Why don't they come to the health services? So, one of the scenarios offered is a scenario using telemedicine.

Telemedicine is not something foreign. What doctors often do is teleconsultation. When a patient calls the doctor from home, asks various questions, and the doctor answers, telemedicine is in its simplest form. Telemedicine today should be much more complicated. Telemedicine is not only used for teleconsultation. Telemedicine can be started from tele-registration, then screening, triage, and teleconsultation. The approach just like that is certainly not enough. Patients expect doctors to provide input that is far greater than just consulting, namely, up to the diagnosis and drug administration stage. The Circular of the Minister of Health, *Perkonsil*, and the Indonesian Doctors Association's regulations have provided limits on they what can. Doctors cannot do it all, so they must pay attention to these limits[5,6]. If only for teleconsultation, it is sufficient to have STR alone. However, if you want to provide a diagnosis, especially when prescribing medicine, the doctor must have a Practice License. This Practice License provides legal protection to doctors in conducting teleconsultation. Before carrying out teleconsultation, the doctor must know exactly the advantages and disadvantages of teleconsultation. It is hoped that patients' strengths and weaknesses will also be recognized so that patients can tolerate parts that cannot be fulfilled through teleconsultation or telemedicine.

A doctor does telemedicine, and the doctor must also consent to telemedicine. Then the entire telemedicine process is appropriately recorded. This telemedicine process is undoubtedly desirable, especially for patients suffering from chronic diseases. Patients who have comorbidities have a much greater risk of contracting COVID-19. Therefore, patients with chronic diseases should be assisted as much as possible through telemedicine. Doctors do not need to wait for the patient to contact the doctor first.

Nevertheless, if necessary, the doctor contacts the patient first if they already know the patient. So, through the medical records that doctors have, doctors who have been having regular treatment can be contacted by doctors. The relationship that has been formally established through visits can be replaced through telemedicine.

It seems that it will be used forever both as a compliment and as the primary in telemedicine. It means part of health services so that doctors can as much as possible start planning from now on how and to what extent of development of health care services because it is not easy to change the system that has been built for decades. This system and changes must be known by the patient so as not to trouble the doctor. Rules regarding registration hours, consultation, monitoring, and so on are all shared with patients. If necessary, then there is a standard procedure arranged in such a way and communicated/disseminated to patients and their families. So, when the doctors apply telemedicine, everything can go well. Both parties understand each other's advantages and disadvantages so that telemedicine can slowly be developed. Doctors should choose comfortable patients for the initial stage, patients who have known doctors and have a single disease. For patients who have a more complicated disease, it is advisable not to consult via telemedicine. Then, to reduce the risk, doctors must always keep in mind this limitation of telemedicine. The doctor must convey to the patient to check and re-check starting from the examination, diagnosis, and medication. The doctor must also be prepared to take the time if there are aspects that the patient does not know or cannot be understood when contacted by the patient. Then the doctor is not disturbed, and can spend a set time together if they want to do additional consultations.

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