OPEN ACCESS Freely available online

International Journal of Physical Medicine and Rehabilitation

Mini Review

A Telephone First Approach in the COVID-19 era

Abigail Maria O'Reilly*

Department of Occupational Health, Old Health Centre, Dooradoyle, Limerick V94 FX05, Ireland

ABSTRACT

With the advent of the Covid-19 pandemic and resulting exponentially increased workload for occupational and other health departments worldwide; telemedicine has been brought to the fore at rapid pace. Healthcare and the management of services have seen a drive to innovate and reinvent the way we conduct our communication with colleagues and patients alike. It is imperative that healthcare professionals, especially occupational health physicians, continue to uphold standards and maintain utmost professional levels of communication to preserve the doctor patient relationship in these challenging times. After all, occupational health in particular is responsible for the health and wellbeing of so many staff, most notably the hard working, -and most at risk- health care staff.

Keywords: Telephone consultation; Occupational health; Communication; telemedicine

INTRODUCTION

Communication has always underpinned the very fabric of medicine through the doctor patient relationship; in a world of evolving technology, the use of the telephone in medicine has grown considerably in the last number of decades. Indeed the very first reported telephone call by Alexander Graham Bell to his assistant in 1876-"Come here, Mr Watson, I want you" was a call for medical attention after Bell reportedly spilled sulphuric battery acid on his clothes. As far back as 1879, the Lancet reported the use of the telephone in aiding a doctor (who did not wish to leave his home at midnight) speak to an anxious mother and assess her baby for croup [1]. Upon hearing the baby cough via telephone the doctor was satisfied that croup was not causative and the mother was reassured. The telephone has become indispensable as a means of communication in medicine which can be seen throughout history and indeed today as the Sars CoV 2 pandemic remains. There are still challenges associated with the use of the telephone in medicine and the legal implications of same have not been thoroughly tested. While telephone consultations can be beneficial and efficient, there are also pitfalls to be aware of in this context.

TELEMEDICINE AND SARS COV 2

Healthcare professionals across the different medical specialties have newly instituted the use of telephone triage over the last year to ensure the safety of staff and patients in preventing transmission of Sars CoV 2. We now recognise, as per the WHO [3], transmission can occur through respiratory droplets or fomites; further research is required to ascertain whether airborne spread is possible outside of aerosol generating procedures. The days of patients waiting in a GP practice waiting room side by side, or busy outpatient clinic waiting areas teeming with patients and staff abreast have ceased. Management of healthcare has shifted, and this is likely to continue in some capacity into the future as the benefits of pressure driven change come to light; indeed, while we may continue to hope for a return to some level of 'normalcy', the reality is that even with a selection of vaccines being administered worldwide, COVID-19 is likely to be with us and impact our lives for a considerable time to come. Maintenance of usual levels of service is crucial otherwise we are left with a growing 'care debt' of deferred medical treatments etc., which further strains healthcare service [4]. A recent study in an Orthopaedic clinic showed that both patient and clinician were satisfied with this new means of telephone consultation [5]. Conversely, another study in San Francisco looked at the 'readiness' of older adults regarding telemedicine; they found that for many of those with dementia, hearing impairment or social isolation, telemedicine posed a significant challenge [6]. Healthcare staff and patients worldwide have been compelled to embrace radical changes in their day-to-day practice.

Correspondence to: Abigail Maria O'Reilly, Department of Occupational Health, Old Health Centre, Dooradoyle, Limerick V94 FX05, Ireland, E-mail: oreillab@tcd.ie

Received date: Februrary 04, 2021; **Accepted date:** Februrary 18, 2021; **Published date:** Februrary 25, 2021

Citation: O'Reilly MA (2021) A Telephone First Approach in the COVID-19 era. Int J Phys Med Rehabil. 9:596.

OCCUPATIONAL HEALTH CONTROLS

Returning to the very pillars of risk management which bears the foundation for Occupational health with the hierarchy of control, risk of harm through transmission of COVID-19 cannot easily be eliminated or substituted. We are left with the options of engineering controls, administrative controls, and lastly (also least preferentially) the use of personal protective equipment (PPE). In the context of COVID-19, engineering controls such as negative pressure ventilation have been employed as well as no touch taps/bins etc. Administrative controls including the dispersal of information regarding hand hygiene, physical distancing, and respiratory etiquette as well as the limiting of only necessary staff in staggered shifts have also been adopted. While PPE is the least desirable level of control, it remains a cornerstone in the prevention of transmission of COVID-19 to healthcare workers and is relied heavily upon in this area. Telephone or remote consultation where possible sits at the top of this hierarchy because it succeeds in eliminating the risk of COVID-19 transmission altogether.

EVIDENCE BASE FOR TELEPHONE CONSULTATION

Telephone triage and consultation was introduced to an Occupational health department prior to the pandemic in a recent study [7] and identifies potential for growth in efficiency of delivery in healthcare services. Triage of patients seeking appointments with their General practitioner in the UK has been widely carried out, but a solid evidence base is still moderately lacking. One study (again prior to the pandemic) showed that up to half of consultations could be successfully carried out on the telephone alone but there was significant variation in the effect of this new triage system amongst different general practices [8]. Remote consulting was introduced more broadly in the UKs National Health Service (NHS) in response to the COVID-19 pandemic and the addition of video consultation was also used [9]. Both advantageous and disadvantageous factors were noted from this study, some clinicians found it less satisfying and raised concerns over possibly missing physical signs [9]. Others noted that telephone consultation was particularly suited to the follow up reviews of chronic conditions; nurses were able to carry out training on wound care and injectable medications with ease [9]. Telemedicine is also now being employed in the management of COVID-19 patients post pneumonia. An Irish study introduced telephone consultation 8-12 weeks post discharge for COVID-19 patients [10] as a means of monitoring symptoms and recovery as part of a hybrid approach to follow up. Patients were triaged in multi-disciplinary meeting as to whether they would be followed up in person or via the physician associate run virtual clinic [10]. It would appear telephone consultation has its place in a variety of diverse prospective settings in medicine to varying degrees.

ADVANTAGES AND DISADVANTAGES OF TELEPHONE CONSULTATION

The potential benefits of telephone consultation in the context of covid-19 are apparent, most obviously in reducing potential transmission to healthcare staff or indeed potential nosocomial transmission from staff to patients in those asymptomatic or pre-symptoms onset. In more general terms, patients are not required to travel for an appointment, the difficulty for which is not to be underestimated depending on co-morbidities etc. Access to transport for those living in more remote or rural areas is also a factor. Satisfaction appears to be high thus far among patients undergoing this form of consultation [5,7]. While it can be quicker and more efficient for clinicians, many are still concerned about the risks of potentially missing a serious condition [11]. It can also be difficult to properly establish rapport with a patient with the comparative anonymity of telephone consultation. Body language is such an integral part of the doctor patient interaction giving a myriad of non-verbal cues. Many researchers and academics have tried to attribute a number or percentage to what body language contributes to communication: from Dr Mehrabian's projected 93% 12 of information being non-verbal to Birdwhistell's 65-70%13 estimate; it is arguably something not quantifiable or not easily so in any case. As mentioned earlier, older adults are a group that can be least catered for with telephone consultation as they may be less familiar with technology, having hearing impairment6 or difficulty communicating [6]. Privacy and confidentiality are also an issue warranting attention and can be difficult for patients to ensure this is sustained when proceeding with telephone consultations from their homes with other household members present.

Telephone consultations have also allowed healthcare workers to continue working remotely when they might be self-isolating or suffer from a medical condition placing them in a higher risk group. It is an adaptation that allows certain people to remain in the workplace where they might otherwise simply remain on sick leave. With healthcare facilities globally straining to keep their staffing levels to par in the midst of this pandemic, maximisation of the workforce has never been so critical.

ETHICS AND LEGAL OBLIGATIONS

As briefly mentioned, many clinicians are concerned regarding the risks of telephone consultation and the potential to miss clinical signs. The Medical Protection Society (MPS) has issued some guidance, advising that it is preferable to carry out remote consultation on those already known to the clinician [14] as well as reiterating the importance of correct identification of both clinician and patient. The NHS have also provided a similar guidance document15 regarding virtual consultations. In the absence of any randomised control trials comparing face-to-face versus telephone consultation, a robust evidence base is unfortunately wanting. The Irish Medical Council published a guide for doctors in telemedicine but also importantly included a separate booklet for patients [16]. Clinicians are exposed to the same degree of liability whether consulting in person or on the phone; only time, review, and audit of the now broadly used

means of telephone consultation will reveal its comparative malpractice incidence. The three-stage test in determining negligence applies regardless of the method of consultation; there must be a duty of care which has been established and then breached, and as a direct result of this breach-damage or harm has occurred [17]. It is incumbent on the clinician to ensure they are satisfied with their own assessment via telephone, while being mindful of its limitations. All guidance documents mentioned expressly highlight that clinicians do not hesitate to arrange an in-person assessment if they feel it is warranted [14-16].

CONCLUSION

Telephone consultation has been implemented internationally to facilitate safer provision of health care services and prevent further transmission of Sars CoV 2. It has many benefits but there are also numerous potential pitfalls that those employing this type of consultation need to be aware of. Ideally specific training should be undertaken, national guidance followed appropriately, and patients must also be well informed. Evidence to date suggests that telephone consultation could be acceptable to patients and clinicians with relative ease of introduction but further research is required to determine how telemedicine might fit into the different medical specialties.

REFERENCES

1. Aronson SH. The lancet on the telephone 1876-1975. Med His. 1977;21: 69-87.
2. Workplace Health and Wellbeing Unit. Safer Better Care: Standards for occupational Health Services 2017.
3. Transmission of SARS-CoV-2: Implications for infection prevention precautions. WHO. 2020.
4. Wosik J, Fudim M, Cameron B, Gellad ZF, Cho A, Phinney D, et al. Telehealth transformation: COVID-19 and the rise of virtual care. J Am Med Inform Assoc. 2020;27(6):957–962.
5. Vusirikala A, Ensor D, Asokan AK, Lee AJX, Ray R, Tsekes D, et al. Hello, can you hear me? Orthopaedic clinic telephone consultations in the COVID-19 era-a patient and clinician perspective. World J Orthop. 2021;12(1):24-34.
6. Lam K, Lu AD, Shi Y, Covinsky KE. Assessing telemedicine unreadiness among older adults in the United States during the COVID-19 Pandemic. JAMA Intern Med. 2020;180(10):1389–1391.
7. A O'Reilly, C Mc Donnell. Management referral triaging process pilot study: A 'telephone first' approach. Occup Med (Lond). 2020;70(9): 656–664.
8. Newbould J, Abel G, Ball S, Corbett J, Elliott M, Exley J, et al. Evaluation of telephone first approach to demand management in English general practice: Observational study. BMJ. 2017;358:4197.
9. Murphy M, Scott LJ, Salisbury C, Turner A, Scott A, Denholm R, et al. The implementation of remote consulting in UK primary care following the COVID-19 pandemic: A mixed-methods longitudinal study. Br J Gen Pract. 2021.0948.
10. O'Brien H, Tracey MJ, Ottewill C, O'Brien ME, Morgan RS, Costello RW, et al. An integrated multidisciplinary model of COVID-19 recovery care. Ir J Med Sci. 2020.
11. Foster J, Jessopp L, Dale J. Concerns and confidence of general practitioners in providing telephone consultations. Br J Gen Pract. 1999;49:111–113.
12. Mehrabian, Non verbal Communication, 1972.
13. Jolly S. Understanding body language: Birdwhistell's theory of kinesics. Corp commun Int J. 2020;5(3):133-139.
14. Medical Protection society, COVID-19 and remote consultations – how we can help, 2020.
15. NICE, Clinical guide for the management of remote consultations and remote working in secondary care during the coronavirus pandemic. 2020.
16. Irish Medical Council. Telemedicine Phone and Video Consultations A guide for doctors, 2020.
17. Daniele Bryden, FRCA LLB (Hons) MML, Ian Storey, LLB (Hons). Duty of care and medical negligence, Continuing Education in Anaesthesia Critical Care and Pain. 2011;11(4):124–127.