Telephone Consultations

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Introduction

Telephone consultations are **increasingly common** in modern medical practice, driven in part by technology and convenience, and more recently by the COVID-19 pandemic.

While most frequently used in **primary care**, telephone consultations are now commonplace in **outpatient clinics** within secondary care.

Telephone consultations may be used for a variety of reasons:

- Routine consultations (primary care or outpatient clinics)
- Triage (e.g. to determine the urgency of a referral or assessment)
- Follow up (e.g. to discuss test results)
- Out of hours consultations
- Third-party consultations with other health professionals (e.g. with a nurse in a care home)
- Chronic disease reviews

Advantages and disadvantages

Advantages

Advantages of telephone consultations include:[1]

- Reduced disruption to patients' lives
- Greater flexibility for working patients
- Avoid unnecessary travel
- Improve access to healthcare for housebound or isolated patients
- Reduce hospital infrastructure requirements

Disadvantages

Disadvantages of telephone consultations include:[2]

- Difficulty building patient-doctor relationship (e.g. more difficult to demonstrate empathy and understanding)
- Communication may be more challenging (e.g. patients less likely to volunteer hidden agenda; potential to miss cues)
- Limited examination
- Difficult to determine patient satisfaction

- Increased clinician fatigue

It is important to remember that telephone consultations are **not appropriate for all patients** or circumstances. For example, patients with hearing loss or cognitive impairment, learning disability, or frailty. The use of telephone consultations should be **carefully considered** for each individual case.[3]

Building rapport

Building a **patient-clinician relationship** is very important. Patients may find it helpful to meet the clinician in charge of their care. You may wish to use a face-to-face consultation to establish contact and **build rapport**, with subsequent telephone follow up.

Preparing for the consultation

While the patient may not be present, ensuring an **appropriate setting** for the consultation is equally important.

Prior to any telephone consultation, ensure you are comfortable in a quiet room, free from distraction, with access to the patients' medical record.

Before starting the call, familiarise yourself with the patient's background and medications, and review recent test results, letters and consultations.

Beginning the consultation

First impressions are powerful. A good **introduction** is crucial in any telephone consultation.

- Introduce yourself
- Confirm the patient's identity (name and date of birth)
- Is the patient free to talk?
- Can they hear you?
- Check who else is present on the call

There may be times where you need to arrange an urgent ambulance (999), therefore, you should always confirm the **patient's current location**, as this may differ from the address noted on their records.

To avoid harm to the patient or others, telephone consultations should not be conducted whilst the patient is **driving**.

Confidentiality and safeguarding

To maintain **confidentiality**, always check who else is present on the call, and ensure the patient is able to talk openly and honestly. For example, if the patient is at work they may not wish to disclose information openly, which may prevent accurate diagnosis and treatment.

Be aware of **safeguarding** issues; these may be flagged on the patient's record. If you feel the patient is being coerced or is under pressure, consider arranging a face-to-face appointment instead. If you have concerns about a patient's wellbeing, this should be raised with a senior clinician and safeguarding services.

Information gathering

Much like face-to-face consultations, you should take a **focused history** and try to establish:

- Symptoms
- Timeline
- Impact on wellbeing, occupation, social activity, relationships and driving
- Red flags
- Ideas, concerns and expectations
- Previous consultations regarding this issue and the impact of any intervention

Remember to use an **open-to-closed** style of questioning. Much of the information required can be gathered in the first 'golden minute'. Give the patient time and space to talk, uninterrupted, and encourage them to share their concerns.

Active listening is essential. Unlike face-to-face consultations, you can't rely on body language and physical cues. Listen to the tone and content of speech to identify verbal cues.[4]

Summarising, **chunking and checking**, and **empathetic statements** will help the patient feel listened to and understood.

Clinical examination

The **biggest challenge** of telephone consultations is the clinical examination. While traditional clinical examination is not possible, with a little resourcefulness you will be surprised how much information you can gather.

Inspection

The first part of the examination involves trying to build a **mental image** of the patient. Much of this information comes from the history, and from listening to the patient.

How do they sound when speaking to you?

- Do they sound in pain?
- Are they talking in full sentences?
- Are they short of breath?

Try to think about the patient's **functional status**:

- During the consultation were they at home, work, school or elsewhere?
- Are they able to carry out activities of daily living?

If a patient has **visible signs** (e.g. a rash), you could ask the patient to send **photographs**. Remember to **obtain consent** for the storage of images, and always use a secure and approved platform.

Observations

Where possible you should try to check the **patients' observations**. Many patients have access to home blood pressure cuffs, thermometers and pulse oximeters. If the patient is diabetic, they may be able to check blood sugars and ketones.

Remember, you can ask them to manually record their pulse and ask a relative to count respiratory rate.

You may wish to convert to a **video consultation** to obtain observations.

Tip: Many people have smartwatches that can record basic observations. However, be careful with non-medical grade equipment as the results may not be reliable.

Physical examination

Although challenging, you may be able to ask the patient to follow a set of instructions to assess function and range of movement. This is particularly useful for **musculoskeletal problems**.

For example, if the patient has a shoulder problem:

- "*Place your hands behind your head/back"* – is movement restricted?
- "*Move your arm out to the side"* – do they have a painful arc?

You may wish to convert to a **video consultation** for a more detailed assessment.

Mental state examination

Mental health problems are common, and telephone consultations are a useful tool for reaching patients who may be reluctant to attend face-to-face.

While you may not be able to comment on the patient's appearance, all other aspects of the **mental state examination** are possible via telephone consultations.

Try to comment on each of the following:

- Behaviour
- Speech
- Mood and affect
- Thought
- Perceptions
- Cognition

- Insight

See the Geeky Medics OSCE guide to mental state examination for more information.

Decision making and disposition

Once you have gathered enough information from history and examination, you need to formulate a **management plan**.

Firstly, you should determine whether the patient is **acutely unwell**. These patients should be risk assessed to determine the most appropriate disposition:

- Emergency department (this may require an ambulance)
- Ambulatory care
- Face-to-face review (same day in clinic or home visit)
- Treatment in community with safety netting

Treatment in the **community** includes self-care, medications, or treatment by another appropriate health professional (e.g. community mental health team, dentist, pharmacist, district nurse, physiotherapist or social prescriber).

For patients who do not require same-day review or treatment, you may wish to consider other options such as:

- 'Watch and wait', with safety netting
- Referral to specialist service (urgent or routine)
- Routine face-to-face review for further examination

Be careful with **repeat telephone consultations** regarding the same issue. If this is the third consultation and the problem has not been resolved by previous consultations, this should prompt you to consider an alternative type of consultation.

Safety netting

As with any clinical encounter, a **robust safety net** should be provided. This should include:

- The expected path and timeline to recovery
- Red flag symptoms that would prompt review
- Timeframe for review (e.g. "*if no better in X days*")
- Who to contact (e.g. GP, emergency department, 111, 999)

You must document your safety net clearly within the patient's notes.

Example

"Your back pain should start to improve with analgesia and exercise within 2-4 weeks, if the pain has not improved within that time please book another appointment. If you develop leg weakness or numbness, incontinence, or change in bowel or bladder

function, please go to the emergency department as this may be cauda equina syndrome which requires immediate assessment."

Reviewer

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References

1. Royal College of Physicians, *Outpatients: the future – adding value through sustainability,* RCP 2018. Available from: [LINK]
2. Ambrose, L. *Remote consulting: recognising the cognitive load*, British Journal of General Practice 2020; 70 (695): 295. Available from: [LINK]
3. General Medical Council, *Remote consultations*. Published 2021. Available from: [LINK]
4. van Galen L S, Car J. Telephone consultations *BMJ* 2018; 360 :k1047 doi:10.1136/bmj.k1047. Available from: [LINK]