

Supplementary information

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Triage and remote consultations: moving beyond the rhetoric of access and choice

Bunn *et al*, in their systematic review published in this issue of the Journal,¹ review the evidence underpinning the role of telephone consultations in triaging access to health care.¹ Remote consulting, however, has the potential to impact far more broadly on clinical practice than simply facilitating triage, and, in so doing, raises important issues around the political imperatives of access and choice. In this editorial, we consider these issues and discuss a number of practical points that need to be resolved.

The telephone is increasingly used to access advice from both general and disease-specific helplines (for example, NHS Direct, Terrence Higgins Trust and Asthma UK) and there is also growing interest in telephone consultations as an alternative to traditional face-to-face reviews of people with long-term diseases.^{2,3} 'Texting' may encourage teenagers and young adults, to use the health service.⁴ Although use of e-mail consultations is currently limited, the majority of people with internet access (now approximately 60% of the UK population) express interest in using it to communicate with their healthcare provider.^{5–7} Plans for electronic patient records, linked with the

patient's personal internet account (available to UK residents at www.healthspace.nhs.uk) will offer further innovative possibilities for interacting with healthcare professionals.

In parallel with the imperative to improve access, policy rhetoric implies that alternative modes of consultation will offer patients choice about when, with whom, and how they consult.^{8,9} This may not always be the case. Telephone triage may actually reduce choice as requests for face-to-face appointments or home visits are intercepted by a clinician (usually a nurse) who may address the problem or allocate 'appropriately', potentially overriding the patient's original choice of provider and mode of consultation. In such scenarios it is not surprising if telephone calls increase re-consultation rates and may not always be acceptable to the patient.^{8,9} Similarly, incoming e-mails and text messages are sorted into prescription requests, appointments, and clinical queries and then forwarded to the 'appropriate' member of the team.⁶ From the patients' perspective the 'dragon at the door' reputation of receptionists may be being replaced by the 'triage genie', ensuring that the doctor

remains hard to reach. Real choice of when, where and how a patient is treated,⁸ requires breaking the link between 'telephone' and 'triage' — exemplified by Bunn *et al*¹ who observed that the 'terms were used interchangeably' — and inviting patients to select the mode of consultation appropriate to their presenting problem and personal preference. Reassuringly, early experience does not suggest that this will 'flood' the service with additional work,^{1,3,6,11,12} but trials incorporating patient preference will be needed to examine the overall effect on workload.

Patients and clinicians should be free to choose and mutually agree the mode of consultation most suited to the task and personal circumstances. Email consultations may be ideal for seeking health information and text messages may economically communicate progress with an understood condition. People with asthma may choose the convenience of a telephone review when their asthma is controlled, but a face-to-face consultation for the assessment of a problem. Preferences may not always coincide, and clinicians must be free to arrange a timely face-to-face consultation if

it is clear that an e-mail interaction is inadequate, or if a series of remote consultations fail to resolve an issue. This approach will relieve the unhelpful pressure on a triaging clinician to reduce the number of face-to-face consultations when telephone calls are used to deal with excess demand. Remote consultations are not a panacea for lack of appointments.

The telephone imposes psychological distance and both patients and clinicians may be concerned that they lack the verbal and auditory skills to explain and understand a complex clinical situation in the absence of non-verbal clues.¹³ E-mail relies on literacy skills as even verbal clues are lost: for some people this may limit its suitability to relatively simple requests for test results, repeat prescriptions or information.⁶ The practical approach of using previously prepared 'cut and paste' messages in reply to e-mail requests for information may lead to an unintended impersonal feel to responses. 'Texting' has a language of its own, potentially incomprehensible to the uninitiated, providing a further challenge to successful communication. Systems that impose the type of consultation, or limit face-to-face access to those sufficiently articulate to negotiate telephone triage, risk compromising equality of access.¹¹

In traditional UK primary care, both clinician and patient may have prior understanding of a problem and trust each others' assessment and advice, potentially facilitating remote consultation.^{14,15} It is less clear how a relationship is maintained if face-to-face meetings are rare, or how trust is built in remote consultations between an unknown patient and advisor. Conversely, the choice of impersonal communication styles, such as 'texting' and e-mail, potentially offers patients wishing to ask sensitive questions a less embarrassing option than a face-to-face conversation hampered by avoidance of eye contact.

Despite the policy drive to increase use of these alternative modes of consultation, there are unresolved issues about their official status. For example, UK certification for sickness benefit requires a doctor to sign to say that they, or a colleague, have 'seen' a patient. The UK General Medical Services contract sets targets for regularly reviewing people with a range of chronic diseases, but it is not always clear whether the choice of a

telephone or e-mail review is acceptable. The lack of reimbursement in some healthcare systems for remote consultations similarly discourages clinicians from offering patients the choice.

The different status accorded to telephone consultations may be reflected in the way appointments are made. It is unusual for receptionists to ask a patient the nature of a face-to-face consultation, yet telephone appointments may be annotated with the reason for the requested consultation, a practice inherited from an era when telephone calls were described as 'messages'. Patients e-mailing a clinician may not be comfortable with sorting arrangements that involve their message being read by someone other than the intended recipient.⁷

As the 'gateway to the NHS' primary care could lead the development of professional training by including remote communication skills teaching within both undergraduate and postgraduate courses. Computer algorithms have been developed to support telephone advice, an approach that may discourage patient-centred primary care consultations. Safety and security are generic issues that apply to all consultations, but procedures will require adaptation for remote consulting.^{3,16} The need to ensure that face-to-face or telephone conversations are not overheard is understood: maintaining confidentiality with video, texts and e-communication is similarly important. Software designed to transfer e-mail and text consultations into patient records could facilitate record-keeping and audit trails.

Thinking beyond triage and offering genuine choice of mode of consultation has the potential to improve access and is an aspect of the choice agenda which is potentially deliverable and may enhance primary care services. Defining the official status of remote consultations, ensuring that professionals have appropriate consultation skills, and that safety and security issues are understood and implemented are important first steps.

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