TALC skills for consulting remotely

Clinicians often ask for help with specific consultation problems or issues. Examples could include “how to break bad news” or “how to speed up my consultations” or “how to say no to unrealistic expectations”. “What skills do you need for remote consultations?” is another question that is commonly asked.

In all of these special circumstances the CONTENT and CONTEXT of the consultation is variable. The good news is that the PROCESS of the consultation in all these circumstances is the same, and uses the CORE SKILLS of the consultation that are covered fully in TALC modules 1 to 6. In remote consultations these core skills will make for effective interactions and need to be used with greater intensity, increased attention and a focused awareness of what is needed at the time. Most of the chapters in the TALC resources make specific reference to how the skills in questions will be applicable and how they can be used in remote consultation situations. When thinking about remote consultations we need to consider:

- What types of remote consultation are available?
- What other purposes can a remote contact fulfil?
- Do remote consultations alter the pattern of demands for services?
- How are the skills of the TALC modules used to ensure that remote consultations are effective and safe?
- What is irreplaceable about face to face consultations?

The accompanying podcast discusses all these issues.

What is a remote consultation?

Consulting remotely is any interaction between a clinician and a patient when they are not actually face to face in a room with each other. There are three types of remote consultation currently available in most Primary Care situations, although this may differ in hospitals or other settings. These are messaging, telephone or video consultations.

Messaging (using a variety of applications such as Ask my GP or email). Interactions that take place purely through messaging can be very helpful for concrete matters such as prescription queries, requests for information, or for the patient to feedback follow up information to a clinician, after an OPD assessment or trial of treatment, for example. The skills needed should include a written version of active listening (feeding back where relevant to ensure the patient knows they have been properly understood), building the relationship by expressing empathy where relevant, and mutual clarity about any safety netting arrangements

Telephone consultation (which can be initiated by the clinician or requested by the patient).

Video consultation (usually initiated by the clinician, in various contexts).

The skills needed for telephone or video consultation are discussed in detail below.

A consultation by remote means should still be a **full consultation**, with the same structure and process as in any face to face interaction. This may be synchronised (as in a telephone call) or asynchronous, for example if a patient and clinician exchange text type messages about a medication query.

What other purposes can a remote contact fulfil?

There are many remote contacts which are NOT consultations. For example, a telephone call may be used for **simple signposting**, (for example, a patient may ask a GP or administrative colleague for an appointment regarding treatment for an acute dental problem. They need to be signposted to a suitable dental service. This is not a consultation.)

Some telephone contacts are about **triaging** the patient to the most suitable service or to the most suitable person within a local network or practice. Triage is a complex task which often requires considerable expertise to do safely. Thus it is usually carried out by a suitably trained/qualified individual in the team. **Triage is not a consultation**. The consultation follows triage, sometimes, but not always, in the same contact.

In many circumstances it may be helpful to make sure the patient knows that signposting will result in them having a telephone or other type of appointment for a full assessment. Otherwise they will feel 'fobbed off'.

If doing triage, the clinician should clearly signal how they intend to deal with the problem; is this a triage situation as in:

"From what you have said, I think I need to arrange for you to come and see ... today and they will do a complete assessment of the problem."

Alternatively if the triage has become a telephone appointment:

"From what you have said so far, I think we could really help you with this telephone appointment, so can we clarify all the things we are going to talk about..."

Many patients feel that an appointment is a term only used for face to face contacts. Clinicians can help to loosen this concept by explicitly referring to "telephone/video appointments" when a full telephone consultation is anticipated.

Do remote consultations alter the pattern of demands for services?

Many patients greatly appreciate the flexibility and ease of access of messaging or telephone/video consultations. The ease with which a messaging query or request for phone can be made also reduces the opportunity costs of contacting a service, and this may increase the uses of that service beyond what easily be managed.

In contrast, those who are 'digitally disenfranchised' may feel excluded and find it harder to access services when they are delivered remotely. This may lead to patients walking into reception when others consider this inappropriate (for example, in pandemic conditions) or calling the service at different times, driven more by access to scarce telephone credit, different waking hours or the demands that addictions create.

There is another way in which remote consultations may actually fuel demand for services. Some contacts are triggered by what has been termed FAILURE DEMAND. This concept was coined by systems analyst Professor John Seddon. He terms "value demand" as the kinds of requests that a service is designed to deliver, and indeed should deliver. In a health context this would be the provision of diagnosis, ongoing management and planning of care. Failure demand, is quite different. It occurs as a result of the service in question having previously failed to complete its purpose in an earlier encounter. Here are some examples to make this concept clearer:

A patient has a telephone appointment to discuss their new symptoms of urinary infection. The clinician fails to assess the full agenda of the patient. Near the end the patient says "I also need to ask about my asthma review that I accidentally missed, and can I ask if you have had a letter from the consultant I saw two weeks ago". It can be tempting at this point to say "please call back, we have run out of time". This approach will create failure demand and is best dealt with by proper setting and analysing of the patient's agenda at the start of the consultation (see TALC MODULE 1, CHAPTERS 5 & 6). Signs in the waiting room saying "one problem per consultation" can have a similar effect.

An elderly patient is unwell and their carer thinks they need a home visit to assess this and also to review their ongoing heart failure leg swelling and a rash. A telephone consultation is arranged, and a prescription arranged for a possible UTI, which is supposed to be sent to the patient's usual pharmacist. No one tells the carer when it will be ready. She calls at the pharmacist who says "It has not been sent here, I think you have to collect it at the surgery". She calls the receptionist who says, "I will check with the duty doc after their meeting, call at 14:00" The carer calls again then but can't get through. She calls again and finds the prescription is ready, collects it, gets it dispensed. The pharmacist says "just checking, isn't your mother allergic to nitrofurantoin?" More phone calls follow. Most of this 'demand' on admin and clinician's time is due to a failure to get it right first time. Moreover, the wish for a home visit was not discussed, so the carer calls again 24 hours later...

Failure demand is wasteful of time, the most precious resource we have.

There is more information about failure demand at: https://vanguard-method.net/failure-demand and an interesting discussion of how one practice greatly reduced the number of telephone calls at the front desk, improving patient and staff satisfaction, here: https://www.youtube.com/watch?v=4stS8v4xHQA&ab_channel=RoyalCollegeofGeneralPractitioners

Increased calls on clinician's time are also related to the way in which remote consultations can become TRANSACTIONS rather than ongoing RELATIONSHIPS. It can be easy to do what's minimally safe, but this sometimes defers actually solving the problem, which crops up again at another consultation down the line. This is like kicking a can down the road, which defers and even increases demand, as patients become more anxious when their problem is not fully dealt with. Everyone working on systems in healthcare needs to be aware of the pitfalls of failure demand, which can be designed out of systems, to everyone's benefit.

How are the skills of the TALC modules used to ensure that remote consultations are effective and safe?

The core skills of consulting effectively are dealt with in the TALC modules 1 to 4 and TALC 6, and in most chapters there are specific comments about how the skills described relate to remote consultations. The way core skills are used in remote situations is discussed in more detail below.

If the situation is complex enough to require the skills of MODULE 5 – TALC ADVANCED SKILLS FOR EFFECTIVE EXPLANATIONS AND PLANNING OF PERSONALISED CARE it is very likely that a face to face discussion will be required. Some follow-up by a known and trusted clinician could occur in more complex situations, but this requires personal experience and knowledge of the patient and considerable consulting expertise.

A remote consultation should be well structured and complete. See also MODULE 7 –TALC SKILLS FOR MANAGING TIME EFFECTIVELY for more discussion about creating effective structure, which often leads to more effective use of time.

Module 1: TALC skills for beginning consultations effectively (when consulting remotely)

The skills of preparation outlined in chapters 1 & 2 of TALC MODULE 1 are even more important when consulting remotely. Preparing the notes and the technology is essential. Any kit used must be working properly and the clinician should be familiar with how to use video or hands free telephone arrangements. A quiet private room is needed for the extra concentration required and the clinician needs to be psychologically focused and ready, using the skills of chapter 2 – Can you go home with energy to spare.

When opening the consultation, it is essential to ensure that the patient is free and safe to talk (not driving for example), and to introduce anyone else in the room with the clinician. Find out who is with the patient and whether that is appropriate. Non-verbal skills such as using an appropriate speed and warmth of speech can help build rapport, and using language appropriately can clarify the purpose of the call; is this a telephone appointment or a call to see who is best placed to help? Use the agenda setting skills described in chapter 5 – How is a consultation like a business meeting? – to ensure nothing is missed.

Module 2: TALC skills for building effective relationships (when consulting remotely)

Building the relationship with the patient is even more important when consulting remotely and is one of the key elements that prevent consultations becoming mere transactions. A dispassionate transactional approach can actually increase a patient's needs for follow up appointments. Transactions are less likely to meet a patient's actual needs if clues and cues are ignored, or because a patient's real concerns or expectations are not properly elicited. Expressing appropriate empathy, exploring concerns and feelings and being clear about the clinician's concern for the individual may only take 30 to 40 seconds, but has long-lasting effects.

Module 3: TALC skills for effective information gathering (when consulting remotely)

Information gathering needs to be well-structured, sensitive and use all the active listening skills of MODULE 3. Using encouraging phrases such as "go on" or "tell me the whole story" combined with active listening skills and effective summarising, will go a long way to reassure patients that they are being fully assessed. Open questions and open directed questions may follow. Closed specific questions may be needed to clarify detail, but care should be taken not to close down the consultation with excessive use of directed, closed questioning. It is vital to pick up clues and cues about things that are left unsaid or only hinted at, as there is often crucial clinical information there. The patient's thoughts about their problems, their concerns and their expectations must be elicited skilfully and with the use of empathic statements and active listening skills.

Module 4: TALC essential skills for effective explanations and planning of personalised care (when consulting remotely)

When consulting remotely, the subtle human communication clues of tone of voice, facial expression and body language are considerably weakened. This means that the clinician needs to express concern verbally and more explicitly. The summarising skills of TALC MODULE 4, chapter 1 become even more important. Facts AND feelings must be included in an effective summary to ensure the patient really knows that they have been understood fully. Explanations need to be broken into manageable chunks, with frequent checking of the patient's responses. The patient's ideas and concerns need to be elicited again in respect of any explanations or proposed plans to ensure that clinicians and patient's ideas are suitably congruent. This is essential for patient safety, as well as patient satisfaction.

Using appropriate and positive language (see TALC MODULE 4, chapters 4 & 5) can allow for helpful framing of any explanation or plan. Sometimes it is appropriate to give bad news remotely, especially in urgent or serious situations. The clinician needs to be sure that the patient is appropriately supported in the way that they prefer, and follow up arrangements need to be clear. Expressions of concern, and clarity about the clinicians role in supporting a patient when the situation is a serious one, are both feasible and increase safety. This is covered in detail in TALC MODULE 5, chapter 6.

Collaborating to produce a shared management plan when consulting remotely will ensure clinical safety, because if the patient has not collaborated in the plan it is unlikely that it will be completed successfully. The skills of TALC MODULE 4, chapter 7 are clearly relevant here.

Module 6: TALC skills for effective endings to the consulation **(when consulting remotely)**

Summarising and agreeing the plan, with complete clarity about the next steps for patient and clinician, help to ensure effective endings when consulting remotely. Safety netting skills are of great importance here and need to be personalised to the unique needs of the individual patient, not generic or vague. The closing stages of a remote consultation provide further opportunities to cement the clinician patient relationship. When the patient says: “thanks so much for speaking to me, I feel so much better now we have a plan” the clinician will also be satisfied and even energised by the consultation.

What is irreplaceable about face to face consultations?

Although skilled remote consulting can achieve much, there is so much more to healthcare than simple accuracy about diagnosis, or successful treatment of disease. Healthcare is a human interaction. We can recall the motto that informs the Royal College of General Practitioners, “Cum Scientia, Caritas”, which means “science with care”. When facing illness, long-term conditions, mental health problems and the prospects of disability and even death, we all need to be accompanied on those journeys with other human beings, who will care **about** us, as well as providing care **for** us.

Remote consulting offers many benefits in terms of time that is saved because there is less travel, because there is flexibility of access and because telephones, messaging and the internet are now a daily reality. Not everyone has access to the technology that makes remote consultation feasible; many patients feel that they are ‘not much good on the phone’ and most clinicians get their greatest satisfaction from face to face interactions, where their clinical skills can be combined with a personalised approach. People who do not have the skills or the resources for remote consulting to be feasible must not be disadvantaged. Those with disabilities that impede remote consultations, those in poverty who do not have credit or electronic devices, the technophobe or the abused person who needs to be seen away from home, must all be properly and personally cared for.

A sympathetic glance, an encouraging pat on the hand, an empathic expression in the eyes cannot be replaced. Clinicians can take pride in the skills that make face to consulting so effective, and build on these skills throughout their careers. These skills can be used remotely also. The technology may serve us well, and yet we must ensure that we do not end up simply serving the technology. The care of patients is our first concern, whether in person or with technological assistance.