Making remote healthcare safer

The proportion of healthcare consultations undertaken remotely (by telephone, video, text message, or asynchronous e-consultation) is significant and remains higher than prepandemic levels [1–5]. In UK primary care, for example, 29% of consultations occur by telephone, with an additional 2–4% by other remote modalities [5]. Test results and instructions are often sent by text message, and patients seeking advice on a skin or eye problem may be asked to reply to a text message or email and attach a picture of the affected part.

Remote healthcare can be convenient and efficient—but is it safe? What guidance can we give to medical practitioners and patients to maximize the delivery of high-quality safe healthcare?

A recently published empirical study gives practical steps that clinicians, patients, and the healthcare system can take to help ensure remote care is safe [6]. The researchers analysed 95 extremely rare safety incidents involving death or serious harm relating to remote encounters in primary care (sometimes termed a ‘safety I analysis’ [7]). Additionally, they followed 12 general practices for 30 months as they introduced—and, in some cases, withdrew—remote and digital services (a ‘safety II analysis’ [7]). No cases of harm were identified in the 12 practices, with analysis revealing the subtle ways in which professionals worked to prevent such incidents [6]. The study demonstrated that telephone consultations were safer when there were (for example) sufficient phone lines, enough well-trained staff, a full medical history available and few distractions. Also important were well-established, widely-understood routines for next steps—such as for converting a phone call to a video call. or for asking the person to bring in a specimen to be tested; seeking advice; or sending an ambulance. Where provider organizations were under-equipped or when staff were insufficient in number, undertrained, or unfamiliar with key routines, the risk of safety incidents appeared to increase.

This new study affirmed previous research which showed that communication is at the heart of safe diagnosis and successful care, whether remote or face-to-face [8–11]. Establishing rapport, getting all the key points of the story from a patient (who may be shy, confused, frightened, or struggling with language or cultural barriers), assessing the level of concern, and probing for more detail where needed are all inherently more difficult when the patient is at the end of the phone than when they are physically present in the same room. It is also important to ascertain that the patient is genuinely alone and speaking confidentially.

The study also identified that some medical conditions are inherently risky for remote assessment [6]. ‘Tummy ache’ is usually innocent but can indicate a serious condition like appendicitis; a physical examination, however brief, may be needed to exclude the latter. Other conditions where an in-person consultation is strongly preferred include new-onset chest pain, thunder clap headaches, breathing difficulties, a severe deterioration in mental health, a sick child whose parent is very concerned, a person with multiple health problems who deteriorates suddenly, or any condition that has worsened or failed to improve as expected after telephone advice. The longitudinal study of general practices revealed that, when clinical and support staff applied collective knowledge about which conditions or patients need in-person assessment, ‘double-handling’ of patients who required a second face-to-face assessment after an initial telephone call could be reduced.

This research generated some practical tips for remote consultations for patients and carers, co-produced with a patient co-author, to promote safety [6]. These include: before a telephone call, ensure you are somewhere quiet with good reception; remember that you need to consent to the call taking place and perhaps to it being recorded; if calling as a carer, explain who you are and why the patient cannot call themselves; think about how to describe the issue to someone who cannot see the patient; give a comprehensive history and description of the immediate and recent state, including any noteworthy conditions such as diabetes; do not assume that information has been passed through to the clinician; declare any herbs, medication, or drugs taken; explain recent interactions with other health providers; and, ensure that photos are high-quality—use adequate lighting and the back camera of a phone. Remember, doctors are not mind-readers, so if you feel you or the patient needs to be seen face-to-face, ask for an in-person appointment. Finally, many instruments a clinician uses in the surgery are now available to buy. Adding a thermometer, pulse oximeter (adult and child versions), and blood pressure machine to the family medicines cabinet means you can take important physiological measurements to inform the doctor’s judgement.

Remote healthcare can be safe and patient-focused. For it to be so requires appropriate technology; trained staff; careful triage to ensure the modality is appropriate for the nature and trajectory of the problem; and patients capable and confident, perhaps with support, to navigate the system and engage in the consultation.
Conflict of interest statement

TG is a member of Independent SAGE.

References


7. Hollnagel E, Wears RL, Braithwaite J. From Safety-I to Safety-II: a white paper. The Resilient Health Care Net: Published Simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia. 2015.


Trisha Greenhalgh1, Rebecca Payne1, Flora McCabe,2

1Nuffield Department of Primary Care Health Sciences, University of Oxford, United Kingdom
2Head of Advocacy and Risk Management Healthcare, Lockton Companies LLP, London, United Kingdom

*Corresponding author. Nuffield Department of Primary Care Health Sciences, University of Oxford, United Kingdom.

E-mail: trish.greenhalgh@phc.ox.ac.uk

Handling Editor: Dr. Phillip Phan