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Title

A reflection on an adapted approach from face-to-face to telephone consultations in our Urology outpatient department during the COVID-19 pandemic – a pathway for change to future practice?

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A reflection on an adapted approach from face-to-face to telephone consultations in our Urology outpatient department during the COVID-19 pandemic – a pathway for change to future practice?

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Abstract: The sudden and unanticipated COVID-19 viral pandemic of 2020 and its profound impact on the NHS prompted an almost overnight change in the services we are able to offer our patients to fulfil clinical demands. From March 2020 we have changed outpatient appointments from face-to-face to telephone led consultations. We have performed an early review of this service to ensure its sustainability during the unknown duration of this current crisis and to establish its potential utility when normal services resume in the future. Our results show a patient satisfaction of 93% with 83% happy to have telephone follow-up in the future and a clinician satisfaction of 82% in adequacy of the telephone consultation in making a clinical decision. Telephone clinics are a safe and efficient alternative to face-to-face outpatient consultations for many patients, particularly non-complex benign follow-ups.

As history pages turn to a new decade, we face the unimaginable crisis of the pandemic COVID-19, which has challenged the NHS and many medical management principles as we know it. Within days, this grew from rapid disease spread with fatalities in continents afar, to a very real presence in our own country, cities and soon the departments in which we work. Its enormity and life after the aftermath is yet unknown.

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On 16th March, the British Prime Minister, Boris Johnson, recommended all members of the public practice 'social distancing', a term we are now immediately familiar. This was shortly followed by announcements for suspension of non-urgent elective surgeries from 15th April, with a final declaration of a nationwide lockdown on 23rd March without confirmation on the likely duration.

Additional NHS, measures have been taken to minimise disease spread, by reducing the number of patients in hospital, early discharges and limiting hospital visits, including outpatient clinics. However a large cohort of patients rely on our services for assessment, monitoring and treatment of urological diseases posing a significant impact to quality of life, morbidity or mortality risk if services ceased entirely. We have therefore adapted our Urology outpatient service to telephone-led consultations to fulfil demands whilst reducing risk to patients and staff.

Face-to-face consultations have been tradition, addressing private problems in safe environments, born from an era where the lack of technology meant no alternative. Psychologist Albert Mehrabian demonstrated the importance of non-verbal aspects of communication in research of salespersons, quoting 7% attributable to spoken words, 55% body language and 38% voice and tone (1). Such aspects are useful in clinical settings for developing doctor-patient relationships, building trust, increasing compliance with treatment and for physical assessment.

The concept of selected telephone consultations is however an alternative for conveying information rapidly and can alleviate pressures of targets, long waits, decision making delays and providing patients' reassurance. Studies have found telephone consultations are well received by patients, wanting contact with their doctors (2).

Our Urology department consists of 12 consultants spanning subspecialist interests in a large teaching hospital, receiving tertiary referrals from neighboring counties. We already, pre-coronavirus, run a well-established nurse-led PSA surveillance clinic for select patients based on strict protocols. Our outpatient department serves a wide range of new and follow-up consultations, from benign to malignant pathologies,

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discussing surveillance, medical treatment, surgery and onward referrals. Many consultations involve review and reassurance without physical examination, for example post TURP. A study of nurse-led telephone reviews post TURP showed this to be effective after screening appropriate non-complex patients and 79% did not require a further face-to-face appointment (3).

As a specialty, Urology serves a predominantly older population, over 80% over the age of 60 years (4) many of whom may have poor performance status and mobility. Some of our patients live in rural parts of the county with limited access to public transport and with a wide catchment area, travel to hospital is often a lengthy one, requiring the aid of relatives, expensive taxis or hospital transport. In addition, overbooking of clinics and staff shortages often leads to long clinic waiting times.

With Public Health England guidance and British Association of Urological Surgeons (BAUS) recommendations, we implemented telephone consultations to replace our existing Urology outpatient clinics, supported by Consultants, Associate Specialists, Specialty Trainees, Trust Grade Urologists, a clinic coordinator, nursing staff and cancer nurse specialists.

Patients were contacted ahead of their appointments by telephone, text message or letter to inform the change from face-to-face to telephone appointment, and confirm preferred contact number. Notes were brought into the doctor's clinic room in time order, with use of a secure hospital landline or departmental mobile phone with the usual computer results systems and dictation devices.

Consultations commenced after patient identification checks to ensure confidentiality. An anonymised record was made including the complaint, diagnosis, subspecialty, new/follow up, whether it was necessary for the patient to be brought in for examination, outcome and call duration. An anonymous patient survey was performed at the end of the consultation with two questions marked 1-5: Question 1: "how satisfied are you with the telephone consultation?" *(1:very dissatisfied, 2:disatisfied, 3:neutral, 4:satisfied, 5:very satisfied)*; Question 2: "how likely are you to consider opting for a telephone consultation as alternative in the future, when services resume?" *(1:very*

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unlikely, 2:unlikely, 3:neutral, 4:likely, 5:very likely). Additional comments from patients were noted. The consulting doctor answered the final question whether the telephone appointment was sufficient to make a clinical decision.

We reported on 62 telephone consultations during the period of reduced service of the COVID-19 crisis to date. These included 50 males and 12 females, with an average age of 65.5 years (range 23-90 years), covering clinics of 5 Consultant Urologists with varied subspecialty interests.

There were 8 new referrals and 54 follow-up appointments, including 34 benign and 28 malignant. Average call duration was 8 minutes, ranging from 3-22 minutes. One patient needed to return urgently for examination for suspected penile cancer. 5 patients were rebooked for non-urgent examinations to complete their consultation; these included 3 new referrals with benign disease and 2 follow-up examinations for penile cancer.

One non-English speaking patient was unable to be offered their telephone follow-up due to lack of interpreter service and was therefore written to with an outcome. 4 patients did not answer the phone at their scheduled appointment time, nor subsequent attempts and were written to with their results and rebooked, deemed appropriate by the clinician.

The outcomes of consultations included further follow-up with investigation results or MDT discussion, non-urgent return for examination, review of symptoms and discharge.

Consultations achieved via telephone in our review were adequate for a clinical decision for 82% of our patients. 93% of patients were satisfied with their consultation, rating an average satisfaction score of 4.7/5. 83% of patients stated they would opt for a telephone consultation in future. 10% expressed a preference for face-to-face consultations and the remainder were neutral.

Specific patient comments for preferring telephone consultations included convenience, avoiding long journeys into the hospital, eliminating costs and difficulties finding hospital car parking, waiting times in clinic and reducing risk of general infection

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exposure within hospitals. Comments regarding preference towards face-to-face appointments were based predominantly on personal choices, communication barriers over the telephone, including hearing and cognitive impairment requiring next of kin support and preferring sensitive information/breaking bad news to be done in person.

Our results show telephone consultations to be appropriate and well-received by patients undergoing follow-up for benign disease and selected cancer follow-ups, including PSA monitoring, post-operative follow-ups not requiring physical examination, and those with reassuring results requiring no change in management. We recommend telephone consultations be offered to these groups in the first instance and extended based on the review of long-term outcomes.

New referrals favour face-to-face appointments in order to perform a thorough examination and establish rapport. In addition, cancer follow-ups requiring examination, (for example prostate cancer under active surveillance, penile cancer follow-ups) and those requiring breaking of bad news, sensitive discussions around treatment options, or cancer nurse specialist support should be seen in person. Those with personal preferences or specific needs, including language barriers, hearing and cognitive impairments should also be offered face-to-face consultations to improve efficiency and patient satisfaction of information delivery.

We have found telephone consultations in our Urology department to be effective and appropriate during the restricted services resulting from the coronavirus pandemic. Currently these clinics represent all of our consultations due to the specific circumstances of lockdown. We expect however, when full service resumes in the future and we vet patients for appropriately selected telephone clinics, benefit to continue.

For patients, telephone led consultations save time, reduce the burden and expense of travel to hospital, need for accompanying relatives, hospital transport and often long waiting times in the outpatient department. For the department, we expect a significant positive impact on optimising the efficiency of our services, reduced waiting times to

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appointments, reduced non-attendance and potentially increasing the capacity of clinics and fulfillment of targets, with subsequent financial benefits.

It is important to address training opportunities and accessibility of advice for Urology trainees and junior doctors involved in clinics. It is also essential that a robust recall system exists for patients needing face-to-face assessment.

The adaptation of services in the current crisis has paved a way for a long-term change in our practice and one which is likely to also apply to other surgical and medical specialties across the globe.

Conflicts of Interest

None declared

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