

Research

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Volume 2 : Issue 1

Article Ref. #: 1000PMHCOJ2113

Article History

Received: February 6th, 2016

Accepted: June 17th, 2016

Published: June 20th, 2016

Citation

Weru J. Telephone versus face to face palliative care consults during referral. *Palliat Med Hosp Care Open J*. 2016; 2(1): 17-20. doi: [10.17140/PMHCOJ-2-113](https://doi.org/10.17140/PMHCOJ-2-113)

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Telephone Versus Face to Face Palliative Care Consults During Referral

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ABSTRACT

Introduction: Palliative care aims at ameliorating patients and families suffering when they are faced with life-limiting illnesses. It involves symptoms management as well as psychosocial, spiritual support. As such, proper communication between clinicians taking care of the patient is an important aspect of this care. Studies have shown that errors in communication are common and relevant in palliative care as they negatively impact on the quality of care provided. The service at Aga Khan University Hospital, Nairobi (AKUHN) provides both in and out patient consult services. Primary physicians to patients consult the palliative care team *via* telephone models as well as face to face talks. There is a lot of literature regarding patient/family member consultation with a doctor but little has been done on understanding the efficacy of doctor to doctor telephone discussion on a patient being referred from one service provider to another.

Objective: The aim was to assess the adequacy of information regarding the patient given in telephone consults *versus* face to face consults during the referral process.

Methodology: This was a cross-sectional study. 60 consults to the palliative care team were assessed, these were consults received over a period of 4 months; 36 were telephone consults and the rest face to face. The information was assessed for inclusion of the following details: I) name II) age, III) gender, IV) longevity of illness, V) ward/clinic location, VI) Patient's diagnosis, VII) reasons for referral, VIII) current treatments, IX) patient's knowledge of their diagnosis and prognosis, X) family's knowledge of diagnosis and prognosis and XI) patient's and family's knowledge of referral to palliative care.

Results: Overall, there are more missed characteristics of a patient in a telephone consult compared to a face to face consult. The most missed characteristics in both types of consults were name, patient and family knowledge of referral, patients' and families knowledge of diagnosis.

Conclusion: It is evident that a telephone consult is less informative than a face to face consult. It is therefore important to have a face to face discussion on a patient after telephone consultation. It is also evident from these findings that doctors are still poor in the aspects of communicating with patients, their families and also among themselves and more need to be done to improve this.

KEYWORDS: Palliative care; Telephone consults; Communication; Palliative care consultation.

INTRODUCTION

The technology of telemedicine has been used for over 20 years and may be useful in palliative care for the patients lacking access to medical services and the use of mobile telephony has been recommended as an easy way of providing timely and quality assessment of patients in palliative care.¹ In palliative care, proper, timely and sensitive communication is recommended in order to offer high quality care to patients and family's. Understanding the patient's and family's knowledge of the disease, prognosis and treatment guides the palliative care team to adequately plan care for the patient. One of the key components in palliative care is communication and mobile telephony technologies can be an effective way to support communications between clinicians.² There is need to quantify the adequacy of this mode of communication compared

to the traditional face to face model as its use is more applicable in palliative care due to the fact that mobility for these patients sometimes is limited.³

There is lack of information about the use and adequacy of telephony communication for palliative care referral and the general outcome on their use. This is particularly urgent given the great and accelerating penetration of information technologies, especially mobile phone and Internet connections in developing countries, which is creating large numbers of potential users that could benefit from well-designed systems to support health in general and palliative care in particular. The availability of effective ways to communicate with patients and caregivers, along with effective Health interventions or applications, might significantly improve the availability of palliative care especially in underserved populations and in poor resource settings.² However, communication errors in telephone medicine can result in adverse outcomes ranging from inconvenience and anxiety to serious compromises in patient safety, identity and quality of care.⁴

METHODOLOGY

A cross-sectional survey was performed based on registration of referral consults to the palliative care team. The policy is that the primary doctor calls, talks or writes to the palliative care team when a patient meets the palliative care referral criteria and thus requires access of this service. There were a total of 82 consults during the 4 months period of study, June- September 2015, with 60 of them being face to face and telephone consults combined. Of the 60, 36 were telephone consults to the palliative care team while 24 were face to face. The 22 patients sent to the palliative care team with a referral form or note were excluded from this study as the pre-prepared form has details that guide the referring doctor on the information to fill in. The details given by the referring doctor, *via* face to face or telephone consult, were recorded verbatim. There was no prompt for more details during the initial consultation discussion. We did not assess the time taken for a consult as the primary research concern was the adequacy of information given by the referring doctor. The

information given by the referring physician was assessed for the inclusion of the following patients’ characteristics using a checklist developed by the researcher (Table 1):

- I) Name
- II) Age
- III) Gender
- IV) Longevity of illness
- V) Ward/clinic location
- VI) Patient’s diagnosis
- VII) Reasons for referral
- VIII) Current treatments
- IX) Patient’s knowledge of their diagnosis and prognosis
- X) Family’s knowledge of diagnosis and prognosis
- XI) Patient’s and family’s knowledge of referral to palliative care.

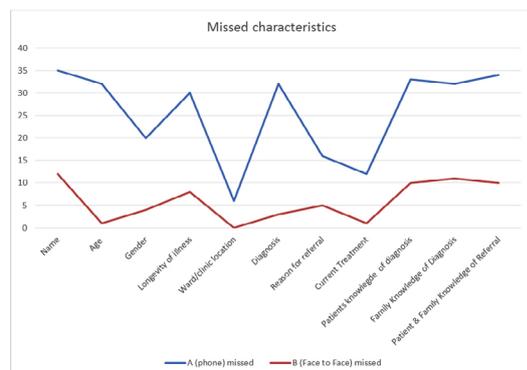
RESULTS AND DATA ANALYSIS

Overall, there are more missed characteristics of a patient in a telephone consult compared to a face to face consult. The most missed characteristics in both types of consults were name, patient and family knowledge of referral, patients’ and family’s knowledge of diagnosis (Graphs 1A and 1B). Significantly, 89% (n=32) of the phone consults did not mention the age of the patient compared to only 4% (n=1) of the face to face talks. The non-verbal prompt by the member of the palliative care team during a face to face consult could explain the reason why the age of the patient is largely given during this type of discussion. The location of the patient was detailed in all face to face consults and 83% of phone consults. This is therefore the least missed patient characteristic in this study in both types of consults being considered. This may be due to the fact that primary doctors usually call the palliative care team after reviewing a patient and thus the physical location is usually indicated. 79% of all consults had the patient’s name not mentioned during the entire conversation in the referral process. The fact that doctors consider the location of the patient as an important identifier is a contributing factor to this scenario. There could also be an

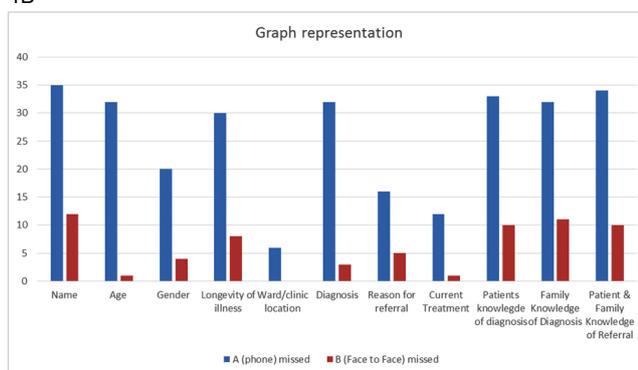
Characteristics	A (phone) missed	B (Face to Face) missed
Name	35	12
Age	32	1
Gender	20	4
Longevity of illness	30	8
Ward/clinic location	6	0
Diagnosis	32	3
Reason for referral	16	5
Current Treatment	12	1
Patient’s knowledge of diagnosis	33	10
Family knowledge of diagnosis	32	11
Patient and family knowledge of referral	34	10

Table 1: Missed number of patient’s characteristics per type of consult.

1A



1B



Graphs 1A and 1B: The missed patient characteristics in the consults.

assumption that the palliative care team being consulted will be able to generally locate the patient and thus know their name once they arrive at the patient’s station. 88% of phone consults did not mention the diagnosis of the patient, a significant challenge in the provision of quality care as the diagnosis of a patient is a very important guide on types of challenges that they may be facing and in clinical decision making.

DISCUSSION

The findings in this study reveal that during telephone consults, significant patient information can be missed. It is evident that telephone consults are not as adequate as face to face consults in palliative care. As technology grows, consultations *via* mobile telephony will increase and thus there is bound to be a significant challenge in the adequacy of information passed from referring clinician. Although telephone consultation has been hailed as time saving and a more modern method of communicating, it has also been noted that doctors behave in a less patient-centred way on telephone and at the same time, more biomedical and less psychosocial or affective information is exchanged.⁵

It is recommended that the “attending health care practitioner” should provide the patient and family with a) information regarding palliative care and end-of-life options appropriate to the patient, and b) information and counseling regarding prognosis and reason for consulting the palliative care team.³ This should be based on the patient’s clinical and other circumstances; and the patient’s reasonably known wishes and beliefs. The “attending health care practitioner” should make clear to the patient and/or to his/her authorized health care decision maker that decisions concerning options rest with the patient and/or his/her decision maker. These discussions need to be clarified with the palliative care team member who is being consulted.

A significant number of consults do not identify patients by names both in face to face and telephone talks as is evident in this study. Identifying patients by their names when talking to them or when discussing their illness with colleagues

is important, a show of respect and also individualizes patient’s diagnosis, prognosis and plays a crucial impact in the quality of communication between health care providers, patients and families.⁶ In a hospital setting where there can be multiple patients with similar illnesses at the same trajectory of illness, it would be disastrous to mistake the patient who was referred for care. It is ethically recognized that patients need to be identified using at least 2 aspects, most importantly being their names.

The study reveals that most doctors do not provide information regarding the longevity of illnesses and stage at which it is. At the same time, both models of referral experienced a significant miss on patients and families knowledge of disease and their being informed of referral to palliative care. This could be due to the fact that physicians themselves still experience stigma when it comes to issues regarding end of life and they might find it challenging to even inform their patients about prognosis leave alone need for supportive care service from the palliative care team. Giving bad news remains a big challenge for effective and efficient communication in medical practice; this negatively impacts on the quality of care provided.⁷

CONCLUSION

Patients and their families should be informed by the primary consultant that the patient is being referred for palliative care. It is important that when making the referral, the following information is provided: Patient’s name, Patient’s diagnosis, Patient’s location and their knowledge of the illness. It is evident that a telephone consult is less informative than a face to face consult. It is therefore important to have a face to face discussion on a patient after telephone consultation. It is also evident from these findings that doctors are still poor in the aspects of communicating with patients, their families and also among themselves and more need to be done to improve this. The findings of this study mirrors¹ findings that bedside or face to face consultations have a surplus value compared to telephone consultations. More rigorous studies should be undertaken to study the merits of the different modes of consults. Familiarity with common errors in telephony consults would decrease the

likelihood of referring physicians making omissions regarding important patient's information.⁸

To enable the palliative care team provide quality care from the first moment of contact, it is imperative that full information regarding patients is provided and this can be made possible by educating doctors on communication skills especially when using mobile telephony to cross-consult. It would also be useful to develop mobile apps and tools that can be used for doctor to doctor communication regarding a patient. This way, missing crucial patient data will be minimized. A developed referral form that requires to be filled by the referring clinician even after telephone consult to the palliative care team will also enhance adequacy of information provided.

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