Remote Consulting (For Lessons of the Week) No. 6

Here are some tips on remote consulting which colleagues have shared during courses which have been run around the region and have been collated.
Please note - there will be exceptions to every rule, trust your instincts, and if something doesn't feel right, it probably isn't right. And remember … although we may question whether we need to go back to the good old days of seeing every patient when this virus eventually tires and there is an awful lot that can be done safely remotely, there is a reason why we have trained generations of doctors to examine their patients.
I'd love to hear others from colleagues who are happy to share … that's how we all learn
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6. When is a video actually going to be useful?

It's tempting to default a video consult when you're getting nowhere on the phone, but always ask yourself, do you need "ears on the phone", "eyes on the video" or "hands on the patient"? Otherwise video just becomes a procrastination tool.

Video is especially useful when...

- you want to be curious and assess the surroundings a little more for safeguarding purposes
- you are really struggling to get a feel of how unwell the patient is and you just want that "end-
- of-the-bed-o-gram" (especially useful in care homes where multiple patients can be viewed)
- and there is someone on hand to support a remote consult
- The situation is vague and you can't be sure that all the important red flags for that complaint
- are excluded
- the patient or clinician is self-isolating
- the patient (or clinician!) is anxious and needs additional reassurance

AND

- Like it or not, (and noting that most of us went into clinical practice for reasons other than death certification) the new rules around death certification counts a video consultation in the 28 days prior to an expected death as having seen the patient.

BUT remember that video is favoured by younger patients who tend to be healthier and more technologically proficient (though not always!) and is less useful when the patient.

- Is confused or has dementia
- Has serious anxieties about the technology
- Is hard of hearing (though they still may be able to use the "chat" facility or lip read)
- Is less forthcoming about psycho-social problems

And finally...

- Remember - you don't NEED to video if a good phone call will do - try to see video as a visual
- upgrade from a telephone call rather than a replacement for a F2F
- Be prepared to switch modality (in any order from video => telephone => F2F) if technical,
- patient or clinical factors dictate
- Consider use of a chaperone
- Watch for the visual cues from the patient while maintaining "camera contact" when talking

AND listening

- Consider inviting the patient to disconnect first