

## Remote respiratory consultations

### INTRODUCTION

Remote consultations have become a normal, and in some regions, the only, method of contact for routine visits for respiratory conditions during the COVID-19 pandemic. This has arisen to protect both patients and healthcare professionals. Our expectation is that this situation will influence future provision: new “desire lines” have been created and we anticipate both face to face and remote consultations will become a normal part of the model of respiratory care globally. Questions remain about the balance, how to protect patient choice, clinician and patient safety and how to reduce inequity. This desktop helper provides some answers. Policy implications are described separately.

### WHAT, WHERE, WHEN?

Remote respiratory consultation is any consultation without physical contact between the HCP and the patient, for example via videocall, telephone or web-based devices. It may also include consultations where patients are in a separate room and communication is via a telephone or intercom for viral infection control.

Telephone consultations have been a common feature of primary care (typically not reimbursed), usually accompanied by face to face later, the use of video-consultation was previously rare but has accelerated during the COVID-19 pandemic.

Primary care relies on developing close, continuous relationships with patients, using talk, eye contact and touch; where the way the patient behaves, walks and coughs drives the diagnosis. These and “doorknob”/secondary agenda moments can be hard to replicate remotely. In addition to patient choice, sustainability may be a challenge.

#### Use remote respiratory consultations for:

- Routine reviews
- Medication review, including polypharmacy
- Inhaler technique training and evaluation (single or group)
- Triage of known patient with new onset breathlessness
- Education and support (individual or group)
- Pulmonary rehabilitation (individual or group)

HCPs report online consultation fatigue and cognitive stress as well as a loss of connection, satisfaction and identity when the rituals of face to face contacts are lost.<sup>1</sup> But remote consultations reduce travel, improving the carbon footprint.

### Routine management & review

This is the best opportunity for remote consultations, with appropriate preparation by both HCPs and patients. However, consider:<sup>2-5</sup>

#### Suggests remote consultation:

- Patient preference eg neutral location
- Their comfort with technology, e.g. apps for monitoring; note-taking; record-keeping
- Access to smartphone or webcam
- Travel or parking difficulties, financial issues
- Value of involving family living apart from patient
- Opportunity to gain insight into home situation
- Has equipment for observations: O<sub>2</sub> saturation, temperature, blood pressure, peak flow
- Where face to face puts individual at risk

#### Suggests face to face:

- Preference for the traditional approach
- Complex needs
- Hearing or sight problems
- Low digital literacy
- No access to internet
- Low trust for accuracy, safety or confidentiality of remote consultation
- Lack of privacy at home

**Be conscious of how the community might perceive any variation in approach between patients. Avoid increasing inequity for those who cannot use or afford apps or other home-based technology.**

### Multidisciplinary consultations

Patients with multiple comorbidities may benefit from a joint remote consultation with their primary HCP and other specialists. However, be mindful that speaking with several people at the same time remotely can be overwhelming. Check understanding during the call, or in a follow-up call.

### Telephone triage<sup>6,7</sup>

This can be used to decide which patients need face to face contact. However, there

is currently limited evidence on value beyond infection control. If a patient reports any red flag symptoms during a remote consultation, conduct a usual urgent review either face to face or via video, or direct them to emergency care.<sup>8</sup>

### Assessment of exacerbations

If a patient is already under the care of a community respiratory service and is well-known to you, assessment of new onset breathlessness and decisions about the diagnosis, whether to escalate treatment and action may be possible remotely even using the telephone alone. Provide self-management tips; check these are understood.

### Diagnosis

IPCRG colleagues advise remote consultations for diagnosis are only appropriate when the need for infection control is paramount. They may be sufficient to assess probability of diagnosis and inform a trial of treatment alongside mitigation of any risk factors.<sup>9</sup> Video offers the closest match to a face-to-face consultation that employs looking and listening. Include a structured clinical assessment with a focus on meticulous history taking. If the patient has a peak flow meter, diaries can be useful. Questionnaires may help. Defer referral for additional testing such as spirometry (if this is available safely), chest X-ray or computed tomography but follow up later if circumstances allow. Asthma is a variable disease therefore several consultations will probably be needed to confirm the diagnosis and perhaps with more than one HCP if additional tests are needed. Communicate this to the patient in terms of probability, explaining the diagnosis has been reached by their clinical team who ‘suspect that’ it is, for example, asthma. Help your patient navigate to approved information and ensure they are clear what to do if their symptoms do not improve or worsen. Be sure to spend time on your patient’s understanding of the situation.

### Group consultations

Effective group and supportive consultations can be carried out remotely and offer the opportunity to gain from several experts in ►

◀ one session. They may help the patient feel in the epicentre of care, and also give them confidence to ask more questions. This may spark support between the patients themselves, facilitated and guided by the HCP.

## PROVIDING THE REMOTE RESPIRATORY CONSULTATION

Prepare well: use checklists (green boxes). Follow a structured approach, noting types of talk (Figure 1), and need for "tidying up" after the consultation e.g. email or messaging with links to further information. Consider that the consultation may take longer than a face to face consultation when you might talk with the patient while simultaneously taking observations or evaluating their overall health status.

### App-based technology: examples

- MyHealth (UK; paid for) eg myCOPD and myASTHMA
- SaniQ (Germany; paid for)
- Hailie™ (free): medication monitoring for asthma and COPD
- Smart Peak Flow (free): Smart sensor technology to track PEF
- AsthmaTuner (Swedish and English)
- MASK Air (for allergic rhinitis)

### Checklist for HCPs (some could be done by trained receptionist/administration)

- Am I aware of this patient's needs?
- Can I access their medical history?
- Do I know the patient's goals?
- What is their physical, smoking and mental health status?
- Do they have access to a phone, smartphone, tablet or computer?
- Should I be expecting any questionnaire results or peak flow diary?
- Do they have access to respiratory function testing equipment?
- Can they use it correctly?
- Do I need to see them – if so, is a video-consultation possible?
- Is the family/home condition supportive?

### Checklist for patients

- Have I completed any tests, diary or questionnaires my HCP has sent\*?
- Have I prepared a list of questions for my HCP?
- Am I in a quiet and private place?
- Which symptoms are bothering me most at the moment?
- Do I have my medications to hand, including my inhaler(s)?
- Do I have a pen and paper to hand to make notes?
- Do I have my glasses with me (if I need them)?

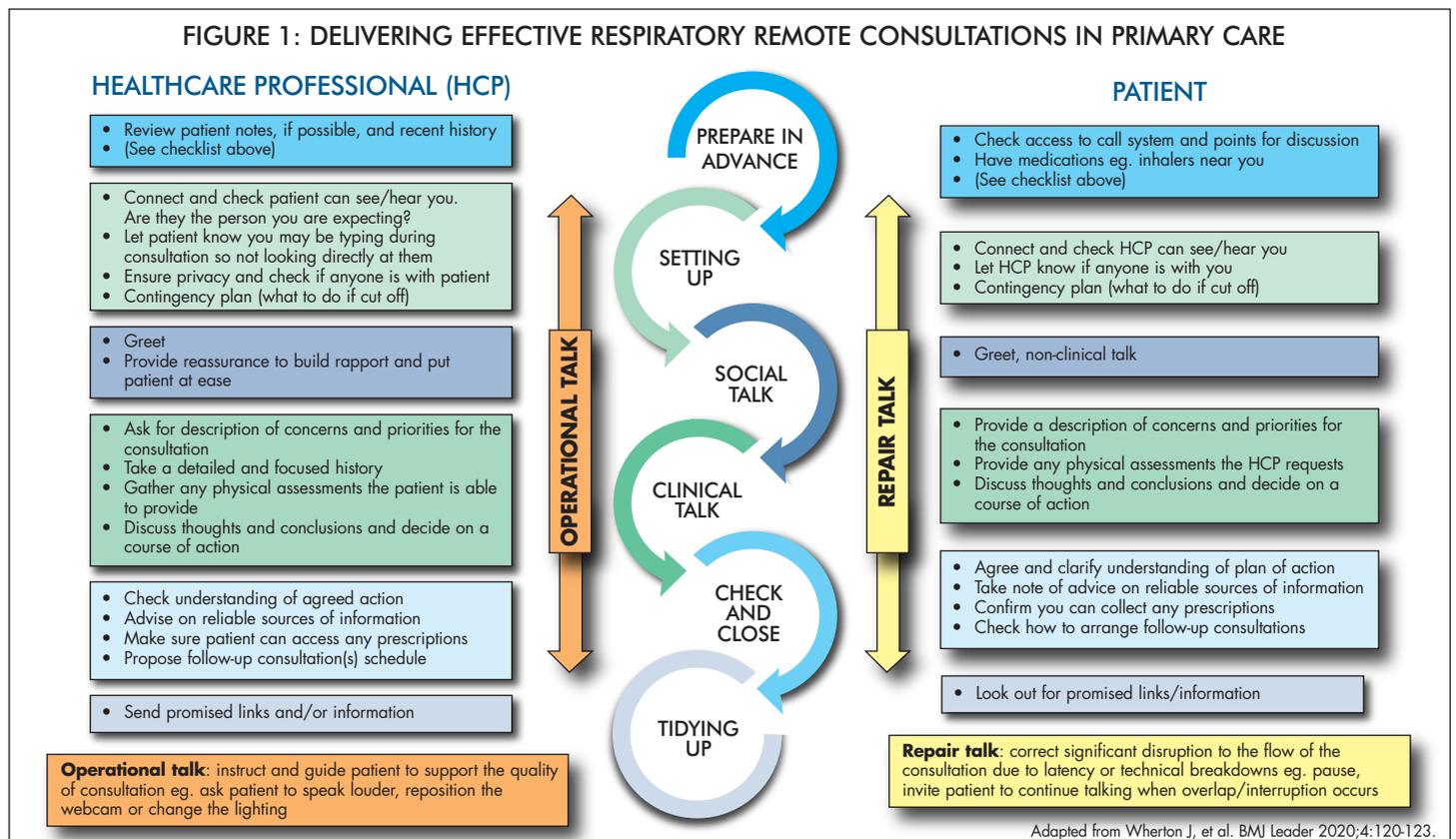
\*You may prefer to complete these with your HCP during the consultation

### Useful tests that can be done remotely\*

- **Vital signs** – temperature, pulse and respiratory rate - <https://www.youtube.com/watch?v=YCWTqKilhQ>
- **Peak flow test** – <https://www.asthma.org.uk/advice/manage-your-asthma/peak-flow/>
- **1 minute Sit to stand**
- **Inhaler technique** – <https://www.asthma.org.uk/advice/inhaler-videos/>
- **Pulse oximetry** – <https://www.youtube.com/watch?v=YCWTqKilhQ>
- **Breathlessness questionnaires**
  - MRC Breathlessness Scale - [www.pcrs-uk.org/mrc-dyspnoea-scale](http://www.pcrs-uk.org/mrc-dyspnoea-scale)
  - Modified MRC - <https://academic.oup.com/occmed/article/67/6/496/4095219>
- **COPD questionnaires**
  - COPD Assessment Test - <https://www.catestonline.org/>
  - Clinical COPD Questionnaire (CCQ) - [www.ccq.nl](http://www.ccq.nl)
- **Asthma questionnaires**
  - Asthma Control Test - <https://www.asthmacontroltest.com>
  - CARAT - <https://core.ac.uk/download/pdf/62692897.pdf>
  - RCP 3 questions - <https://cks.nice.org.uk/topics/asthma/management/follow-up/#the-royal-college-of-physicians-3-questions>
- **See IPCRG guide to tools here: asthma** <https://www.ipcr.org/resources/search-resources/users-guide-to-asthma-control-tools-2016> **and COPD** [https://www.ipcr.org/sites/ipcr.org/files/content/attachments/2019-10-23/ipcr\\_users\\_guide\\_to\\_copd\\_wellness\\_tools.pdf](https://www.ipcr.org/sites/ipcr.org/files/content/attachments/2019-10-23/ipcr_users_guide_to_copd_wellness_tools.pdf)

\* Links are to some open source videos and instructions – note none were designed specifically for remote consultations

FIGURE 1: DELIVERING EFFECTIVE RESPIRATORY REMOTE CONSULTATIONS IN PRIMARY CARE



Adapted from Wherton J, et al. BMJ Leader 2020;4:120-123.

**References:** 1. Hyman P. JAMA Intern Med. 2020;180(11):1417-1418. 2. Mold F, et al. JMI Med Inform 2019;7:e13042. 3. Osman MA, et al. BMJ Global Health 2019;4:e001629. 4. Thyagarajan A, et al. BJGP Open 2020;4:bjgpopen20X101020. 5. Iyengar K, et al. Clin Res Rev 2020 ;14 :797-799. 6. McKinstry B, et al. BMJ 2017;358:j4345. 7. Newbould J, et al. BMJ 2017;358:j4197. 8. Greenhalgh T, et al. BMJ 2020;368:m1182. 9. Beaney T, et al. BMJ 2020;369:m2092.

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