It's good to talk… … but do I really need to see you?

The potential of telephone consultations for providing routine asthma care

Hilary Pinnock

The British Thoracic Society / Scottish Intercollegiate Guideline Network (BTS/SIGN) British Guideline on Asthma Management advocates a regular, structured review for all patients with asthma.[1] This seems reasonable. Regular review has been linked with improved asthma morbidity.[2] As clinicians we have a professional responsibility as well as compelling medicolegal reasons to review patients for whom we are prescribing. Theoretically, therefore, we should welcome the inclusion of routine asthma reviews as a quality indicator in the new UK General Medical Services (GMS) Contract.[3]

In practice, however, people with asthma are reluctant to attend for asthma reviews.[4] Despite over a decade of proactive asthma care in general practice only about a third of patients are seen each year for a routine review. [4,5] Anecdotally, this contrasts with relatively high attendance at diabetic and coronary heart disease clinics (over 90% in my practice). We know that asthma affects quality of life[4] but perhaps it is not sufficiently inconvenient, or not perceived as sufficiently serious, to warrant the investment of time and effort involved in attending a clinic review. If we are to achieve the 70% target set by the GMS Contract we will need to think outside the four walls of our surgeries.

The telephone, invented 125 years ago, can hardly be described as a modern invention but it is only recently that its use as a medium for consultation has been explored. The telephone has established a role in responding to patient-initiated requests for advice, offering an effective means of triaging calls for same day appointments or home visits[6] but there has been surprisingly little interest in its potential for reviewing chronic disease. We have recently completed a randomised controlled trial comparing telephone with face-to-face consultations for the routine review of asthma.[7] Telephone consultations reached 74% of the patients: only 48% responded to the invitation to attend the asthma clinic. With an average duration of 11 minutes, telephone reviews took half the time of the face-to-face consultations, an efficiency reflected in a cost saving of nearly £4 per consultation achieved.[8] Participants were impressed by the convenience of telephone consultations, suggesting that this helped overcome the barrier to care imposed by having to devote nearly an hour of their time to attending the asthma clinic for review of a condition that they perceived as mild.[9]

Interesting practical questions remain to be answered about the implementation of a telephone service for asthma reviews. Our trial randomly imposed telephone or surgery consultations - clearly in real-life patients will be given a choice and we do not know how they will respond to the option. Our trial nurses phoned the participants opportunistically, but the number of abortive calls would probably be reduced if patients could book telephone consultations as a timed slot in the asthma clinic. Telephone triage may increase subsequent consultations[10] perhaps because the triage call had focused on only one of the list of problems patients bring to acute consultations. A routine asthma review initiated by the clinician may be less likely to have additional unmet agendas.

Is it possible to fulfil all the demands of an asthma review on the phone? Asthma medication and self-management can be discussed, smoking cessation and influenza vaccination can be advocated, supporting literature either posted or web-site addresses provided. It will only be possible to measure a peak flow if the patient has a meter at home. However, in a variable condition such as asthma, a 'one-off' peak flow reading is of limited value; control is better assessed using standard morbidity questions (such as those recommended by the Royal College Physicians).[11] A potential disadvantage, warranting further investigation, is the inability to observe inhaler technique on the telephone. Pragmatically, if control is good, there seems little need for concern, but poor inhaler technique should be considered as a cause of sub-optimal control and the need for a surgery appointment to assess appropriate devices considered. Our trial nurses adopted this approach and, reassuringly, asthma morbidity was similar in both telephone and surgery groups.

The dynamics of telephone consultations are clearly different to consultations conducted face-to-face. They appear to achieve the same functions in less time, probably reflecting a more focused dialogue. Some patients commented that, particularly if their asthma were causing problems, the lack of visual clues may might be a disadvantage.[9] The nurses acknowledged that telephone consultations were easier if they had previously met the patient.

As partners in the management of their own asthma, we should trust patients to make the choice of a face-to-face, telephone (or even e-mail?) consultation appropriate to their need. We must ensure that nurses have the skills to respond to requests for such varied styles of review.[12] By improving access to health care, such an approach offers the potential to reduce the morbidity of asthma for more of our patients. It may also be the only cost-effective way to achieve the 70% review rate set by the new GP Contract. ■

Hilary Pinnock
GP Principal

Correspondence to:
Dr Hilary Pinnock
Whitstable Health Centre,
Harbour Street,
Whitstable, Kent
CT5 1BZ

Tel: +44 (0)1227 594400
Fax: +44 (0)1227 771474
Email:
hpinnock@gpiag-asthma.org

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