Virtual consultations: are we missing anything?

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Abstract
The COVID-19 pandemic has resulted in a rapid transfer of most diabetes care from face to face clinics to virtual consultations, and in general the response from people with diabetes and health professionals is positive. Advantages include saving time, travel and time off work. Disadvantages relate mainly to technological barriers but include increased difficulty in recognising and addressing emotional distress if non-verbal clues are lost.

People report that there is more focus on glucose levels and in this sense the consultations are more ‘efficient’. However, emotional issues may be more difficult to identify, particularly if the consultation is phone-based. Diabetes distress and other diabetes-related psychological issues are well recognised but people may be wary about discussing them remotely with a health care professional. To address this, the consultation should focus on the agenda of the person with diabetes, in particular life events or emotional difficulties that may be a barrier to good glucose control.

Virtual consultations are certain to become a mainstay of future diabetes care but will not be suitable for everyone. First meetings should be face to face wherever possible to establish rapport; continuity of care is essential to maintain this. Access to technology, safeguarding issues and personal preference all influence suitability for virtual follow up. Training should be offered to diabetes professionals to help them get the most out of a virtual consultation. Copyright © 2020 John Wiley & Sons.

Key words
virtual consultations; COVID-19; diabetes distress; technology; continuity of care

This article reflects the content of a webinar entitled ‘Minimising the emotional disconnect during your consultations’, organised by Diabetes Professional Care on 21 May 2020. Some original quotes are included and we have tried to address questions posed online by the audience.

Introduction
There is nothing new about using virtual consultations to replace traditional diabetes clinics; as long ago as 2014 the NHS future plan included digital technology to improve efficiency and allow appointments ‘closer to home’.² In 2017, an article in this journal spelt out the advantages of virtual consultations for diabetes in Newham, a deprived, ethnically diverse part of London with poor health outcomes.³ In short it was a great success for those under 65 but the uptake in older people was poor. (Box 1.)

The process of setting up a virtual clinic normally involves a business case and collaboration with the local information technology department. Anecdotally the process can drift on for several years. Suddenly, everything has changed. The recent COVID-19 crisis has prompted the widespread implementation of virtual clinics with little preparation or experience. Staff in some areas are restricted to telephone consultations, while others use a variety of video technology platforms, in what is now a rapidly evolving field. NHS Digital has sanctioned use of simple methods such as Skype, Facetime and WhatsApp in the short term and, as of May 2020, it has also approved 11 systems for use in primary care.⁴ More specialised systems for secondary care such as Attend Anywhere and AccuRx are expanding exponentially and the BMJ has published guidance on setting up and using virtual systems.⁵ Videos demonstrating how to implement and get the best out of remote systems are available for both patients and professionals.⁶ Diabetes organisations are already turning their attention to how diabetes services will be delivered in the future and virtual consultations are certain to be central to the re-organisation.⁷

Advantages of virtual consultations
During the current crisis, the main priority is to reduce the infection
risk by keeping away from hospitals and clinics. Beyond this immediate advantage, saving time is the most obvious benefit, particularly for those who have to take time off work. There is no need to travel to the clinic, find a parking space or wait in the waiting room. The timing of clinics becomes more flexible and can take place at any time of day. While there may still be a wait in a virtual waiting room, this does not preclude undertaking other activities at the same time.

As in the Newham experience of virtual clinics, people report that the conversation is more focused on the diabetes and hence ‘more efficient’, which may or may not be a good thing depending on the individual circumstances. If straightforward advice for blood glucose management is required, focusing on this is a positive. However, the consultation will be pointless if the person with diabetes feels unable to discuss other matters such as their emotional well-being or the important things in their life, which impact on their ability to look after their diabetes.

For people with type 1 diabetes the opportunity to view downloaded blood glucose data provides the clinician with vital information, but it is important that the person with diabetes is treated as an equal partner in the decision making.

Disadvantages of virtual consultations
There are practical barriers to accessing virtual clinics. A video consultation, which is the best option, depends on both parties (health care professional and person with diabetes) possessing technology skills and equipment. At the other end of the spectrum, access to a telephone, via landline or basic mobile, allows communication, but with significant limitations. Non-verbal clues are not visible when using a phone and as these contribute to at least 55% of communication in a conversation, the clinician’s ability to pick up on signs of distress is restricted. Virtual consultations, either by telephone or by video, are more difficult for both parties if the participants have never met in person and the first meeting should be face to face whenever possible.

In a comprehensive linguistic analysis of video-mediated virtual consultations with participants from four clinical groups (diabetes; antenatal diabetes; heart failure; cancer) in people pre-selected for suitability for a remote consultation, Shaw et al.5 identified three challenges to the process:

• Opening the video consultation (mainly technical issues).
• Dealing with disruption to conversational flow (e.g. technical problems with either audio or video) which affected 27 of the 37 conversations analysed.
• Conducting an examination.

They concluded that although a video link may adversely affect the flow of conversation, people with diabetes and their clinicians were usually able to work together to find a solution. There was potential for limited clinical examination to be undertaken remotely but, in most cases, there was no substitute for a face to face consultation.

Environment
There are advantages and disadvantages to home-based consultations. Convenience is an obvious positive but home can be a distraction, with external events intruding on the conversation, making it harder to focus on the diabetes. Confidentiality may be an issue; people often tell us things they wouldn’t want others to hear and they may be inhibited in their home surroundings. Sometimes they may become emotional and in this sense the consulting room is a safe space. If they become upset at home, they may have no recovery time before they encounter other members of the household.

‘Going to a consultation is a big deal. It involves “lifting the lid” and letting someone analyse every aspect of your life. The clinic is a safe space…with time to get upset and time to recover.’ (Person with diabetes.)

Box 1. Summary of Newham virtual consultation study

- Reduced ‘did not attend’ rate of 13% compared with 28% in live clinic
- Increased productivity with clear savings for people with diabetes (PWD)
- Short appointments: consultant time 9 minutes vs 25 minutes in clinic
- PWDs felt ‘more connected’ and ‘more equal’
- Acceptance rate: age <20 years = 78%, 20–49 = 84%, 50–59 = 64%, 60–69 = 29%
- No deterioration in HbA1c in participants

Identifying and addressing emotional distress in video consultations
Diabetes distress describes the range of emotions people may experience as a result of the burden of living with diabetes and includes such feelings as guilt, denial, anger, anxiety.10 This is associated with higher HbA1c and decreased self-management efficacy and affects 35–45% of people with diabetes.11 Other psychological issues such as depression, fear of hypoglycaemia or eating disorders are also common in diabetes and may require specialist psychological intervention.12 Whether the consultation is face to face or virtual, the health care professional (HCP) has a responsibility to explore the emotional side of living with diabetes and to address diabetes distress. There is evidence that when their distress is acknowledged and discussed, people experience relief, reduced distress and improved glycaemic control.13

People with diabetes may not be aware that their distress is a natural response to the burdens imposed by diabetes and therefore may not disclose their feelings spontaneously. Talking about emotions may be more difficult in a virtual consultation because of a focus on the ‘business’ of glucose management. Non-verbal clues to distress may be lost. This particularly applies to mutual gaze (breaking of eye contact in a face to face meeting may be a sign of distress) and silence may be less effective as a means of providing space to talk if there is concern about technology failure or latency. When this happens both participants may try to fill a silence.9 Health professionals may be reluctant to open a Pandora’s box which they fear they may not be able to contain in a virtual situation.

Asking the person to complete a questionnaire such as DDS2 or PAID in advance of the consultation may flag up emotional distress;
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Even psychologists, who are familiar with addressing emotions, may be less confident about this in remote consultations, though these have been used in psychological therapy for some years. In countries like Australia, where distance makes face to face meetings impossible, virtual consultations are used by default. However, the big difference between diabetes clinics and psychology sessions is that people in consultation with a psychologist expect to be talking about their emotions and come prepared for this, so are more likely to open up. As with virtual consultations in general, the confidence of the clinician increases with experience.

‘I was initially concerned about whether it is possible to contain emotional distress over the telephone (which feels somewhat remote) but in the last eight weeks I have learned it is possible both to open up and to contain strong emotions during telephone conversations. Having said that, some people have said it is harder for them to open up over the phone and generally there seems to have been less uncontainable emotion in the last few weeks.’ (MD.)

Giving people the chance to express their distress in a virtual consultation

Psychologists have produced guidance on conditions required for an effective virtual consultation and this includes the following:

• Mindset matters. Maintain a positive attitude to what can be achieved in a virtual consultation.
• Prepare in advance. Ensure the person knows what to expect (time of consultation/technology to be used/back-up plan if preferred technology fails).
• Ensure the person has privacy.
• Wherever possible, encourage a video consultation with a view of the upper body as well as the face, so that non-verbal clues are more visible.
• Be relaxed. Sit back, do not gaze intently at the screen.

When holding a diabetes consultation, it is easy to log on, have a matter of fact conversation about the glucose measurements and log off again, but this will not address any emotional needs. Lack of time is often cited as a reason for not engaging with people’s emotions but, as the work on diabetes distress demonstrates, if distress is ignored the consultation is unlikely to be effective. The following recommendations should help the person to open up about their concerns:

• Try to establish rapport and put the person at ease at the outset – this is easier if you know the person already.
• If you cannot see the person, be aware that you will be unable to pick up on the non-verbs; listen hard for verbal signs of distress.
• Avoid the temptation to get into the detail of glucose levels immediately – focus on the person, not the diabetes. Use open questions.
• Ask how they are feeling/coping, acknowledge emotions and difficulties and give them space to talk.
• Maintain continuity of care whenever possible – it may be some time before the person feels able to reveal their feelings – they need to get to know you first.
• Consider the option of pre-consultation questionnaires such as the DDS2 or PAID tools to support the identification of diabetes distress.

‘One of my DSN colleagues said “I’m not really doing anything” (i.e. not trying to improve blood sugars) during telephone calls [during the pandemic]. It should always be remembered that people are very grateful for the support they are receiving from HCPs and that attachments with HCPs can help to contain distress in times of upheaval.’ (MD.)

Personal preference

It is crucial that the individual is comfortable with whichever process is selected. There are a number of reasons why people might choose a face to face consultation and these may change with time so a choice should be offered when discussing future follow-up arrangements. For virtual consultations a choice of audio or video meeting should be offered where feasible.

‘In March, when face to face appointments were suspended, about 1/3 of people on my caseload chose to put their case “on hold” rather than avoid of telephone calls. In the last couple of weeks, I wrote to those people to let them know there is no immediate prospect of face to face appointments resuming and some have subsequently contacted me to request telephone support.’ (MD, May 2020.)

Age

The Newham study took place between 2011 and 2014 and the acceptance rate was high among those aged 20–60 years but fell to 29% between the ages of 60 and 70 and to 11% in those over 70. Fifty-two percent of those who declined the offer of a virtual consultation had no access to the internet at home. Since the restrictions brought about by COVID-19, some older people have embraced platforms such as Skype or Zoom to keep in touch with their families, especially grandchildren. Faced with no alternative, older people are now more prepared to keep in contact with their diabetes team using either a telephone or, for those with the technology, a visual display.

Safeguarding

There will be situations where a virtual consultation may put the person with diabetes in a difficult or even a dangerous position. A professional cannot know what is going on off-screen but should pick up clues if the person appears to be uncomfortable. Communicating in advance (by text, email or letter) to invite the person to participate in a virtual consultation at a specified time allows them the option to accept or decline in principle. Each consultation should start with a check that privacy and confidentiality are in place and the
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Person is not vulnerable to anyone within earshot.

Privacy is required. I phone at a designated time so people can arrange for privacy. A number of my clients choose to sit in their car when I phone. This would not be possible with a video call. The majority of my clients have told me they are content with a telephone call. Their reasons for not wishing to “upgrade” to a video call are individual to them and include “I don’t like looking at my own image” and “I would have to put on make-up.” (MD.)

Language barriers

Some webinar participants raised questions about the use of interpreters when there is a language barrier between the professional and the person with diabetes and/or their carer. A number of translation services appear to work well online (Language Line, Clear Voice). Although a bilingual relative may offer help, this undoubtedly raises safeguarding issues.

Serious mental illness and psychological distress

Although psychologists and psychiatrists are using virtual consultations for follow up, this is usually after initial careful assessment face to face. This allows the HCP to establish rapport with the person and to agree whether remote consultations are mutually acceptable.

What does the HCP need to bring to a virtual consultation?

Many clinicians have found the transition to remote consulting challenging because they have to adapt to a new way of working. People using video for the first time may be distracted by their own image on screen and any idiosyncratic mannerisms become more visible to both parties. Video and communication skills training is standard practice in other medical fields, for example general practice, and should be made available to diabetes teams as part of this shift onto virtual platforms. HCPs must give people the opportunity to talk about what is important in their lives and should avoid the temptation to focus only on glucose results.

Structured education online

The benefits of group education for adult learning were established in 200415 and self-management education programmes based on group interaction have been developed for type 2 diabetes, e.g. DESMOND, X-PERT; and type 1 diabetes, e.g. BERTIE, DAFNE. The first three have been adapted for online access and DAFNE is in the process of piloting a virtual course. Any group-based course converting from ‘real to virtual’ will need to consider the impact on group activities and dynamics.

Conclusions

The COVID-19 pandemic has led to a rapid transfer of diabetes consultations from face to face to virtual and it is likely that many consultations will remain virtual once the regulations are relaxed. Technology is developing rapidly and there are a number of advantages to virtual clinics. However, a focus on glucose results and loss of non-verbal clues may make it more difficult for the HCP to pick up on signs of emotional distress. HCPs are not always comfortable when dealing with emotions; they need to understand the limitations of virtual consultations and incorporate emotional well-being into basic (virtual) diabetes care. Time spent on emotions is not time wasted; it can directly impact on efficacy of self-care.

During the webinar, a number of participants referred to the Knuston Hall Diabetes Counselling and Empowerment Course for Health Care Professionals wishing to enhance their communication and patient empowerment skills.16 As a consequence of the COVID-19 pandemic the faculty is exploring the possibility of adapting the course for distance learning.

References

5. https://bmj.com/content/early/2020/05/17/leader-2020-000262 [accessed 3 June 2020].