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SPECIAL ARTICLE

Recommendations of the Valencian Society of Digestive Pathology for the use of telemedicine and non-contact consultations☆

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Abstract The COVID-19 pandemic has meant a qualitative change in the way patients are treated in outpatient clinics. The need to take measures of social isolation as prevention for contagion by the new coronavirus has forced the use of telematic and telephone consultations in most medical and surgical units. The specialty of digestive medicine, due to the characteristics of its patients and frequent support in complementary techniques for diagnosis, is especially suitable for the use of non-contact consultations. In this document a series of recommendations are proposed that can serve as a guide for the establishment or improvement of non-face-to-face digestive medicine consultations.

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Recomendaciones de la Sociedad Valenciana de Patología Digestiva sobre uso de consultas no presenciales y telemedicina

Resumen La pandemia COVID-19 ha supuesto un cambio cualitativo en el modo de atender a los pacientes en consultas ambulatorias. La necesidad de toma de medidas de aislamiento social como prevención para el contagio por el SARS-CoV-2 ha obligado al uso de consultas telemáticas y telefónicas en la mayoría de unidades médicas y quirúrgicas. La especialidad de Aparato Digestivo, por las características de sus pacientes y el apoyo frecuente en técnicas complementarias para el diagnóstico, es especialmente adecuada para realizar consultas no presenciales. En este documento se plantean una serie de recomendaciones que pueden servir como guía para el establecimiento o mejora de consultas no presenciales de Medicina Digestiva.

Introduction

The COVID-19 pandemic has changed the nature of outpatient care. The need to implement social distancing measures in order to prevent the spread of SARS-CoV-2 has required most medical and surgical units to make use of remote and telephone consultations. In a recent document, the Consejería de Sanidad de la Comunidad Valenciana [Regional Ministry of Health of the Valencian Community] recommended using remote consultations in both primary and specialised care[1] and minimising in-person care to the extent possible. Recent outbreaks within the pandemic have heightened the need for these recommendations.

The specialisation of gastroenterology is suited to remote consultations, given the characteristics of its patients and its frequent use of complementary techniques for diagnosis. In addition, large numbers of existing clinical practice guidelines and management protocols provide legal coverage and enable decision-making in various clinical situations. This type of consultation represents important savings in terms of resources and time, especially for patients, who through care of this nature can in many cases avoid visits to hospitals and specialised centres.[2] As many professionals may be unfamiliar with the use of remote consultations, the Sociedad Valenciana de Patología Digestiva [Valencian Society of Gastrointestinal Disease] (SVPD) is proposing a series of recommendations that can serve as a guide for establishing or improving remote gastroenterology consultations.

Remote consultations may be of two types:

1. Between healthcare workers:
   - Virtual interconsultation: a tool for communication between the family physician and the gastroenterologist in which the former asks the latter about a patient and requests advice or guidance on diagnosis or treatment.[3] For this purpose, a pathway can be established within programmes of interconsultation between family medicine and gastroenterology. This modality is currently available in some health departments. The SVPD seeks to support and assist with efforts to render it universal.
2. *Between patients and healthcare professionals*, in which three main remote consultation modalities are distinguished:
   - Telephone consultation: a consultation modality in which the patient is informed of test results or given healthcare recommendations by a physician or nurse, without the patient having to be present for the taking of a suitable medical history and in which there is no need a priori for a physical examination. It is possible to take a medical history, perform disease follow-up and even prescribe drugs through this modality.
   - E-mail consultation: a consultation modality in which the patient can contact the department through a hospital corporate e-mail address that duly ensures data confidentiality and/or in which the patient can receive guidelines for action. Through this modality, the patient can be given answers to questions, education, solutions to administrative problems (electronic prescribing, appointment scheduling, etc.) and documents and/or can request an in-person home consultation due to exacerbation of their symptoms.
   - Video consultation: a remote consultation modality enabling real-time transmission of image and sound data for purposes of remote evaluation of the patient's clinical condition and the results of their complementary examinations.

Recommendations

A series of recommendations on the different types of remote consultations is set out below:

Virtual interconsultation

1. It is recommended that all consultations from primary care to specialised care be made initially through this modality.
2. Responses to virtual consultations should preferably be daily, with delays no longer than two days and never longer than one week.

3. Both the query from primary care and the response from specialised care should be clear and direct and should contain as much clinical information as possible.
4. The gastroenterology department should use a uniform system of response with shared criteria across department members.
5. Primary care specialists should have alternative communication procedures for urgent cases and to clear up any uncertainties. It is recommended that a direct telephone consultation line be available for any cases that require it and that a schedule of preferential care for regular use be established.
6. Virtual consultation should be based on protocols for action and referral developed and agreed upon by primary and specialised care for the most common diseases. These protocols should be periodically reviewed as advances in knowledge are made. Virtual consultation should facilitate interactive communication and should enable, on the one hand, rapid prioritisation of consultations and complementary tests and, on the other hand, suitable management of scheduling in specialised care. It is recommended that working committees with a mix of nursing, primary care and specialised care professionals be formed to develop and implement it. Direct access to tests from primary care should be made available and promoted to limit the need for in-person consultations.

   In these protocols the following should be agreed upon:

a. The basic initial study that should be conducted in primary care.
b. The criteria for referral to specialised care.
c. The diagnostic algorithm with the parts that correspond to primary care and to specialised care
d. The therapeutic algorithm for the most common diseases.

7. A sample joint primary care/specialised care protocol for action can be found in the AEGASTRUM programme of the Asociación Española de Gastroenterología [Spanish Association of Gastroenterology] (AEG) and the Sociedad Española de Medicina Familiar y Comunitaria [Spanish Society of Family and Community Medicine] (SEMFyC) (www.aegastro.es).

Telephone consultation

1. Telephone consultation is an alternative to traditional in-person consultation.[4] If there is the slightest doubt as to whether the patient requires an in-person evaluation, then an in-person consultation should be held. The same applies should communication difficulties arise during the telephone consultation (elderly patient, intellectual impairment, speech or hearing abnormalities, etc.).[5] Should a consultation be held with a family member, this should be reflected in the medical record.
2. It is important to obtain the patient's spoken or written consent to be evaluated through a telephone consultation.
3. It is important to specify in the medical record that the patient was evaluated by telephone and who conducted this remote consultation.
4. The results of the examinations done and the conclusions thereof should appear in writing in the medical record.
5. The main scenario in which a remote consultation takes place is the evaluation of complementary tests and examinations in clinically stable patients.
6. Delays in telephone consultations should be avoided: the patient will be waiting for their physician to contact them, and therefore the pre-established telephone consultation should be neither delayed nor cancelled without prior notice.
7. In a remote consultation, a schedule for upcoming visits and examinations should be established.
8. A pathway for collection of test orders and future visits should be created.
9. After each telephone consultation, it is recommended that the patient be sent written information including a summary of the diagnostic impression, therapeutic indications, a plan for diagnosis and treatment, and appointments for upcoming visits and examinations.
10. It is recommended that tools for assessment of patient satisfaction be available in telephone consultations.

E-mail consultation

1. It is considered necessary to have a department/unit corporate e-mail address used in compliance with data protection regulations to leverage this modality.
2. All departments/units should have a healthcare staff member (a physician or nurse) responsible for answering e-mails within 24–48 h.
3. The consultations best suited to this modality are those that are non-urgent or related to administrative matters.
4. It is recommended that an automatic reply be sent in response to all messages received from patients to confirm receipt as well as specify response times.

Video consultation

1. In cases in which this modality is available, it can be used as an alternative to telephone consultation to improve remote verbal and non-verbal communication with the patient.
2. This modality requires appropriate technical resources; it also requires the physician and the patient to each have a suitable Internet connection.
3. It is important to obtain the patient's spoken or written consent to be evaluated through a video consultation.
4. It is important to indicate in the medical record that the patient was evaluated by video call and who conducted this remote consultation.
5. This modality is most akin to traditional in-person consultation, and it can be used in any type of patient in whom physical examination is not essential.

6. It is advisable to adhere to the established schedule to an even greater extent than in other remote consultation modalities.
7. If limitations in the proper remote evaluation of the patient are detected, then the scheduling of an in-person consultation should be considered.

Conclusions

This document seeks to establish general recommendations for the use of remote consultations and telemedicine in the care of patients with gastrointestinal disease. The development and implementation of telemedicine tools is now a reality in our setting and, at present, the advantages offered by information and communication technology (ICT) must be leveraged to optimise patient management and care. These recommendations are intended to establish a framework of basic standards for the use of these tools, and, at the same time, serve as a foundation for the future use of more advanced tools, such as computer applications for the follow-up of chronic disease. However, there is little evidence on efficiency, patient satisfaction or safety with the use of these tools in clinical practice.[2]

Virtual interconsultations between professionals from different fields decrease numbers of in-person consultations, enhance decision-making in primary care, reduce intermediate steps in patient care and establish elements of consensus and dialogue between primary and specialised care. Virtual interconsultation is considered an alternative care model to respond to increased demand[3]; in this regard, given its advantages, the SVPD considers virtual interconsultation to be the tool of choice in relations between primary care and gastroenterology. Virtual interconsultation breaks down existing barriers to patient access to specialists and has demonstrated its efficacy in different specialised care settings.[6] Generally speaking, user satisfaction in both primary and specialised care is optimal.[7]

The different remote consultation modalities should be suitably combined with in-person consultations in order to offer patients the most efficient and convenient care, with as little interference as possible with their day-to-day and occupational activities. It is also important to establish rules enabling proper use of telephone consultation in place of regular care. It is necessary to reliably evaluate overall patient satisfaction with telephone consultations and determine how this type of consultation should be combined with general patient care in our specialisation. It seems clear that certain types of patients can be followed up by telephone over long periods of time[8]; it also seems clear that many of our patients require in-person evaluation and sustained monitoring. In addition, remote consultations can replace routine follow-up visits that do not require the patient to be present. It is important for the right to suitable medical care to prevail at all times. In this regard, telemedicine may potentially mitigate difficulties in accessing this care under circumstances such as the current circumstances created by the SARS-CoV-2 pandemic.[9] However, good clinical judgement should dictate the nature of the doctor–patient relationship in this and other forms of care. Clear guidelines are needed for the suitable and ethical use of telemedicine, and administration requires evidence for decision-making.[10] There are clear limitations in remote consultations, including certain legal limitations, specifically with respect to two important points: the signing of informed consent forms and the transmission of important information that may not be understood by and may have an impact on the patient. In addition, administration should establish standards for holding these types of consultations and clarify matters such as the method for obtaining patient agreement, whether such consultations must be recorded and the method for auditing the quality of and satisfaction with these consultations on the part of not only patients but also the professionals who hold them. Under these special circumstances, we must take advantage of the opportunity to explore new approaches to the doctor–patient relationship, always with a view to providing patients with the best care. Scientific societies have an obligation to facilitate, support and guide the adoption of the most suitable measures based on high-quality scientific evidence.

Finally, it would also be a good idea for gastroenterology departments and units to be equipped with tools to improve patient access to their portfolio of services. Healthcare administration must provide information technology tools and tools for access to patient medical information. The SVPD recommends that gastroenterology units and departments have their own web page providing information to patients and offering access to downloadable recommendations, informed consent forms and other types of documents. These web pages also serve as tools for patients to get to know department staff. The SVPD will provide resources that gastroenterology departments and units can link to from their own web pages.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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