Virtual visits in palliative care: about time or against the grain?

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ABSTRACT

While the additional value from adding the option of virtual visits is not in question, numerous issues are raised around how to decide between face-to-face and virtual visits in individual cases and how best to set up such provision within an organisation. With only limited palliative care-specific literature and no time to set up and evaluate pilots, we had to get on and set up a prototype 'virtual visits' model, retro-fitting guidance and a supporting ethical framework. We looked at the issues spanning clinical, ethical and logistics domains; identifying areas of benefit as well as drawbacks, some specific to the rushed implementation because of COVID-19's infective risks and the 'rules' of lockdown, but many are generic areas to help guide longer term service design. Unsurprisingly, it appears clear that a 'one-size-fits-all' mentality is a poor fit for the individualised needs of the heterogeneous palliative care population. Virtual visits have great potential even if they are not a panacea.

INTRODUCTION

What is the place for video-call patient assessments in the current and future delivery of palliative care services in the community? Traditionally hospice community teams have based their specialist palliative care support around face-to-face assessments in patients' own homes, supplemented by planned and when needed telephone calls. More recently, outpatient assessments have become more common, though usually only suitable for patients earlier in their 'life-threatening' disease trajectory.

However, while the world has embraced digital solutions and virtual visits have an appeal both to patients as more convenient, and to palliative care providers as a more sustainable way to care for more patients,[1] it has taken the COVID-19 pandemic to force an 'instant' culture change in our service. Virtual visits now form the majority of our hospice community team's activity. Previously, pride in face-to-face interactions and achieving a level of personalised care not possible through most healthcare systems has potentially held back community palliative care providers from embracing technology-driven contacts. However, reducing income generation and escalating staff costs mean this has become a luxury charitably funded hospices can no longer afford.

While the additional value from adding the option of virtual visits is not in question, numerous issues are raised around how to decide between face-to-face and virtual visits in individual cases and how best to set up such provision within an organisation. With only limited palliative care-specific literature and no time to set up and evaluate pilots, we had to get on and set up a prototype 'virtual visits' model, retro-fitting guidance and a supporting ethical framework. We looked at the issues spanning clinical, ethical and logistics domains; identifying areas of benefit as well as drawbacks, some specific to the rushed implementation because of COVID-19's infective risks and the 'rules' of lockdown, but many are generic areas to help guide longer term service design. Unsurprisingly, it appears clear that a 'one-size-fits-all' mentality is a poor fit for the individualised needs of the heterogeneous palliative care population. Virtual visits have great potential even if they are not a panacea.

FINDINGS

We identified a range of influences, relating to patient/family/all stakeholder interests that would favour a decision for a virtual visit (table 1). We also identified a range of influences, relating to staff and organisational agendas that would favour a decision for a virtual visit (table 2).

In parallel, we identified a range of influences, relating to patient/family/all stakeholder interests that would favour a

Table 1

Stakeholder	When to favour virtual visits
All stakeholders/ society	► When face-to-face is not essential; to fit COVID-19 'social distancing'/lockdown rules; a virtual visit eliminates infection risks/COVID-19 fears for all stakeholders; patients/family, staff member/their family and colleagues, subsequent patients and the public. ► More responsive; when an urgent 'immediate' review/decision is warranted, for example, Advanced Care Planningincluding Cardiopulmonary Resucitation/Do-Not Attempt Cardiopulmonary Resuscitationif it feels less appropriate to do by phone, and would introduce a delay/require more time to visit in person. ► When input is needed from people who can help inform/provide support, but are unable to be there in person in the home (because of COVID-19 social distancing, because at work, or not local/live abroad): – Relatives/friends. – Other relevant Health care professionals. ► When more control over timing is wanted that is, any contributor can instantly end the video-call at any point—by contrast, not always as easy to leave/get staff member out of house, and there are fewer unpredictable delays, for example, professionals stuck in traffic on way to face to face visits. ► To prevent unnecessary use of Personal Protective Equipment (COVID-19).
Patients/families	► Personal choice; when a virtual visit is 'preferred' to face to face—for any or no reason. ► When the convenience of a virtual visit is preferred, for example, over travelling to/waiting at an Out Patient Department assessment or when do not want to get house ready for visitors. ► When would prefer the privacy, that is, no visitors in home. ► In place of phone assessments, for more sensitive conservations/situations and to build rapport, when predictably need the enhanced communication from staff member's facial, non-verbal cues. ► For lip-reading patients to alleviate need of a mask/when phone will not work. ► When 'unhappy' for any additional infective risk for themselves or their household, despite staff being 'allowed' within guidelines to visit. ► When happy to put in more effort than would be required for a phone assessment (eg, prepare house shown on video, and own physical/ body image).

decision for a face-to-face visit (table 3). We also identified a range of influences, relating to staff and organisational agendas that would favour a decision for a face-to-face visit (table 4).

DISCUSSION

Workforce considerations when working from home

During the COVID-19 outbreak some staff have been required to continue their professional roles and responsibilities remotely, outside of hospice grounds. For much of the country the question has arisen—can 'shielding' people continue to work from home as effectively after the pandemic 'isolation phase' has passed? For healthcare this question is even more acute as not only does working from home achieve goals such as not over-crowding the work place but more particularly it protects the more at-risk members of workforce from contracting and/or spreading communicable conditions. This creates a dilemma as working from home, using virtual visits appears safer, but it does then put a greater burden, greater risks on those not working from home; who to offer face-to-face visits; who will need to see patients with a greater relative frequency. When considering this, we should remind ourselves that equity in approach is not the

Table 2

Stakeholder	When to favour virtual visits
Staff	► In place of phone assessments, as more comprehensive: – For more sensitive conservations/situations and to build trust/rapport, when predictably need enhanced communication using patient's facial, non-verbal cues. – To allow more 'on examination' assessment, for example, check for jaundice, twitching (opioid toxicity) and so on. ► When a planned follow-up assessment, that is, after a 'new patient' face-to-face visit. ► When working from home: – Saves time/money/stress as not commuting, while can still work when 'shielding' at home (COVID-19). – More empowered—work more autonomously, developing professional independence. ► If patient's home is too distant/difficult to access (outskirts of catchment or remote, eg, island on Thames). ► If does not or dislikes driving; removes inconvenience of finding right flat/house, busy traffic, parking problems. ► To improve time management; more likely on time/less of imposition if late. ► When needing to avoid the higher personal safety risks linked to some home visits in some areas at some times of day/night. ► When lacking the necessary resilience for a more intense home visit.
Organisations	► When very limited/no Personal Protective Equipment is available (COVID-19)—to keep some service running. ► When very limited staffing numbers (sickness, COVID-19 or not) and/or unusually high demand for hospice community advice/support (again COVID-19 or not); removes travelling time and time accessing/donning and doffing PPE (COVID-19). ► When need more people to be working from home (as lack of space at base). ► To aid recruitment; when able to recruit more people only wanting to work from home/non-drivers. ► When want more productivity; virtual visits are a more cost-effective and more scalable approach, to address current shortfall in hospice coverage, while considering that virtual visits may be less cost-effective than phone assessments.

Table 3

Stakeholder	When to favour face-to-face visits
All stakeholders/society	► When human contact is needed/wanted—unique value of face-to-face visits. ► To avoid technological issues; when IT is absent/following frustrating IT failures—inadequate skills, equipment (software, hardware) and internet connections at both ends. ► When physical examination is needed for diagnostic reasons, for example, evaluate a pleural effusion or neurological examination to exclude metastatic spinal cord compression or checking for a bladder when someone's in retention. ► Face-to-face visits can still happen, as before, provided that the appropriate Personal Protective Equipmemt is available and used. ► Keep critical mass of face-to-face visits to demonstrate value, to ensure we do not lose the current level of specialist palliative care Multi-Professional Team face-to-face visiting.
Patients/families	► Personal choice; when a face-to-face visit is 'preferred' to virtual—for any, or no reason. ► When more enhanced communication is needed, to build trust/rapport and benefit from the better sensing of Health Care Professional empathy when face to face. ► When physical or mental condition hinders remote communication, for example, hearing impairment, confusion, use of assisted communication devices, for example, eye gaze. ► When not comfortable with video-call technologies. ► When never seen by any doctor/nurse in person for this illness/issue—when all HCP services delivered by video, the novelty may wear off—leaving patients increasingly desperate to see someone in person. ► When patients want privacy but they would need physical or IT help to establish/maintain a video call—or even if happy to be supported, when no help is available in the patient's home, a virtual visit simply not possible. ► When therapeutic value of physical examination is necessary (despite being highly skilled communication, 'touch can replace 1000 words'). ► When not wanting to use their mobile data allowances if using a smartphone.

same as equality. Each individual in a workforce has greater or lesser risks attached to their health, their personal contacts and so where possible, must be treated individually. In reality the number of staff who must 'shield' under Public Health England guidance[2] is relatively low. However, to avoid feelings of isolation among shielding staff or feelings of heightened anxiety among non-shielding staff it may be necessary to carry out more 'catch up' meetings with line managers. Our hospices have taken additional measures to help remote workers take part in professional meetings and teaching sessions, and extra support, for example, two times per week meditation sessions, has been provided, open to all staff, remote and otherwise.

An additional consideration when using remote working more widely is whether rotation of staff so that some may be asked to work from home at any one time, could create a more efficient use of resources. If working from home is able to support staff that have other responsibilities, for example, child-care this may lead to a greater pool of available staff than previously available. The counter to this will always be whether staff that may have other duties and distractions at home are able to work as well as they would in a workplace and whether they are able to maintain confidentiality and similar concerns.

It is acknowledged that the healthcare workforce is an organisation's greatest resource and expense. In using individuals in a manner that more effectively caters for their needs we are able to provide solutions to problems existing prior to the COVID-19 pandemic. These alternative ways of working may include rotating staff on to shifts at home, greater use of webcasting when delivering internal teaching, early identification of remote appropriate tasks, for example, routine follow-up or discharge from service discussions. The drawbacks are identified in part in the tables, but may include additional concerns around resource allocation of electronic devices, greater time burdens on line managers needing to follow-up a greater remote workforce and a feeling of dissociation from the workplace for those having to spend more time away from face-to-face contact with colleagues.

Repercussions within the community sector

Many of the points made earlier are natural extensions of our reach in to the community, whether from a staff or a patient view point. It is important to note that the holistic care of the patient and family is considered, there are many people for whom hospice input in the form of complementary therapies, day unit visits and bereavement support is vital. At our hospices we have noted a move for therapists and volunteers who would have previously delivered these services in person, to do so over digital media. Classes that have been previously face to face only are now virtual and with significant numbers in regular attendance. Some examples of these classes include: choir singing, meditation and particularly popular: yoga. The possibilities for these are tremendous and include the potential for engagement with different groups such as the elderly and lonely through services that wouldn't normally have had capacity for them.

Limitations of a review of virtual visits in COVID-19 times

We set out to collate the key issues facing hospice-based community teams having to 'choose' between either a face-to-face assessment or a virtual visit during the COVID-19 pandemic. We knew this was not straightforward; even with the full availability of Personal

Table 4

Stakeholder	When to favour face-to-face visits
Staff	► When staff individually/collectively struggle to adapt from face-to-face to virtual visits, feeling professional unsure/unsafe in their clinical practice and/or inadequate job satisfaction—virtual visits will not be wanted by all, as disruptive to usual working style. ► When offering a first visit, complex scenarios or when a rapidly or unexpectedly changing picture, or when phone and virtual visits have failed to address issues adequately. ► For those professional groups that are more likely to struggle to impact if working remotely for example, doctors, practical care nurses and physiotherapy teams, as opposed to 'talk-based therapies', for example, bereavement support teams. ► Visit in person to avoid introducing a dilemma/self-doubt—moral distress could increase if staff suspect that they may not be visiting face-to-face only because of (1) self-interest; as easier/safer (removes own fear of COVID-19) or (2) rule; disproportionate/blanket response 'not visiting patients in person' without calculating the current risk/the need for face-to-face input or (3) when need for a visit is not clear, balanced decisionbut enough to question our decision making/equity—acknowledging there's always uncertainty, are we visiting that patient at home because of a 'real' need or 'those who shout loudest'? ► When need to offer the additional support, in person, if a predictably 'difficult' interaction for example, breaking bad news. ► When we feel we need to see all those present in the home, so we can better gauge reactions and not miss other's cues/distress. ► When need to gauge the suitability of living arrangements social circumstances, that is, potential difficulties in the home, for example, no heating, dangerous stairs, overcrowding, no working lifts and so on. ► For staff working from home, risk of being socially isolated/disconnected could be mitigated in part by face-to-face visits; get out the house, interact with others, be more mobile/not 'stuck at desk'. ► When staff lack the IT skills/adequate IT equipment at home, to mean they can carry on/only function face-to-face; exposes those staff that lack IT skills. ► When we need to prescribe/change administration charts. ► When need to write in patient-held records and/or leave physical items in house; information booklets, reminders/instructions/notes for patient and relatives or other Health Care Professionals. ► When we need to check on/look for missing medications, or find the Do Not Attempt Cardiopulmonary Resuscitation form to check it/update it and so on. ► If staff working from home, but their environment is not conducive to 'professional' video calls disruptions due to needs of other family/residents happily interrupting—creating an incongruous tone.
Organisations	► Perception; if suspecting that patients/primary care colleagues (customers) are feeling 'short-changed' by hospice—feeling missing out/as expecting face-to-face visits; hospice's services could appear to being 'down-graded' (reputational risk for hospice—if using video calls for the benefit of organisation, not the individual patient). ► Reality; if concerns of a harmful drift to default of virtual visits, such that missing when needed face-to-face visits, reducing quality and effectiveness of service. ► When staff are struggling to adjust from face-to-face to remote working—virtual visits have been rushed in (enforced by COVID-19), without usual preparatory time, energy and planning; though can be sustained in short term, it is a 'bigger ask' for staff to maintain this, particularly if less professionally rewarding for some. ► If begin to lose key experienced staff who 'require' face-to-face visiting in their roles—current employees match established roles—skill-set and job satisfaction is different for face-to-face care from a team hub, if compared against video assessments from home—it may not feel as rewarding, may not match what 'signed up' to do. ► If positivity of 'honeymoon period' wanes, and longer term drawbacks, not yet visible, become apparent for patients/families, staff, organisation. ► If staff resilience drops in line with shift to virtual visits; driving between visits allows refection/preparation (on both professional and human levels), if go from intense video call to intense video call, may miss a vital reboot. ► If staff are working from home this removes the unsung benefits of the commute … the mental reset when driving to and from work, and the loss of distinction between home and work life, loss of boundaries, no escape (simultaneously lonely and claustrophobic)—and reduces the quality of clinical care (as removes the vital informal colleague support/access to rest of Multi Professional Team) and also risk to quality of self-care of staff. ► When need to 'make connection' remotely—patients/relatives may not realise which HCP/which service is providing the specialist palliative care/making a difference (may impact on hospice fundraising).

Protective Equipment a face-to-face assessment still presents additional risks—for that patient, subsequent patients, that staff member, their colleagues and wider society. While a virtual visit, though often suitable, could leave questions for hospice staff around not 'putting the care of the patient first' in understanding that a remote assessment will be clinically inadequate on a sufficient number of occasions. Instead of the patient, the priority for staff could become: themselves, their family, other patients, their colleagues or society.

We wanted our review to inform clinically appropriate, sufficiently safe and equitable guidance to help hospice staff making decisions at the bedside (or at a personal computer screen), even if just through the explicit provision of the under-pinning issues/principles. Unsurprisingly, the already-obvious issues were multiple and broad ranging, and then the more we looked, the more issues that emerged. We found ourselves exploring a multitude of themes surrounding virtual visits:

- A mix of theoretical issues and actual first-hand feedback, both positive and negative.
- COVID-19-specific reasons for virtual visits as well as the generic reasons for virtual visits.
- The merits/risks of virtual visits per se, merging with the broader merits/risks of working from home.
- The now 'known' short-term successes, as well as the just-emerging/potential longer term drawbacks of virtual visits.

- A diverse spectrum; from virtual visits only being used as an extra option (eg, only when bringing specific benefits or as an 'upgrade' to a telephone call) to virtual visits being the replacement for face-to-face assessments.
- The incommensurable, conflicting patient/family/staff/organisational/societal agendas.
- The different starting premises behind the observed support for virtual visits:
  - Guidance-based argument; because we cannot offer face-to-face visits (duty; with COVID-19 rules only allowing 'essential' contacts).
  - Clinical argument; because a virtual visit is all that's usually needed (beneficence; appearing as effective, 'good enough').
  - Infection-control argument; because we want to be safe (non-maleficence and consequentialism; to not put staff/others at risk).
  - Consumer argument; because a virtual visit is wanted (respect for autonomy; patient/staff choice).
  - Economic argument; because our future employment/hospice success depends on it (distributive justice and consequentialism; virtual visits are a more scalable and more sustainable model of care).
  - Pragmatic argument; because virtual visits will usually be possible even if acknowledging they will not be always be the most effective form of support (practicalities; how many people must miss out/be disadvantaged to matter?).
  - Values-based, individualised argument; because tailored, case-by-case decisions are best (virtue ethics; the most worthy thing to do at that point in time for that scenario, considering all relevant factors) despite the inherent subjectivity and lack of direction for less-expert, less-confident decision makers.

With hindsight, these are inevitable limitations of a paper looking at the role of virtual visits in COVID-19 times, there are many competing interests—or looked at the other way, this is the strength of this article, as it reveals the complexity of the predicament that we found ourselves in. This then serves as a warning against knee-jerk decisions around the wholesale re-design of hospice community services, which could quickly appear hasty and/or inappropriate. Regardless, when the need for black-and-white guidance from our colleagues could not be higher, our final position of 'it depends' and 'make an individualised, nuanced decision' having considered a 'huge range of factors', appears the 'right' approach, although we acknowledge that it fails to serve the desire for a quick and easy answer to these questions. We hope that in highlighting the complexity of this situation we will support decision makers in taking a more balanced and cautious approach as services adjust to new forms of working.

CONCLUSION

Remote assessments have been used widely and are felt to have been very successful through this period of rapid change to service delivery triggered by COVID-19. They have maintained contacts with the majority of patients, in a safe and effective way with face to face options becoming the exception rather than the rule. However, their long-term use and triggers for different modes of assessment needs to be better evaluated in the palliative care setting. Has the use of remote consulting only been effective because there has been no better alternative during the pandemic or has this simply been an expedited process of both practical and cultural change in working practices that was bound to happen over time anyway? We feel that we have an idea of the positive contributions that remote consulting has made but are there more complex issues with the long-term use, some of which have been laid out in the tables.

The changes we have implemented in the hospices are aligned to those recognised by both professional bodies including, for example, the General Medical Council[3] and Royal College of Physicians[4 5] and to the National Health Service (NHS) larger scale organisation goals as set out by NHS England,[6] NHS Digital[7] and NHSx.[8] However, they need to be contextualised in the hospice setting, taking into account localised community needs and those of the organisation, including the unique holistic offering that hospices provide to patients and families.

As with any service striving to provide individualised care there needs to be a range of approaches for assessment, treatment and support in the armoury. Remote consulting has elevated its status in this list but must be used appropriately and both the patient and workforce considerations taken in to account.

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