EDITORIAL

The algebra of clinic and telephone medicine

Michael Leveridge, MD, FRCSC

Department of Urology, Queen's University, Kingston, ON, Canada, and CUAJ Editor-in-Chief

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I have developed a small habit at the end of many clinic visits. After rounding off the visit with, "Does that sound reasonable?" I stand up, say, "Nice to see you" or "Take care," and tap the patient on the knee or shoulder with the paper chart as I head to the door. This has become automatic, and though it may waft a whiff of paternalism and oh so "art of medicine" affectation, it is not an act. It feels like earnest relationship-building, the shared experience called rapport.

When the bustling outpatient clinic era ended abruptly in March, these interactions vaporized with it. The move to care-by-telephone was accompanied by much ink to aid our navigation, speaking almost exclusively on how to manage GU presentations and pathology (*www.cua.org/UROpedia;* search: COVID). Some seven months later, as we re-integrate patients into the clinic, we face the choice of reverting to the familiar before times or maintaining some proportion of virtual care. It's obvious to me that this fraction exceeds zero; enter the algebra of choosing telemedicine vs. face-to-face visits.

Beyond logistical bafflement, the obvious victim of urology by telephone is the physical exam. Outside symbolic bond-making, the hallowed "laying on of hands" is amenable to the familiar math of sensitivity and specificity, and occasionally of unambiguous need. In the first instance for example, we can find that a suspicious digital rectal exam increased clinically significant prostate cancer diagnosis proportional to PSA and use this information in deciding the utility of the test in a given man.[1] In the second, we agree there is no substitute for *always* assessing a patient with a scrotal mass in the flesh.

Another consideration is also obvious and roughly quantifiable — the literal burdens of travel and time on patients attending our clinics. Gas prices, parking prices, half-days off work, and advocates called to duty; we can think easily in dollars and minutes. It has always felt problematic to me when a patient makes a 120 km round trip (never mind a 500 m walk) to discuss an ultrasound performed two weeks prior regarding a surgery performed four years prior. We can work outward from such an example, and factor in the rising relative impact on those of limited socioeconomic status (SES), to see the burden of a doctor's visit for many patients. In any case, a patient's time is almost never best spent in a car or waiting room. On the other hand, accessibility issues make computers and the telephone impossible to use effectively for some patients; our patients with physical or cognitive disabilities, and those with whom we have a language barrier need advocates, interpreters, or office visits.

Now back to the nebulous and less quantifiable content of our patient visits. At first blush, it seems obvious that the connection of the in-person visit blows the cold informality of the telephone out of the water. A handshake, subtle shifts of vocal cadence, tone and body language, proffered tissues, heartening and reassuring tractor-beam eyes like Seinfeld's The Wiz (nobody beats him) cannot be replicated remotely. But like a crisp dream escaping memory, these don't obviously withstand scrutiny. We all project warmth, authority, acumen, and wisdom differently in face-to-face encounters, but would we *really* use these to imply one of us is better than another at clinical medicine? And surely, we represent some facsimile of our in-person selves over the phone, so the baseline we might compare to the quality of in-person care is hardly zero. We're not comparing excellence with dismissiveness, but our normal selves to a slightly hampered version of the same.

The data available on the "feel" of clinical encounters is tough to unpackage. There is a literature on bedside manner, on style of dress, and warmth of delivery, but it is most often performed either through simulation with wide distinctions in verbal tone, or retrospectively and so colored by the type of news delivered rather than the mode of delivery (that is, bad news is remembered badly and vice versa). Even the question of delivering bad news, where intimacy, time, and empathy are critical, is not impossible over the phone. Clinicians can develop scripts for use when planning visits that

may involve bad news by suggesting patients prepare their space and gather advocates and supports just in case.[2]

I like seeing urology patients. The phrase, "I really like the patient population," has 100% penetrance in residency interviews because it is true. I like silly metaphors, gesticulating and drawing bladder schematics, and seeing assent in someone's face when I ask, "Does that sound reasonable?" I feel like I lose something important about who I am as a doctor when I'm on the telephone. I *really* like telephone medicine though, despite the squall of paper and the curious persistence of a cord on the office phone, bafflingly chromosomed around invisible histones. We now know from this month's *CUAJ* paper by Turcotte and colleagues in Quebec that urologists perceived remote care to be sufficient for complete case management in 2/3 of 1700 visits.[3] We know as well that 96% of patients viewed their telephone visits favorably in a recent survey.[4] We have a logical case that ongoing telehealth care is a desirable future outside of pandemic-related restrictions.[3]

It is clear there are cases when the patient's needs are best served by convenient telehealth. Though it may ring cold, fundamentally, our clinic visits are transactions with our patients. The majority find their way into our practices through the caprice of geography and call schedules. Proud as we should be about our clinical skills and rapport-building, we should understand that very often patients don't pick us at all, and when presenting with a stone or incontinence or an elevated PSA, they may not care who they "get," just that they "get" someone in a reasonable time frame. We may find the comforts of years of clinic workflows difficult to wish to reel back in, but it is clear that clinic life should not return to normal just for the urologist's sake.

So why algebra again? Because it's the fabric of considered decision-making, and the above considerations collapse into a mental equation we can use when deciding how to meet a patient. For a given patient visit, take the importance of the physical exam, add the effects of the delightful face-to-face you and the patient's accessibility limitations. These are variables that favor a clinic visit. Now take the costs to the patient in money, time, and convenience, multiply by an SES factor and add the skills of the charming telephone you to assemble your telemedicine argument. It may be an immediately lopsided equation, in which case, you have clear case for your recommendation. In a tossup, you can use your experience, your existing relationship, or (are you sitting down?) you can just ask the patient.

References

1. Halpern JA, Oromendia C, Shoag JE, et al. Utility of digital rectal examination (DRE) as an adjunct to prostate-specific antigen (PSA) in the detection of clinically significant prostate cancer. *J Urol* 2018;199:947-53. https://doi.org/10.1016/j.juro.2017.10.021
2. Holstead RG, Robinson AG. Discussing serious news remotely: Navigating difficult conversations during a pandemic. *JCO Oncol Pract* 2020;16:363-8. https://doi.org/10.1200/OP.20.00269
3. Turcotte B, Paquet S, Blais A-S, et al. A prospective, multisite study analyzing the percentage of urological cases that can be completely managed by telemedicine. *Can Urol Assoc J* 2020;14:319-21. http://dx.doi.org/10.5489/cuaj.6862
4. Locke J, Herschorn S, Neu S, et al. Patients' perspective of telephone visits during the COVID-19 pandemic. *Can Urol Assoc J* 2020;14:E402-6. http://dx.doi.org/10.5489/cuaj.6758

Correspondence: Dr. Michael Leveridge, Department of Urology, Queen's University, Kingston, ON, Canada; Michael.Leveridge@kingstonhsc.ca