The Use of Telephone Consultation in Primary Health Care During COVID-19 Pandemic, Oman: Perceptions from Physicians

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Abstract

Introduction: To enforce physical distancing measures during COVID-19, Telephone Consultation (TC), a form of telemedicine, was initiated as an alternative technology to face to face consultation in primary health care (PHC) in Muscat, Oman. This study aims to explore the perceptions of physicians about the use of TC with respect to process of implementation; challenges and limitations; lessons learned and the way forward.

Method: This was a qualitative study using interpretive phenomenological analysis. Physicians who were actively conducting TC in PHC were purposively selected and individually interviewed until no new responses were obtained. All interviews were audio-recorded, transcribed verbatim, and analysed using thematic analysis.

Results: Twenty-two participants were interviewed. Participants were predominantly females (98%) and qualified family physicians (77.3%). Overall, all participants accepted this initiative as a possible method to continue health services during COVID-19. Perceptions about the process of implementing TC in PHC were themed to; inconsistent implementation of the guideline, variability in roles and responsibilities, and Semi-supportive infrastructure. Five themes were identified as challenges and limitations: limited staff training on TC, suboptimal patient-physician interaction, insufficient technical support, ensuring privacy, and confidentiality of the communication, and different ways to document the TC. Physicians expressed that TC worked better in following COVID-19 cases, chronic conditions, and, in general, simple cases. They also expressed a reduction in the crowdedness in PHC facilities and the risk of acquiring COVID-19 and other types of infections. Tailoring the existing structural clinical setting, capacity building activities on the use of TC, and improving the quality of the TC are viewed as essential steps for the future sustainability of TC in PHC.

Conclusion: Given the exceptional situation of COVID-19, the current evidence suggests that the use of TC in PHC, especially in chronic cases, is promising. However, measures including training of staff, improving the structural setting, and selecting suitable cases for TC are the main elements for high quality and sustainable TC services in PHC from physician’s perspective.

Keywords
telemedicine, primary health care, COVID-19, experience, physicians, qualitative

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Introduction

It is without doubt that COVID-19 pandemic has reshaped how healthcare services are provided to patients worldwide. As a response to the pandemic and complying with the social and physical distancing, telemedicine has emerged as an essential technology to bring medical care to patients. It is described as the delivery of medical health services such as consultations, review of prescriptions and appointments, etc. at a distance.1

The use of this technology has been a cornerstone to prevent the transmission of the virus and protect both patients and services providers. More importantly, in view of the

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global shortages in personal protective equipment (PPE), it is wise to manage cold cases at a distance via enforcing this technology.2

Telephone consultation (TC) is considered the most common alternative form of telemedicine to face-to-face consultation in clinical settings.3 However, there are several drawbacks of telemedicine. It is a characteristic of TC to focus on the presenting symptoms and often patients are not comprehensively assessed.4 Other drawbacks for the use of telemedicine include lack of visual cues and the examination part of the consultation.5 In addition, there are issues regarding the relationship between physicians and patients, issues concerning the quality of health information, and organizational and bureaucratic difficulties.6 Nevertheless, TC thrived during COVID-19 pandemic due to its ability to deliver the required healthcare service to patients at a distance, especially for high-risk patients. Public administrations around the world, such as Australia, the USA, and the UK, were investing in TC to manage COVID-19, with the specific aim of reducing the volume of patients interacting with emergency departments and, in turn, halt the spread of the virus.7 The NHS in the UK provided online consultation in designated areas to avoid patient visits to general practitioners.8

In Oman, it was necessary for policy makers to respond rapidly to the pandemic by considering several measures to ensure risk-reduction of spreading the infection among patients visiting primary healthcare (PHC) facilities. Since the introduction of TC, in a formal way is relatively new, it was important to evaluate this new initiative. In 2014, a qualitative study by Wade et al,9 reported that clinicians’ acceptance was the key for sustainable telehealth services. This study, therefore, aimed at exploring the perceptions from physicians with the implementation of TC service in PHC in Muscat, Oman, with respect to

- Process of implementing telephone consultation
- Challenges and limitations
- Lessons learned and the way forward

**Method**

**Setting and Conceptual Framework**

According to Alma-Ata declaration, primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technologies which is universally available with affordable cost.10 Primary health care in Oman is the frontline of health care in the country. It responds to a variety of health-related issues and it is available to all citizens almost free of charge. It was structured to deliver its services to the community as service packages which include; general, diabetic and hypertension, asthma, screening, ante-natal and post-natal, infertility, paediatric, immunization, elderly care, pre-marital counselling, congenital screening and counselling, dental, mental health care, laboratory, and radiology services. This study was conducted in PHC institutions (health centres) in Muscat Governorate from 1st of May to 31st of June 2020. All telephone consultations were carried out during working hours, both morning and afternoon shifts, in health centres that were assigned by the department of PHC, in Directorate General of Health Services (DGHS), Muscat, to be responsible for providing telephone consultation service during COVID-19 pandemic. This qualitative research is based on an interpretative phenomenological analysis (IPA) method of understanding an individual’s perception of a particular topic using purposeful sampling.11

**Participants**

Physicians were purposively sampled. Those physicians who conducted telephone consultations by themselves on a regular basis from the time of initiating the telephone consultation service were eligible to be interviewed. The list of physicians involved in telephone consultation was obtained from the department of PHC in DGHS-Muscat. The process of enrolling the participants for the interviews started by contacting the physicians through their personal phone number to filter them and only those who were eligible to be interviewed were selected. Verbal consent to participate in the study was obtained at the same time. Physicians not working in PHC institutions or not actively involved in conducting the telephone consultations or refused to be audio-recorded for any reason were excluded from the study.

**Methodological Approach**

Different locations and timings were utilized to conduct the interviews based on the convenience of the participants. All interviews were conducted in PHC facilities (health centres). A private room was selected to conduct the interview, which lasted approximately 1 h. To ensure the implementation of COVID-19 precautionary measures, around 2-meter distance was maintained between the interviewer and the interviewee and both wore face masks during the interview. A mobile audio record application was used to record the interviews. All interviews were conducted in English. Verbal consent was obtained again at the time of the interview after explaining the aim and objectives of the interview and the purpose of audio recording. It was explained to the participants that all information would be anonymously recorded, and all audio records would be deleted by the end of the study.

**Interview and Topic Guide**

Semi-structured face-to-face individual interviews were conducted at the physicians’ workplace. The interview
Table 1. Semi-Structured Interview Topic Guide Questions.

| Opening questions | How many years have you been working as a physician?  |
|-------------------|------------------------------------------------------|
|                   | What is your job title?                              |
|                   | How many telephone consultations have you conducted yourself since starting the telephone consultation service? |
| Role              | What is your role in telephone consultation?         |
|                   | Is there anyone else involved with you in conducting the telephone consultation? If yes, who are they and what are their roles? |
| Process           | How did you come to know about the telephone consultation service? |
| Physician-patient interaction | How did you schedule the telephone consultation in your health centre? |
|                   | What are the issues you faced when you tried to contact the patients or when patients tried to contact you? |
|                   | How did you make sure that you were talking to the right patient? Are you satisfied with the current practice? Would you elaborate? |
| Quality of care   | What is the documentation process of telephone consultation in your workplace? |
| Content of the telephone consultation | What are the potential risks to patients when managing them through phone? |
| Others            | What were the benefits and difficulties of conducting the telephone consultations? |
|                   | Were there situations in which the technology failed you? Would you elaborate on that? |

questions focused on 5 components: process of conducting telephone consultation, patient’s safety and quality of care, content of telephone consultation, impact on workload, and addressing technical issues. Other information obtained from the interview were gender, job title, years of experience as a medical doctor, and number and type of telephone consultations. The interview was carried out first with 4 physicians to ensure that the questions are understandable and covered all components of the interview. Two interviewers, medical doctors, carried out the interviews. Audio records were reviewed to ensure absence of potential interviewer bias and to create the transcript. Physicians were interviewed one by one until no further information was obtained from their answers based on the concept of saturation. Since all primary health care institutions are providing the same service, maximum heterogeneity of participants was maintained (Table 1).

Analysis

Audio records of the interview were transcribed by (SA) and (HL) and rechecked by the research team for accuracy. Inductive thematic analysis was performed based on the aim and objectives of the study. The transcript was reviewed by (SA), (JM), (AA), and (HL) several times during the analysis and the data was coded and categorized according to the emerging themes. The themes were rechecked by the authors independently. The final themes and subthemes were revised by a qualitative researcher (TA). Table 2 shows themes and subthemes used for thematic analysis.

Each subtheme is described and exemplified with extracts from the interview to reinforce the results. The transcript was revisited whenever conflicts in the interpretation occurred among the authors and an agreement was reached after extensive team discussions.

Ethical Consideration

Ethical approval for the study was obtained from the regional research review and ethical committee in Muscat, Oman.

Results

Twenty-two primary health care physicians were individually interviewed in a three-week period. All of them were actively involved in conducting telephone consultations at the time of the interview. The majority (n = 17, 77.3%) were qualified family physicians and the rest (n = 5, 22.7%) were general practitioners. Apart from 1 male doctor, all were female doctors. The mean ± standard deviation of years of experience as physician was 12.05 ± 4.16 years (range = 6-20). Physicians had approximately 2 months of experience in conducting telephone consultations prior to the interview. The median number of telephone consultations was 124. One physician reported that she had conducted almost 600 telephone consultations while the minimal number of consultations was 20. Physicians were asked about the type of telephone consultation and all of them reported that they have done mixed
type of consultations which included; chronic disease management and follow-up, ante-natal care, general and emergency cases and follow-up of suspected and confirmed cases of COVID-19. Multiple themes were searched for across the interviewees' responses according to the aim and objectives of the study.

Process of Implementing Telephone Consultation in PHC

Three themes emerged in relation to the integration of telephone consultation in PHC: inconsistent implementation of the guideline, variability in roles and responsibilities, and semi-supportive infrastructure.

Inconsistent Implementation of the Guideline

The telephone consultation service started as an urgent response from the department of PHC. A set of instructions, in a form of guideline, was written by the department of PHC for physicians on how to conduct and document the TCs. An excel sheet was utilised for data collection which included non-communicable diseases (NCD), Ante-natal care (ANC), and nutrition. However, physicians showed discrepancy in describing the guideline and its purpose.

"There is no clear format what we should do but sent from DGHS what they want, for example; the number of consultations for NCD and ANC patients, just like a statistic." P3,

"...ourselves in the health centre we put together a template for NCD and ANC patients and what to do in telephone consultations." P7.

"I am aware of a document from DGHS which has given us specific criteria to conduct telephone consultation." P22

Variability in Roles and Responsibilities

All physicians expressed that they worked in a team that consisted of both physicians and nonphysicians that included nurses, clerks, medical orderlies, pharmacists, lab technicians, dieticians, and or health educators. Overall, physicians expressed variations in roles and responsibilities among staffs from the same job category.

"Nurses will follow up patients for vaccination, ANC care, follow-up COVID-19 low-risk patients, and schedule ANC visit and scan in the same day." P3

"Sometimes we involve the nurses to give them the plan, but they are not doing telephone consultations" P4,

"...hotline receives the daily general calls which are replied by a dietician or health educator and any clinical issues or concerns are directed to the physician” P13.

“. . .one dietician gives general advice regarding diet for chronic illness and also involves in covid team for follow-up patients and contacts.” P20

Semi-supportive Infrastructure

Most of the participants expressed that the current infrastructure for use of TC is not TC friendly, which is mostly due to physical restrictions of space.

"In our health centre environment, it's not easy to conduct telephone consultation” P5.

"Basically, we are calling from the admin room where everyone is coming in or going out” P7.

"Whenever I receive a call, I choose a place that is very quiet, nobody ever with me, otherwise I can’t work” P10.
Challenges and Limitations

Several challenges were reported by the physicians themed as: limited staff training on TC, suboptimal patient-physician interaction, insufficient technical support, ensuring privacy and confidentiality of the communication, and different ways to document the TC.

Limited Staff Training on TC

All physicians expressed that only family physicians or senior general practitioners were conducting the telephone consultations.

“Usually the mobile will be with the senior doctor. When they receive the call, they will process accordingly.” P19,

“Some of them don’t have the skills, others have the skills and need to give them a chance” P1,

“...junior doctors will still need to discuss it with the senior doctors” P5.

Suboptimal Patient-Physician Interaction

Conducting clinical consultations via phone is time consuming and there is a probability for communication barriers especially with elderly patients who may not be familiar with the use of TC.

“... the problems are mainly due to time as it is time consuming... we don’t have the culture where a patient calls for only specific things, so they call and take long time...” P17,

“Sometimes a third party is answering the phone, especially with the elderly” P3,

“Some patients they cannot talk Arabic or English, so I was struggling searching for someone to translate” P12.

Insufficient Technical and Financial Support

Majority of physicians expressed insufficiency in the availability of calling devices and related financial support.

“Phone was given for more than one task which was too much for one phone. ...” P6,

“Usually we have one mobile phone which is with both the pharmacists and doctors” P7,

“...prepaid and recharge can run out of charge and it is shared by others” P2.

Ensuring Privacy and Confidentiality of the Communication

Most of the participants expressed concerns about patient’s privacy and confidentiality of information whilst conducting TC.

“First of all, you get the number from the patient file, so most likely if not the patient it would be a relative but to be 100% sure is difficult...” P6,

“I am thinking I am talking to the right patient, but I am not sure is he the right patient.” P22.

Some physicians tried different methods to maintain the privacy of the patients, especially in conveying lab results.

“...we never give lab results to another person, especially for abnormal results or for something sensitive like hepatitis screening” P14,

“... about COVID results, we never give positive results for incoming calls; we will call patients on their private numbers and ask about ID number” P15.

Different Ways to Document the Telephone Consultation

There was discrepancy among physicians on documenting the telephone consultations.

“It’s like a usual general visit and we are writing it as a phone consultation...” P1,

“I don’t document all of them. ... documenting in the form from DGHS. Not all patients are registered in the Health centre I am in” P2,

“Unfortunately, we are not documenting the telephone consultation, and this is mainly for the general calls” P5.

Lessons Learned and the Way Forward

Several themes emerged with regards to lessons learned.

The Effect of TC on Workload

Almost all participants expressed that less than one-fifth of the TC were discontinued and converted to face-to-face consultation, while the remaining, more than four-fifth, were successful. All participants appreciated the reduced crowding in PHC facilities while utilising TC.
“. . .around 10 telephone consultations out of 80 and mainly for doing lab investigations.” P1

“. . .few times, about 8 out of 40, to open a visit for newly diagnosed cases . . .” P6

“Few times I had to bring the patient, if I need more assessment or not stable, or due to language barrier or I am not sure about the identity of the patient.” P7

“It is sufficient, and it is good especially for the current situations, that patients do not need to come to the health, especially high-risk patients” P15,

“The health centre will be more organised and less crowded” P8.

**Appreciating the Value of TC in Reducing Risk of Infection Transmission**

All physicians, without exception, expressed gratitude of reducing the risk of infection to patients by managing them through TC, especially the high-risk group.

“Telephone consultation helped our patients with chronic conditions because those with co-morbidities are at higher risk to develop complications from COVID-19 and we are happy to keep them at home.” P1

“. . .surely it reduced the risk of contracting COVID-19 from the health center, especially in diabetic and asthmatic patients” P19.

Physicians were, overall, comfortable to use TC in simple, chronic patients, patients at high risk for COVID-19 and for prescriptions refill.

“I think telephone consultation should be provided to selected cases, simple direct cases . . .” P1,

“It will work better with those with chronic conditions and for follow up” P2,

“We can give pharmacy prescriptions and normal investigation results like urine and CBC. If the patient is stable and needs only a little bit of adjustment of medications, we can give this” P19,

With regard to the way forward, majority of physicians expressed that the setting in the health centers should be improved to accommodate the TC service and to train staff in conducting TC to be more confident in delivering the service through phone.

“In future, telephone consultations should be in a special place, with phone, computer, IT support, and a quiet room” P12,

“There is nothing related to the low quality of care but as I said we need staff who are confident to reach to the diagnosis by history and without examination.” P11.

**Discussion**

This study aimed at exploring the physicians’ perception about the use of TC during COVID-19 pandemic in PHC setting in Muscat Governorate, Oman. To our best knowledge, this is the first qualitative paper that has looked at the use of TC during COVID-19 in Oman.

The use of technology has been described by the WHO as one of the major building blocks for our health care system.12 The infrastructure of the health care system in Oman has evolved rapidly through enhancements in the electronic health information system. With the pervading situation of COVID-19, the use of technology was exceptionally accelerated. TC was one of the major initiatives to put all protective measures in place such as social and physical distancing. Similar to reports by Mckinstry et al,5 TC was accepted by physicians in the current study and was viewed as a suitable tool for follow-up and management of long-term conditions.9 However, despite acceptance by physicians, replacing routine face-to-face consultation with TC has not gone smoothly and was underpinned with major challenges similarly reported across previous studies.13

The challenges on the use of TC in a clinical setting were consistent across the literature.3 Physicians in the current study expressed concerns about missing a serious condition as the TC were mostly conducted for chronic cases.14 Many doctors were also dissatisfied with communicating by telephone, due to the absence of visual cues, lack of comprehensive assessment, and inability to perform physical examination or share laboratory results.15

Structured training and uplifting competency and skills for conducting TC have been cited as core elements for effective communication.16,17 Based on best available evidence, an article by Car et al,13 presented an approach to telephone consultations in primary care that could provide a solid platform for further building capacity around the use of TC in a PHC setting.

Studies have also showed that documentation While using TC may be insufficient.15 This finding was confirmed by participants from this study. Few studies have suggested a framework for recording the consultations to meet the individual needs of various specialties.18,13 However, more work is required to develop culturally congruent frameworks that are suitable for the Arabic-speaking populations.19

Interestingly, the use of TC to enhance social and physical distancing in PHC during COVID-19 seemed to exhibit less workload on the physicians; however, this could be related to measures taken during COVID-19 pandemic to reduce the number of OPD visits in PHC facilities. It was
unclear from this study whether the use of TC achieved the optimum quality of care. Overall, randomised controlled trials and time series studies showed that telephone consultations do not necessarily reduce workload for clinicians.3

Looking ahead, the use of TC in a PHC clinical setting could be further improved if: a) combined with answering machines, telephone-linked computer systems, and text messaging, b) supported by video consultation, and c) linked to a smart system to report temperature, blood pressure, pulse, serum glucose, and electrocardiograms.20,22

Limitations
This study is not without limitations. Firstly, conducting the study during COVID-19 pandemic may have influenced the way physicians responded to the questions during the interviews. Secondly, the interviews were conducted by 2 medical doctors who were working in the PHC department, which may have introduced interviewer bias unintentionally. However, to ensure no interviewer bias, the interviewers were instructed to read the questions to the interviewees exactly as they are written without interpretation of the meaning or the purpose of the questions. If the question is not understandable, then the question is repeated to the interviewees and allow them to respond according to their best understanding of the question. Thirdly, no software for qualitative analysis were used which may reduce the accuracy of the analysis. However, in our study, we conducted the analysis manually using the 6 phases of thematic analysis by Braun and Clarke23 which are: familiarizing yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. Fourthly, these results are confined to physicians’ feedback on the use and acceptability of TC, thus further studies are needed to explore patients’ perspectives about the utilization of TC in COVID-19.24

Conclusion
Given the exceptional situation of COVID-19, the current evidence suggests that the use of TC as an alternative to face-to-face general practice consultations, especially in chronic cases, is promising. However, the right structural framework needs to be provided to implement a high quality and sustainable TC service in PHC. The main components include training of staff, improving the physical arrangement in the health centre, and selecting suitable cases for TC. Moreover, more work is needed to evaluate the effectiveness of TC post COVID-19 within the current local clinical setting.

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Authors’ contribution
SA is the principal investigator in charge of the project. All other authors were involved in designing the study. The data collection and analysis of the results were assisted by JM, AA, and HL. SA and HL has prepared the transcript and revised by the authors. The thematic analysis was assisted by (TA), an expert researcher in qualitative studies. (HA) has supervised the whole project and facilitated the communication with the participants and visits to the health centers.

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