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LETTER TO THE EDITOR

The "knowing-doing gap" – preoperative assessments via telemedicine during COVID-19

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To the editor

The phrase "knowing-doing gap" was first coined by Pfeffer and Sutton in 2000.[1] They postulated that while big businesses often knew correct management principles, implementation of appropriate change was not always possible. This phrase has also been used by ecologists, highlighting humanity's failure to control environmental catastrophes regarding global warming. It may be feasible to suggest that *remote* pre-anaesthetic evaluation (PAE) by South African anaesthesiologists during the COVID-19 pandemic could also be described as a "knowing-doing gap". Mobile telephone use by anaesthetists is ubiquitous and these devices are mostly smartphones (computerised mobile telephones capable of making video calls). So, by inference, while most anaesthetists would know how to practice telemedicine, most do not practice it, hence the "gap".

There are many reasons for this gap in South Africa. But it should be noted that prior to COVID-19, telemedicine (telehealth) policies were based on recommendations by the Health Professional Council of South Africa (HPCSA), that is, the Health Professionals Act No. 61 of 2003 (as amended) as published in Booklet 10. This Act only endorsed telemedicine for disadvantaged patients who resided in rural areas where no resident specialist facilities were available. The HPCSA's rigid stance was challenged by Townsend et al.[2] in 2019 whose recommendations regarding benefiting population groups, development of telemedicine systems design, ethical consent and confidentiality mediums, were not heeded. However, in March 2020, a national state of disaster was declared in South African because of the COVID-19 pandemic and, in line with most international policies, strategies for social isolation and decreased face-to-face contact were announced by the government. Therefore, on 3 April 2020, the HPCSA responded with an amendment to the telemedicine guidelines. The new recommendations stated that while it is still preferable to physically meet with the patient prior to a telemedicine consultation, telemedicine is deemed to be 'in the best clinical interest of the patient' and allowed 'fee for service' by the practitioner. Medical insurance companies immediately advised their members of the amendments to the HPCSA guideline, and some encouraged comprehensive webinars to point out ethical practice and pitfalls.

During the last two decades, numerous studies have found telemedicine for PAE to be equal to that of face-to-face consultations.[3,4] The important assessments of airway and cardiopulmonary pathology appear to be adequate and allow for formulation of comprehensive investigation and anaesthetic plans.[5] Perceived advantages and disadvantages of these services according to international guideline divisions are given in Table I.[6]

Table I: Perceived advantages and disadvantages for telephonic PAE[3-5]

	Advantages	Disadvantages
Clinical	• Fear of COVID-19 made patients more amenable to telephonic consultations which they perceived in 'best interest'. • Remote PAE has been shown to be reliable. • Patients expressed satisfaction with remote PAE. • Stress on the day of surgery was reduced. • Laboratory investigations and tests were expedited.	• Some patients may be wary of virtual platforms and/or are unable to use technology, necessitating an involved third party. • Technology must be available to both doctor and patient. • Patients with vocal cord or tracheal pathology may be unable to speak on this platform.
Operational	• A set appointment convenient for both doctor and patient is a prerequisite. • Patient needs to understand that clinical examination will occur on the day of the operation. • Documentation during the remote consultation must be as comprehensive as during a face-to-face PAE.	• A secretary/nurse must be available to inform patient and send consent forms. • Patient must understand that this is a medical consultation and cannot be done while working, shopping, exercising, etc.
Confidentiality	• Anaesthetic informed consent and POPIA* consent forms should be sent to patient prior to telephonic PAE.	• Confirmation of patients' identity and respect for their confidentiality is paramount.

* POPIA – The South African Protection of Personal Information Act 4 of 2013 (POPIA) regulations regarding patient confidentiality

POPIA consent forms promulgating telemedicine are readily available and should disclose that information stored on smartphones may not be as secure as when stored on office-based records. The POPIA manual for each anaesthetist must also stipulate that telemedicine may be practiced.

Telemedicine for PAE is gaining popularity in private practice in Johannesburg, South Africa, where patients have access to mobile technology. But even in state hospitals there could be financial advantages for both the government and patients, where functioning scheduled face-to-face PAE clinics could be converted to telemedicine consultations. To date, smartphone user penetration in South Africa is 42%.[7] Those patients who do not have the equipment and/or cannot afford the data have the option to visit local clinics where either computerised video platforms or sponsored mobile smartphones would allow remote communication with the assessing anaesthetist.

Conflict of interest

The author declares no conflict of interest.

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