

# A pilot study exploring clinicians' decisions to implement video consultations for vestibular rehabilitation.

## Introduction

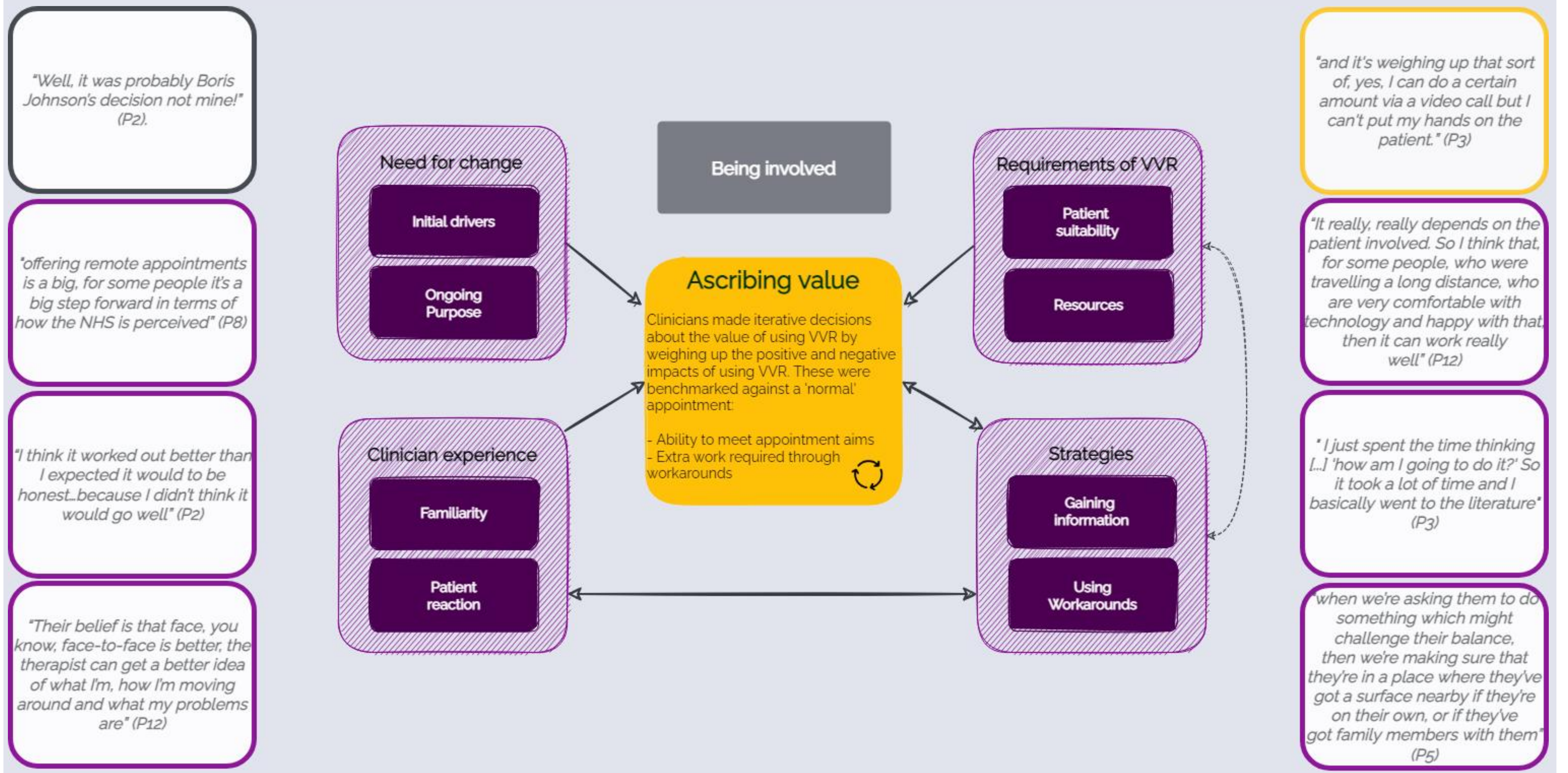
- Despite a huge increase in the use of remote care since the start of the COVID-19 pandemic, uptake within vestibular care has been sporadic.<sup>1</sup>
- Studies in musculoskeletal rehabilitation describe clinicians' experiences with video consultations but do not explore how clinicians decide to implement them.
- Evidence specific to vestibular rehabilitation is limited but does begin to identify factors that may influence decisions<sup>2</sup>.
- This study aims to understand the process of decision-making regarding implementation of video consultations for vestibular rehabilitation (VVR) and the factors that influence this decision.

## Methods

- Online recruitment was conducted through Audiology and Physiotherapy professional bodies. Completion of a recruitment questionnaire allowed maximum variation and theoretical sampling of participants.
- Qualitative semi-structured interviews using Microsoft Teams and telephone. UK clinicians involved in VR were asked about their experiences of VVR and decisions to implement and sustain VVR.
- Interviews analysed using Grounded Theory methods as described by Corbin and Strauss<sup>3</sup>. Member checking and peer review were used to increase credibility.

## Findings

Participants consisted of six audiology and five physiotherapy professionals working across England and South Wales. Nine worked solely in the NHS and two had additional private practices. Four clinicians worked alone. Years of experience ranged from; 0-5 (4), 5-10 (1), and 10-20 years (6).



## Discussion

- Decision-making was prompted by a need for change and change sustained by the perceived ongoing purpose of VVR. Clinicians iteratively assessed whether VVR added value when compared with usual care, but needed technological and support-based resources and a 'suitable' patient to enact this decision. Not being involved in decision making caused tension. Strategies of gaining information and using workarounds increased clinician's familiarity with VVR and reduced its negative impacts. Clinicians experienced decision outcomes first hand and were able to see patients' views on VVR, which informed future decision-making.
- The model can be abstracted onto the COM-B model of behaviour change<sup>4</sup>.

## Conclusions

- This study describes a preliminary model of how clinicians decide to implement VVR.
- For VVR to be sustained, a clear vision of the purpose of VVR beyond COVID-19 must be communicated. Further work will be needed to integrate VVR into long term clinical care, and resources such as time, training and support are essential to achieve this.
- For many settings a hybrid model of care is the most appropriate, with clinicians continuing to decide when, and for whom, VVR will add greatest value.
- Research should look to explore patients perceptions of VVR, as these significantly affected sustainability, and to develop assessment and monitoring methods which are amenable to remote care.

## References

1. Saunders GH, Roughley A. Audiology in the time of COVID-19: practices and opinions of audiologists in the UK. *Int J Audiol.* 2021 Apr;60(4):255-262. doi: 10.1080/14992027.2020.1814432. Epub 2020 Sep 10. PMID: 32909474
2. Harrell RG, Schubert MC, Oxborough S, Whitney SL. Vestibular Rehabilitation Telehealth During the SAEV-CoV-2 (COVID-19) Pandemic. *Front Neurol.* 2022 Jan 20;12:781482. doi: 10.3389/fneur.2021.781482. PMID: 35126289; PMCID: PMC8811028.
3. Corbin, J., and Strauss, A. (2008) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 3rd Edn. London: SAGE Publications
4. Robert West, Susan Michie. (2020). A brief introduction to the COM-B Model of behaviour and the PRIME Theory of motivation. *Qeios*. doi:10.32388/WW04E6.

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