


REVIEW

Patients' and clinicians' experiences of remote consultation? A narrative synthesis

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Abstract

Aims: To identify, evaluate and summarize evidence of patient and clinician experiences of being involved in video or telephone consultations as a replacement for in-person consultations.

Design: Narrative synthesis.

Data sources: Medline; EMBASE; EMCARE; CINAHL and BNI. Searching took place from January 2021 to April 2021. Papers included were published between 2013 and 2020.

Review Methods: Papers were appraised by two independent reviewers for methodological quality. Data extraction was conducted according to the standardized tool from Joanna Briggs Institute.

Results: Seven qualitative studies were included, from five countries and from the perspective of patients, relatives, administrators, nurses, physiotherapists and physicians. We developed two main themes: *Pragmatic Concerns* and *Therapeutic Concerns*. Each theme contained two categories: Pragmatic Concerns: (a) the convenience of non-face to face consultations; (b) using technology and equipment in a consultation; Therapeutic Concerns (c) building therapeutic relationships; and (d) embracing benefits and addressing challenges.

Conclusion: This narrative synthesis presents the existing evidence on clinician and patient experience of participating in non-face to face consultations. Experiences are varied but largely focus on communication and forming relationships, using the technology successfully and the ability for patients to self-manage with support from clinicians who are not in-person. More high-quality studies are required to explore the experiences of patients and clinicians accessing remote consultations as a result of global implementation post-SARS-CoV-2 pandemic to identify any learning and education opportunities.

Impact: Health care staff can provide high-quality care through video or telephone appointments as well as face to face appointments. This review has, however, identified

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that the evidence is limited and weak in this area and recommends there is research further to inform practice and influence future care.

KEYWORDS

narrative synthesis, nursing, SARS-CoV-2, telemedicine, telehealth, technological communication, telephone consultation, video consultation

1 | INTRODUCTION

During the SARS-CoV-2 pandemic, the introduction of remote digital health care such as video consultation (VC) or telephone consultation (TC) has accelerated exponentially (Oxtoby, 2020; Wherton et al., 2021). This occurred globally as the pandemic spread with face to face, in-person, consultations being discouraged unless deemed clinically necessary and remote consultations (either through VC or TC) were actively implemented with immediate effect. Remote consultations refer to non-face to face consultations undertaken by health care professionals, that is, where patient and health care professional are not in the same room (Mann et al., 2021).

Prior to the pandemic, there was a growing body of evidence about remote consultations, with countries such as Australia, New Zealand and Canada showing high levels of patient satisfaction and acceptance with global empirical literature growing. (Fatehi et al., 2015; Host et al., 2018; Lucas et al., 2016; Sevean et al., 2009), yet the United Kingdom (UK) remained reluctant and slow on the implementation of either VC or TC. This reluctance appeared to be due to several reasons, including competence and motivation in the use of digital technology (Harrison et al., 2020), and the clinical suitability of different patient groups to this form of consultation (Greenhalgh et al. (2015). Imlach et al. study (Imlach et al., 2020) suggested that some patients are unsuitable to move to remote (video or telephone) consultation, with many clinicians unconvinced of the NHS's ability in the UK to make this happen.

2 | BACKGROUND

The consequence of the SARS-CoV-2 pandemic meant health care services globally implemented alternative approaches to clinical consultations to protect patients and staff from possible infection (Greenhalgh et al., 2020). This therefore was a shift from the pre-SARS-CoV-2 practices where only 2%–20% of consultations were routinely undertaken remotely (Shaw et al., 2018), to almost all consultations being delivered either through telephone or video means. In the UK there has been an attempt to support staff with resources and guidelines to plan and deliver clinical consultations remotely (e.g. National Institute for Health and Care Excellence (2020). However, the pressure and speed of the pandemic resulted in health care systems often having to implement remote consultations almost overnight, resulting in many resources being left untouched and the implementation just happened (James et al., 2021).

However, this immediate change in practice for all health care professionals was not without challenges. Wherton et al. (2020) reported to successfully implement such a shift in practice required major changes to complex health systems and needed time, resources and embedding of a new model of care. However, with the speed and spread of the pandemic, clinicians and patients were not permitted this time (James et al., 2021).

Previous evidence has explored both VC and TC implementation in acute and primary care health settings (e.g. Donaghy et al., 2019; Shaw et al., 2018). This evidence has shown differing perspectives of this form of consultation. Shaw et al. (2018)'s study explored implementation in an acute NHS Trust, in three clinical specialties and found although there were some technical issues, patients and clinicians liked and supported this form of consultation. However, barriers to either TC or VC have also been shown (Almathami et al., 2020). Technological issues have been found to be a significant barrier, with platforms such as Skype not being seen as appropriate for health consultations (Armfield et al., 2015) and technological literacy from both the patient and staff perspectives proving an issue (Wherton et al., 2020). Mold et al. (2019) also found concerns surrounding risk and risk management, specifically related to privacy and security of patient data, with patient safety also being identified as a risk. McKinstry et al. (2009) found clinical decisions may be influenced by a lack of visual and body language cues which inform clinicians thinking and potential treatment options.

There are many systematic reviews examining virtual (either TC or VC) consultations, with the foci being the ability of health care systems to deliver the virtual consultation, or on effectiveness, efficacy, practicality, satisfaction or cost (see Almathami et al., 2020; Kruse et al., 2017; Mold et al., 2019; Murphy et al., 2020) and have not explored the patient or clinicians' experiences. Furthermore, there are concerns of the methodological quality of some of the evidence with Ekeland et al. (2012) cautioning most research lacks rigour.

Quality of the evidence aside, patient satisfaction in remote consultation has been shown to be high for patients, particularly about convenience and practicality compared with an attended face to face consultation at a health care provider site (Mold et al., 2019; Shaw et al., 2018). However, the concept of satisfaction is not the same as experience (Bull, 2021). These terms are often used interchangeably (Bleich et al., 2009) but are indeed different concepts, with patient experience relating to exploration of what happened and what the person felt about what happened (Berkowitz, 2016); compared with satisfaction which is concerned with the person's expectations (Bjertnaes et al., 2012). To conflate the two concepts is to

misunderstand their individual importance (Jenkinson et al., 2002). Lacking in the evidence base is how clinicians or patients experience the use of TC or VC and what lessons can be learnt as health care providers move forward following the pandemic in a world that will incorporate TC and/or VC as the norm (Thiyagarajan et al., 2020).

This paper aims to review the current research in the field covering the use of video or telephone consultations rather than a face to face, in-person consultation between a patient and a health care provider.

3 | THE REVIEW

3.1 | Aims

To identify, evaluate and summarize evidence of patient and clinician experiences of being involved in non-face to face consultations as a replacement for in-person consultations.

3.2 | Design

The methodology selected for this review is that of narrative synthesis. Narrative synthesis refers to an approach to the systematic review and synthesis findings from multiple studies which relies primarily on the use of words and text to summarize and explain the findings. (Popay et al., 2006). Furthermore, narrative synthesis is a process whereby the synthesis of the findings enables the researchers to 'tell the story' from a wide range of studies and does not require the outcome to show only the effectiveness of the intervention.

There are four main stages to the narrative synthesis process, and these include: the development of a theory of how the intervention

works, why it works and for whom it works; the development of preliminary synthesis; exploring the relationships in the data of the included studies, and assessing how robust the synthesis of the studies is.

Guidance by Popay et al. (2006) notes narrative synthesis may be employed when the studies included are insufficiently similar but with an aim to consider the effects of interventions and/or the factors which shape the implementation (Popay et al., 2006) and can also include studies from a variation of interventions (Ryan, 2013). Thus it was deemed appropriate for this review to adequately include the variety of approaches and evidence currently available and to consider concerns around implementation of non-face to face consultation.

3.3 | Search methods

Search terms using medical subject headings (MeSH) alongside key words and synonyms are detailed in Table 1. Databases searched were: Medline, EMBASE, EMCARE, CINAHL and BNI. Applied inclusion and exclusion criteria are detailed in Table 2, showing a focus on empirical, peer-reviewed research, published from 2010.

3.4 | Search outcomes

Once duplicates were removed, of the 277 articles selected for full article review, 258 were excluded for the following reasons: not available in English (4), abstracts, posters or letters (85) or not relevant in that they did not focus specifically on VC or TC, or explored patient and clinician satisfaction rather than experience, non-medical settings and app-based studies (169). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher et al., 2009), (Diagram 1) was used in reporting this review. Table 3

TABLE 1 Search terms

Keyword	Boolean terms/synonyms
Patient/ population	(patient* OR service user* OR service-user* OR primary care provider OR out-patient* OR out-patient* OR client* OR outpatient* OR support network OR support OR support bubble OR carer* OR wife OR husband OR daughter* OR sister* OR brother* OR family OR significant other OR loved one OR parent* OR spouse OR friend* OR unpaid carer* OR next of kin OR next-of-kin OR NOK* OR doctor* OR physician OR general practitioner OR practitioner OR GP OR nurse* OR healthcare professional* OR allied healthcare professional* OR AHP* OR Service user* OR clinician* OR physiotherapist* OR physical therapist OR dietitian OR dietician OR "speech and language therapist" OR "occupational therapist*" OR psychologist* OR psychiatrist* OR consultant* OR multidisciplinary).ti
Intervention	exp REMOTE CONSULTATION/OR (Teleconsultation* OR "tele-rehabilitation" OR "tele-consultation*" OR videoconsultation* OR "video-consultation*" OR "remote consultation*" OR "virtual consultation*" OR "rural consultation*" OR ((telemedicine OR tele-medicine OR video OR telephone OR phone OR "attend anywhere" OR zoom OR skype OR facetime OR digital OR online OR electronic OR "mobile app*") ADJ5 consultation*).ti,ab
Comparator	It was agreed that the 'Comparator' field would limit the results if included in the search strategy and will therefore not be included in the search terms
Outcome	HEALTH KNOWLEDGE, ATTITUDES, PRACTICE/OR PATIENT SATISFACTION/OR PATIENT PREFERENCE/OR COMMUNICATION BARRIERS/OR DIGITAL DIVIDE/OR LANGUAGE BARRIERS/OR (Support* OR adher* OR complian* OR concordance OR acceptab* OR convenience OR experience* OR advantage* OR disadvantage* OR limitation* OR risk* OR benefit* OR barrier* OR facilitator* OR challenge* OR drawback* OR success* OR effective* OR outcome* OR satis* OR perception* OR need* OR attitude* OR view* OR opinion*).ti

TABLE 2 Inclusion and exclusion criteria

Inclusions	Exclusions
Empirical research	Non-medical settings or populations
Peer reviewed research	App based research
Study Participants over 18 years	Telephone triage studies
All care settings	Patient/clinician satisfaction
Telephone and video consultations	
English language	
Published from 2010-present	

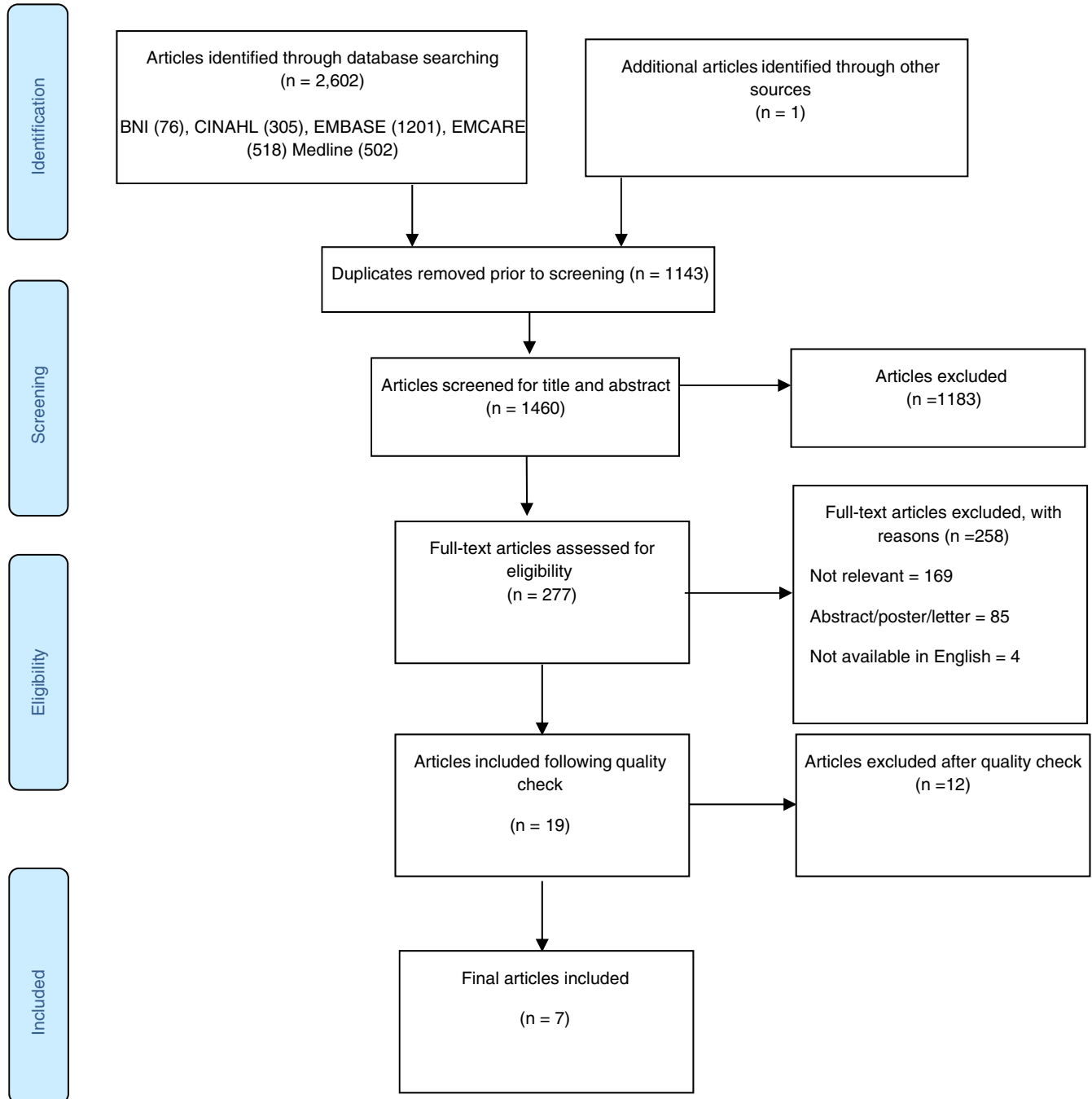


DIAGRAM 1 PRISMA flow diagram

TABLE 3 Included studies

Reference	Article title	Journal	Year of publication	Country
Bazzano et al.	Barriers and Facilitators in Implementing Non-Face-to-Face Chronic Care Management in an Elderly Population with Diabetes: A Qualitative Study of Physician and Health System Perspectives	Journal of Clinical Medicine	2018	USA
Funderskov et al.	Experiences With Video Consultations in Specialized Palliative Home-Care: Qualitative Study of Patient and Relative Perspectives.	Journal of Medical Internet Research	2019	Denmark
Hinman et al.	"Sounds a Bit Crazy, But It Was Almost More Personal:" A Qualitative Study of Patient and Clinician Experiences of Physical Therapist-Prescribed Exercise For Knee Osteoarthritis Via Skype	Arthritis Care and Research	2017	Australia
Imlach et al.	Telehealth consultations in general practice during a pandemic lockdown: survey and interviews on patient experiences and preferences	BMC Family Practice	2020	New Zealand
Kairy et al.	The patients perspective of in-Home Tele rehabilitation physiotherapy services following total knee arthroplasty	International Journal of Environmental Research and Public Health	2013	Canada
Lawford et al.	"I Was Really Pleasantly Surprised": First-hand Experience and Shifts in Physical Therapist Perceptions of Telephone-Delivered Exercise Therapy for Knee Osteoarthritis-A Qualitative Study	Arthritis Care and Research	2019	USA
Wright and Honey	New Zealand nurses' experience of tele-consultation within secondary and tertiary services to provide care at a distance	Nursing Praxis in New Zealand	2016	New Zealand

details the included studies showing that only studies using qualitative approaches remained.

3.5 | Quality appraisal

Results were screened for relevance, initially using the title and abstract against the inclusion/exclusion criteria. Full texts of each included paper were reviewed by teams of two and then discussed in the wider team to assess suitability for inclusion and to resolve any disputes. All included papers were quality assessed using the JBI qualitative checklist tool (Joanna Briggs Institute, 2017). Papers were included if they met the quality points considered essential by the review team. Consensus was confirmed with studies answering a 'yes' response for questions 2–5, 8 and 10 would be included. As question nine referred to ethics, if there was clear evidence the study was conducted ethically, an explicit statement about ethics approval was not deemed essential. See Table 4 for Quality Appraisal.

3.6 | Data extraction and synthesis

Extracted data including author(s), year of publication, country of study, aims, methods, sample size, study setting and key findings are shown in Table 5. Data were extracted by four members of the team and crosschecked by all authors. If discrepancies were identified, they were discussed and agreed on in the research team. Following

extraction, a narrative synthesis was applied (Popay et al., 2006). Analysis followed an inductive approach, whereby four reviewers working in pairs independently coded three of the seven papers to produce a coding frame. The reviewers met to discuss their independent coding of all seven of the papers. Coding of all papers was agreed and resulting themes from the data were determined. Reviewers ensured that exploration and relationships between the different studies was represented in the synthesis. All reviewers agreed the final themes.

4 | RESULTS

4.1 | Characteristics of chosen studies

Seven papers were included (Table 3). All papers presented findings from qualitative exploratory interviews which investigated the experience of the participants (patient and clinician) of using non-face to face consultations in a health care setting.

The seven papers included two from New Zealand, two from Australia and one each from Canada, United States of America and Denmark. They were from a spread of clinical specialties including palliative care (Funderskov et al., 2019), primary care (Bazzano et al., 2018; Imlach et al., 2020; Wright & Honey, 2016) and three from musculoskeletal care (Hinman et al., 2017; Kairy et al., 2013; Lawford et al., 2018). The approach to non-face to face consultations included video consultations alone (x3), telephone alone (x1) or

TABLE 4 Quality appraisal

	1. Is there congruity between the stated philosophical perspective and the research methodology?	2. Is there congruity between the research methodology and the research objectives?	3. Is there congruity between the research methodology and the methods used to collect data?	4. Is there congruity between the research methodology and the representation and analysis of data?	5. Is there congruity between the research methodology and the interpretation of results?	6. Is there a statement locating the researcher culturally or theoretically?	7. Is the influence of the researcher on the research, and vice-versa, addressed?	8. Are participants and their voices adequately represented?	9. Is the research ethical according to current criteria or, for recent studies and is there evidence of ethics approval by an appropriate body?	10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?
Papers/JBI descriptors										
Bazzano et al.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	✓
Funderskov et al.	Unclear	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	✓
Hinman et al.	Unclear	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	✓
Imlach et al.	Unclear	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	✓
Kairy et al.	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	✓
Lawford et al.	Unclear	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	✓
Wright and Honey	Yes	Yes	Yes	Yes	Yes	No	Unclear	Yes	Yes	✓

a combination of both as well as electronic through text messages, websites or email (x3). Participant groups included patients, relatives, nurses, health care administrators, physicians and physiotherapists (Physical Therapists). The participant number ranged from 5 (Kairy et al., 2013) to 38 (Imlach et al., 2020) and represented a combined total of 66 patients, 3 relatives, 13 nurses, 12 physicians, 4 health care administrators and 16 physiotherapists. Six of the studies were conducted pre-SARS-CoV-2 pandemic and one (Imlach et al., 2020) was conducted during the SARS-CoV-2 pandemic. Most studies lacked exploration demographics such as race, socio-economic status, education, language, and access to the technology required for TC or VC. Imlach et al. (2020), Kairy et al. (2013) and Funderskov et al. (2019) each give details relating to sample characteristics but fail to integrate this into their analysis and discussion of their findings, although this is stated as a limitation in some.

4.2 | Quality assessment

The quality of the seven included papers was similar (see Table 5). All papers provided an explanation of their aims and justified their use of qualitative methods and explicitly reported their findings.

4.3 | Themes

We developed two main themes from the synthesis of the seven papers: *Pragmatic Concerns* and *Therapeutic Concerns*. Each theme contained two categories: Pragmatic Concerns: (a) the convenience of non-face to face consultations; (b) using technology and equipment in a consultation; Therapeutic Concerns (c) building therapeutic relationships; and (d) embracing benefits and addressing challenges.

4.4 | Pragmatic concerns

This theme embodied the more concrete and measurable aspects of the evidence presented in the studies reviewed. The findings of each of the studies contained a considerable amount of data that addressed patient and clinician concerns about the technology needed to be used and their preparedness and competence in using this equipment successfully. Nevertheless, there was a very clear feeling from both patients and clinicians that there were significant practical benefits to being able to conduct consultations without travel and in the comfort of their own homes at a time that suited them.

4.4.1 | Convenience of non-face to face consultations

The convenience and perceived ease of access to health care offered by remote consultations are reported by both patients and

TABLE 5 Extracted data

Lead author	Aims	Methods	Sample size and population	Clinical speciality	Consultation type	Key findings
Bazzano et al. (2018)	Understand the perspectives of the successful implementation of Non-Face to Face Chronic Care Management programs.	Semi-structured interviews;	N = 20; Physician(12), nurses (4) and administrators (4)	Diabetes co-morbid with other chronic conditions	Telephone, email and electronic messaging	Barriers: Burden on staff and time commitment; Communication among staff and existence of other similar programs; Financial sustainability; Patients' needs; Selection and retention of patients. Facilitators: Adds value to care that patients receive; Represents a strategic use of resources; Electronic health records and scale of large health care organizations; Appropriate staffing and expertise in billing
Funderskov et al. (2019)	To clarify the use of video consultations in an SPC setting and to explore how and their relatives experience the use of video consultations	Observation and semi-structured interviews	N = 14 (11 patients and 3 relatives)	Palliative Care	Video conferencing	Allowed patient to be active in own care; Preference for video over telephone as patients can see the clinician; As illness progresses video calls may become more difficult; Video allows for others/relatives to join in on consultation or from a distance; providing positive support for patients and relatives/carers alike; Some technical issues raised with video calls
Hinman et al. (2017)	To explore the experience of patients and physical therapists using Skype as a service delivery model for prescribed exercise management of knee OA.	Interviews	N = 20 (12 patients and 8 physiotherapists)	Knee pain associated with osteoarthritis	Skype/video	Technology—ease of use, quality of the video and set up; Patient convenience—flexibility, time efficiency and increased access; Patient empowerment to self-manage—home management and focus on effective treatment elements; Positive therapeutic relationships—personal undivided attention, supportive and friendly; Adjusting routine treatment- Modifying usual habits, discomfort without hands-on, research environment as a safety net; Satisfaction with care—satisfaction and enjoyment and recommend to others; Patient benefits—physical, confidence and self-efficiency
Imlach et al. (2020)	To explore how patients accessed general practice during lockdown and evaluate their experiences with telehealth.	On-line surveys and in-depth interviews	N = 1010 surveys; N = 38 interviews; Patients	General practice	Telephone, email, electronic messaging or website	Overall high satisfaction from survey; Positive response for convenience; Technical challenges experienced including internet access; Positive response for future telehealth appointments but preference for routine appointment/concerns and when relationship already established with clinician; Reports of unsuitability for physical examination and if diagnosis was unknown; Patient choice/preference identified
Kairy et al. (2013)	To explore patients' perceptions about telerehabilitation services received post total knee replacement	Semi-structured interviews	N = 5 Patients	Rehabilitation following total knee arthroplasty	Video conferencing	Access to services without the need for transport; Developing a strong therapeutic relationship with therapist while maintaining a sense of personal space; Ease of telerehabilitation equipment; Felt supported; Desire for face to face visits to compliment telerehabilitation

TABLE 5 (Continued)

Lead author	Aims	Methods	Sample size and population	Clinical speciality	Consultation type	Key findings
Lawford et al. (2018)	To explore physiotherapists' perceptions about telephone-delivered exercise therapy for patients with knee OA	Semi-structured interviews	N = 8 Physical therapists	Knee osteoarthritis	Telephone	Prior to intervention: Perceived convenience and cost savings for patients with telehealth; Perceived increased opportunity for education and access to the service; Expected problems to occur with lack of physical contact with patients; After telephone appointments: Improved opinion of telephone appointment, reporting positive patient outcomes, with pain, function and confidence; Improved patient self-management. -Areas identified to improve the experience-included clinician training in communication skills, written resources for patients to supplement the patient telephone appointment and scheduling of telephone appointment around in-person appointments.
Wright and Honey (2016)	To explore New Zealand Registered Nurses' experience of using tele-consultation to provide care at a distance	Semi-structured interviews	N = 9 Nurses	General community care	telephone, texting, email and videoconferencing	Roles of the nurse—Involved coordination and support for positive experience for patient; Strengthened relationships with health care team. Felt most for those working in remote areas; Tele-consultation allowed for more timely care, increased access to specialist input, proved more convenient and supported a patient and family focus; Overall, positive but technical issues identified, particularly with sound 'Can you hear me?'

clinicians in the studies reviewed. Physiotherapist participants in Lawford et al. study (Lawford et al., 2018), delivering a rehabilitation intervention for people with knee osteoarthritis voiced a perception that video was a convenient way for patients to access this treatment guidance and that it was a way enabling flexible care both in terms of timing and location. From a patient's perspective, Hinman et al. (2017) reported the perceived convenience of non-face to face consultations by both patient and clinicians, allowing more flexibility and accessibility alongside better focus on learning rehabilitation exercise. Patients in the studies reported, regardless of the reason for the consultation, that non-face to face consultations promoted better use of time with fewer delays and with less disruption to their day (Hinman et al., 2017; Imlach et al., 2020) due to not needing to travel, park or physically prepare for the appointment (Kairy et al., 2013). Furthermore, they found it reduced stress levels and was more financially viable for them (Imlach et al., 2020).

Nurse participants in Wright and Honey (2016) interview study reported their perceptions of how remote consultation enabled access to specialized support and more timely care, reducing the need for long distance travel to access this level of expert care. Additionally clinicians Lawford et al. (2018) in a qualitative arm of an RCT, and Imlach et al. (2020) exploring the perceptions of patients in primary care, reported findings around travel and the reduced financial burden of accessing specialist health care services which may be at a distance from home.

4.4.2 | Using technology and equipment in a consultation

In the reviewed studies, *technology and equipment* are terms used to refer to videoconferencing or telephone hardware, software, internet connections and the setting-up of equipment. All studies (except Lawford et al. 2018) reported issues related to how the technology worked and the equipment required to support the non-face to face consultation. Where equipment prepared in advance for remote use is provided, patient experience seems to be better, with Kairy et al. (2013) palliative care patient participants finding the supplied tablet easy to use and, Kairy et al. (2013) argued, promoting more active patient and family dialogue.

It seems generally accepted that the technology and the equipment used in remote consultation can greatly influence patients' and clinicians' experience. In the studies included in this review, both telephone (Bazzano et al., 2018, Imlach et al., 2020, Lawford et al 2018, Wright & Honey, 2016) and video (Funderskov et al., 2019; Hinman et al., 2017; Kairy et al., 2013; Wright & Honey, 2016) consultations are evaluated. Other forms of non-face to face communication such as emails and electronic messaging were also reported by Bazzano et al. (2018). In Funderskov et al. study (Funderskov et al., 2019), use of video as opposed to telephone consultation was felt by both patients and clinicians to be more beneficial because patients and clinicians could see each other's faces.

To overcome some of the technical issues an 'easy-to-use' kit was provided and evaluated by Kairy et al. (2013) and by Hinman et al. (2017). Both studies looked at physiotherapy-led remote consultations where patients were supported to complete exercises at home and required specific interaction and explanation that required a very visual component to the consultation. Kairy et al. (2013) did provide videoconferencing equipment and each patient was 'set-up' on the equipment which is similarly to the experience of participants in Hinman et al. (2017) study where research teams supported set-up or loaned an iPad if they did not have a suitable device. This seems to suggest that preparing users and focusing on specific interventions can ensure a smoother experience.

The quality of internet connections was discussed in the studies, with particular reference to variable or poor internet quality (Hinman et al., 2017; Imlach et al., 2020), poor sound quality (Wright & Honey, 2016) and increased difficulty with multiple users attempt joining a video consultation (Funderskov et al., 2019). Of note, poor internet access, lost connections and occasional loss of visual or audio connections did not seem to negatively affect patients' and clinicians' experience overall as shown in the findings of Hinman et al. (2017), although it is worth noting that Hinman et al. study was focused on a specific group of patients and clinicians in the particular context of orthopaedic rehabilitation. Imlach et al. (2020) found that patients with sensory deficits reported that hearing or visual problems did have a negative impact on their experience and the quality of the non-face to face consultation. The experience of patients who were receiving palliative care (Funderskov et al., 2019) also showed difficulties surrounding the timings of video consultation and involving multiple participants in the call. The broader challenge to health care organizations is raised by Bazzano et al. (2018) who reported how implementation of non-face to face consultations is affected by health care systems' infrastructure and resources.

4.5 | Therapeutic concerns

Deeper exploration of non-face to face consultations explored in the studies revealed a more nuanced and less-expected series of concerns. These largely can be separated into the effects of remote consultation on the therapeutic relationships that seem so valued by both patients and clinicians, alongside reflections on the future of this mode of health care. The complexity of health care provisions, when taking up the challenge of remote or non-face to face consultation, raises issues around support, training and efficient use of resources.

4.5.1 | Building therapeutic relationships

The building of therapeutic relationships is noted in six of the studies as the foundation for providing a positive experience for both

patients and clinicians (Bazzano et al., 2018; Funderskov et al., 2019; Hinman et al., 2017; Imlach et al., 2020; Kairy et al., 2013; Lawford et al., 2018). A pre-existing relationship between patient and clinician was seen to facilitate the building of a rapport in a remote setting with the physiotherapists in Lawford et al. (2018) study of the use of Skype, reporting that physiotherapists found video consultation somehow more personal than face to face and Imlach et al. (2020) primary care study reported patient participants responding similarly about a more 'human' interaction than in the busy GP surgery. Much of the evidence in the reviewed studies around interaction was in the context of existing relationships with Wright and Honey (2016) noting that the lack of such a relationship was not necessarily detrimental. Routine, familiar health issues, alongside mutual trust, contributed to creating a positive experience of remote consultation (Imlach et al., 2020).

Patients and clinicians were seen in the studies reviewed to have a slightly different perspective on what affects the relationship in remote consultation (Hinman et al., 2017). Patients reported that their relationship with clinicians can be built when clinicians offered them undivided attention, where they were able to feel less rushed and where clinicians promoted a supportive and friendly environment; clinicians commented that patients appeared to be more receptive in the consultation which enabled a more positive relationship. Lawford et al. (2018) found that clinicians pre-implementation of a remote consultation study perceived the building of a therapeutic relationship would be lost with a non-face to face consultation, yet post-implementation, this assumption was contradicted and they found that they had more personal conversations with patients, facilitating the building of a rapport.

Self-management, a key outcome in long-term care, is only achieved through strong therapeutic relationships (Mitsi et al., 2018) and structured clinician support (Dineen-Griffin et al., 2019). While the evidence collected from the reviewed papers is limited in this area, there is an indication that both patients and clinicians saw self-management benefits resulting from non-face to face consultations (Hinman et al., 2017; Lawford et al., 2018). Both patients and clinicians in these two studies felt that conducting consultations in a home environment facilitated and empowered patient self-management. Patient participants with palliative care needs (Funderskov et al., 2019) expressed the feeling of becoming an active participant in their own care in the present, although they acknowledged this may become more difficult as their illness progressed, suggesting remote consultations may have a time-sensitive application. The potential for remote consultations to focus care to self-management is not clear from the evidenced reviewed, however, it would appear further exploration in this area is warranted.

4.6 | Embracing benefits and addressing challenges

Patient participants in the reviewed studies reported a positive experience and one they would recommend to others (Hinman et al., 2017). There were perceived benefits of reduced pain, improved physical function, improved confidence and self-efficacy. Other benefits include an increase in patient education, widening access to services, and promoting efficient resource utilization

(Bazzano et al., 2018) and an increase in personalized and efficient and effective care (Kairy et al., 2013).

Patients' unique needs were identified as a limitation to offering non-face to face consultations to all patients particularly if physical examination was desirable. Non-face to face consultations were seen as unsuitable for patients who require physical contact; in the context of unknown diagnosis, or when patients' preference is not for remote consultations (Imlach et al., 2020; Lawford et al., 2018). Consultations that require life-style discussions or social isolation were felt by the participants in Bazzano et al. (2018) to be reasons to return to face to face consultation. Imlach et al. (2020) in a study of patients accessing GP services, patients emphasized the context of the consultation; both convenience and peace of mind may be affected by the nature of the consultation. Clinicians highlighted several considerations and limitations to implementing remote consultations including challenges to communications between staff, and financial stability (Bazzano et al., 2018), and a change in service delivery requiring co-ordination, advocacy and support (Wright & Honey, 2016). Some clinicians expressed a clear preference for seeing the patient in-person to make an accurate assessment (Lawford et al., 2018). Interestingly, Wright and Honey (2016) reported nurse participants' expression of a greater feeling of trust and better communication in the team while using remote consultation, although this study was undertaken in a very remote, rural context and may not be applicable to teams where there is usually daily physical contact.

5 | DISCUSSION

The aim of this review was to explore the experience of both clinicians and patients of non-face to face consultation, rather than exploring the possible health benefits (Flodgren et al., 2015; Greenhalgh et al., 2020), privacy and security concerns (Armfield et al., 2015; Mold et al., 2019; Shaw et al., 2018) or satisfaction. All seven studies reviewed reported some positive experiences, suggesting both patients and clinicians across a narrow range of services perceive benefits from its use. A Cochrane review published by Flodgren et al. in Flodgren et al., 2015 (pre-pandemic) found although health outcomes of patients were similar, they were unable to report on the acceptability for either clinician or patient of this form of consultation.

The studies included in this synthesis were from a selective population comprising patients who were low risk, had routine reviews and standard, well-evidence treatments (e.g. exercise for knee osteoarthritis) and a discrete groups of clinicians. One study (Imlach et al., 2020) explored patients' experience of using telemedicine in a primary care setting post-SARS-CoV-2 pandemic and found similar findings to the pre-pandemic studies. The studies represented five countries from northern western society rather than middle- or low-income economies, which does limit the generalizability of the findings to contemporary use of non-face to face consultation globally. The exploration of the data did enable us to show comparable themes as presented here, yet much of

the evidence remains specific to a particular setting. However, the implementation of a different consultation approach is not merely about the process of implementation, but also about changes to the use of information technology, the organizational processes and interactional components of a consultation (Whereton et al., 2020). What this review has shown is key areas of the patient and clinician experience needs to influence this implementation and learning from such experiences needs to be pivotal as advocated by Bidmead and Marshall (2020).

5.1 | Pragmatic concerns

This review has shown the convenience of this form of consultation and the use of technology in consultations does have an impact on how both patients and clinicians experience the non-face to face consultations. Galway et al. (2020) acknowledge using technology is not without challenges. They identify the need to develop infrastructures in the health care systems to enable administrators and clinicians to be supported in delivering the service through the platform of remote consultations to ensure all aspects of risk are mitigated. This element of risk is being identified in several studies post-pandemic. A study in the orthopaedic clinical speciality by Gilbert et al., 2021 identified factors related to legal and safeguarding concerns and patient safety and security issues. They recommend these issues need to be addressed through the development of local and national framework to enable the facilitation of the ongoing safe delivery of clinical services using non-face to face consultations.

Accessibility and inclusivity are key to patient and clinician experience when exploring wider implementation of non-face to face consultations. Video consultation does require both parties to have access to compatible equipment, a level of knowledge in using the equipment, and present operational challenges such as Wi-Fi and connection issues. We found the experience of both patients and clinicians was different depending on the type of consultation used. Telephone consultations present less of a barrier to the overall experience of the consultation, with Lawford et al. (2018) finding telephone consultations exceeded clinicians' expectations. Paglian (2021) supports this finding and suggests cheap and accessible approaches to remote consultations, such as telephone, SMS text messaging and print may be better than smartphone apps and would enable the inclusion of low-income communities or the elderly. We suggest that telephone consultations would also benefit communities who have a reduce level of digital literacy, or accessibility ensuring parity in access to health care services. Parker et al. (2021) supports this view and advocates caution, so social and health inequalities do not influence the access to health services and impact on clinical outcomes.

In this review, clinicians were limited to physiotherapists, nurses and physicians (and with low numbers) and it is difficult to speculate on how these findings would apply more widely in health care systems and across professions, but as we move to the post-pandemic,

there needs to be an acknowledgement that health care delivery has altered significantly. The focus of digital health, the perceptions of its use and implementation in health care has changed and previous suggestions of clinicians being resistant to implementing non-face to face consultations (Leng et al., 2016), may now have changed.

5.2 | Therapeutic concerns

Our findings in this review have shown patients experience of remote consultations are not only focused on the practicalities of a successful remote consultations, but also focused on the communication and the therapeutic relationship with the clinician during the remote consultation.

Communication skills required for non-face to face consultation can be seen to be different to face to face consultation; Shaw et al. (2020) linguistic ethnographic study analysed the content of a video consultations using conversation analysis and found potential for altered flow of the conversation when using this mode for consultations. Patients we have seen in this review experienced this and questions if there is a need for different communication skills training for clinicians (Jimenez-Rodriguez et al. 2020, Portnoy et al., 2020, Murphy et al., 2020) which focus on conducting consultations when using non-traditional methods. However, with more experience in undertaking remote consultations, further exploration is required to determine if patients and clinicians do alter their communication style and if this impacts on the experience of the clinical consultation.

Therapeutic relationships were found in this review to be key to the experience of clinicians, however, non-face to face consultation were seen as challenging to clinicians to maintain high-quality relationships with patients. Ghosh et al. (2020) found the use of non-verbal cues as an essential component of this relationship with both patients and clinicians acting on each other's cues, with this non-verbal behaviour playing a significant role in the quality, experience and satisfaction of any consultation and adherence to treatment and clinical outcomes. Mishna et al. (2021) further supported this by identifying implementation of remote consultations does require an acknowledgement of how an altered positioning of information technology in the consultation will impact on the process and outcome of the consultation.

This review has shown remote consultations do have potential benefits in different clinical contexts. Understanding how to design remote consultation services that fit both the needs of patients and clinicians will require an ongoing dialogue. Concerns about remote consultation such as those raised by Greenhalgh et al. (2020), Shaw et al. (2018) and Mold et al. (2019) are yet to be explored through empirical research. Studies exploring costs of remote appointments have found significant savings (McKirdy & Imbuldeniya, 2017; Melian et al., 2020; Miah et al., 2019; Nord et al., 2019) although there are others who suggest cost-effectiveness is interdependent on several complex factors (Shaw et al., 2018).

5.3 | Strengths and limitations

Evaluating the literature relating to remote consultations has proved complex as the topic is evolving rapidly. We have found conflation of the key terms and there is no clear definition of each. Designing a comprehensive search strategy for such a disparate collection of literature was challenging and it is possible that we missed some relevant studies because they used an alternative terminology. We attempted to overcome this by using a range of search terms, guided by a librarian and searching of MeSH terms. Furthermore, difficulties arise when reviewing the evidence as there is no clear generic definition of 'remote' consultation and differences are shown across clinical specialties, professions and countries. It is acknowledged that the included papers all originate in the West and Northern parts of the globe and therefore transferability to areas outside of this is not possible.

Most patients in these studies were low risk and stable and therefore for more complex patients, requiring active treatment, the experience of non-face to face consultations cannot be determined. None of the included studies involved situations where a new diagnosis was given, or where patients required difficult discussions about treatment. Several of the included studies reported qualitative data nested in a randomized controlled trial (RCT) and there is an opportunity of bias whereby the relationship between the two approaches and types of data are not always made clear or synthesized in a peer reviewed journal (O'Cathain et al., 2013).

6 | CONCLUSION

More quality studies are required to explore the experiences of patients and clinicians accessing remote consultations in a wider range of specialist care settings and because of global implementation post-SARS-CoV-2 pandemic. We have shown in this review the patients' and clinicians' experiences of remote consultations are key to the successful implementation. Implementation is not straightforward and is multifaceted and learning from experiences is key to this. The global pandemic has seen a need to change how health care is delivered but it is key moving forward in the post-pandemic era to learn from experiences that have been imposed to ensure safe patient care was delivered. There is a need to explore more what the patients' and clinicians' experiences of these consultations were, if they experienced them differently to face to face meeting, and if any learning and education opportunities emerge from this exploration. This will be important moving forward and ensure the establishment of sustainable service transformation. Furthermore, it is essential the implementation of remote consultations do not marginalize hard to reach groups and further perpetuate health and social inequalities that could potentially influence quality of life and clinical outcomes.

CONFLICT OF INTEREST

None declared.

PEER REVIEW

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