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What is the impact of a shift to remote consultations? A qualitative interview study in primary and secondary healthcare

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ABSTRACT

Objective The COVID-19 pandemic prompted a significant increase in the use of remote consultations—by telephone or video—in both primary and secondary healthcare. The reported advantages of remote consulting for both patients and clinicians include greater efficiency, flexibility and convenience. However, disadvantages, such as the uncertainty created by a loss of face-to-face contact, have also been highlighted. The aim of this study was to explore, explain and interpret patients' and clinicians' perceptions and experiences of remote consultations and assist decision-making about their future use.

Design A qualitative study based on semistructured online interviews.

Setting Primary mental healthcare or secondary care cardiology services, London, UK, February–March 2022.

Participants Primary care mental health patients (n=5), primary care clinicians (general practitioners) (n=15), secondary care cardiology patients (n=9) and secondary care cardiology clinicians (n=5).

Results The results demonstrate that a range of factors have influenced the experiences of both clinicians and patients and indicate shifts in the norms of professional practice and clinician–patient relationships.

Conclusions Patients and clinicians demonstrated pragmatic acceptance of remote consultations and, looking forward, a preference for a balanced 'hybrid model' of remote and face-to-face appointments. The study also highlights a need to consolidate and build on the informal learning and adaptation to remote consulting that has already taken place.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ In-depth exploration of the perceptions and experiences of patients and clinicians across two care delivery specialisms.
⇒ Conceptualises remote consultations as discrete healthcare interactions rather than as a substitute for in-person, face-to-face consultations.
⇒ Recruited a digitally literate sample and did not access those who are unable to access services remotely, such as homeless people and service users from lower socioeconomic backgrounds.

INTRODUCTION

Background

The impact of the COVID-19 pandemic on the delivery of healthcare is well documented.[1–4] During the pandemic, a need to minimise face-to-face contact while maintaining access to services prompted a significant increase in the use of remote consultations—by telephone or video—in both primary and secondary care.[5–9]

Formal directives endorsed remote consultations as both a required and acceptable method of service delivery. For example, in March 2020, the National Health Service (NHS) Chief Executive wrote to all healthcare providers and commissioners instructing them to introduce remote consultations for all routine outpatient, general practitioner (GP) and diagnostic appointments where it was safe to do so.[10] It was subsequently announced that all consultations should be 'remote by default'.[11] GPs were advised on how to introduce a model of 'total digital triage' where the patient initially provides some information about the reasons for contact and is triaged to determine the modality—online, telephone, video or face to face—for a consultation.[12 13]

Research question, study aims and conceptual framework

In this article, we report on a qualitative study of members of the public who had accessed remote consultations as patients, and clinicians who had delivered remote consultations in these care settings. The study was conducted in response to a request from the London Clinical Executive Group (LCEG), which asked National Institute for Health and Care Research (NIHR) Applied Research Collaboration (ARC) North Thames to explore the shift to remote consultations in

London to inform whether and how they should be integrated into future service development. This determined the focus of the work, with the research question: 'What is the impact of a shift to remote consultations in primary and secondary healthcare?'

LCEG selected primary care adult mental health and secondary care cardiology as exemplar clinical pathways. Qualitative interview data were collected from patients and clinicians who had accessed or delivered remote consultations in these care settings.

The aims of the study were to:

1. Explore perceptions and experiences of accessing or providing care remotely during the pandemic.
2. Identify factors that have influenced those experiences.
3. Assist decision-making about the future use of remote consultations.

In pursuing these aims, the research team conceptualised remote consultations as a particular form of healthcare interaction which accomplishes a certain purpose. That is, they represent discrete and authentic healthcare events rather than surrogates for in-person appointments.

Our approach to investigating the experience of accessing or providing care remotely in the London region was guided by a phenomenological understanding of the social world. This ontological approach aims to illuminate the range and context of experience and articulate the essential meanings phenomena hold for individuals experiencing them. It is underpinned by a view that 'reality' consists of objects and events (phenomena) as they are perceived or understood in the human consciousness, rather than being objects that are independent of human consciousness.[14 15] This phenomenological approach guided the construction of the questions posed to participants (online supplemental appendix 1).

Our approach was supported by a constructionist belief that a range of social, cultural and personal contexts and processes influence patients' and clinicians' understandings of remote consultations.[16]

We sought to explain and interpret the experience of remote consultations rather than solely describing the meanings participants attributed to them. By doing so, our theoretically informed examination reveals shifts in the norms of professional practice and clinician–patient relationships.

METHODS

We explored the experience of accessing or providing care remotely with patients and staff who, since the start of the pandemic (March 2020), had either accessed or delivered remote consultations (via video or telephone call) within either primary mental healthcare or a secondary care cardiology service. Data were collected via semistructured interviews.

Participants and recruitment

A purposive sampling strategy provided a means of establishing an effective connection between the research aims and the sample. Its goal was to gather insights from individuals who had specific knowledge or experience relevant to the research topic.[17] Participants were chosen based on predetermined criteria such as whether they had accessed primary mental health or secondary cardiology services as a patient or had worked within these services as a clinician during the pandemic. Purposive sampling was deemed the most appropriate method for this study because of the need to understand the experiences of specific subgroups, rather than generalising to a wider population. It allowed for a targeted exploration of the research question and ensured that participants had relevant experience. The sample size (34, see the 'Results' section) was deemed sufficient to capture a range of perspectives and insights related to the study's aims.

We recruited in the London region, using a combination of network-based and snowball approaches across multiple channels including email and peer support groups on social media. Snowball sampling was undertaken after initially recruiting a number of participants who referred others, who met the recruitment criteria to our study. It was therefore reliant on the social or professional networks of the initially recruited participants.

Individuals who expressed interest in participating were asked to confirm that they belonged to one of four groups of interest:

1. Primary care mental health patients.
2. Primary care clinicians (GPs).
3. Secondary care cardiology patients.
4. Secondary care cardiology clinicians.

Once this was confirmed, they were sent a participant information sheet and, if they were agreeable, an interview date was arranged.

Data collection

We recognised the need for patient and public involvement and engagement (PPIE) in our research design.[18] PPIE was established through PPIE Panel meetings at which the key research areas and suggestions for specific questions were discussed and agreed with a diverse group of patients and members of the public.

An interview schedule (online supplemental appendix 1), slightly adapted according to patient or clinician participants, was structured around the following three main areas identified by the research team and endorsed by the PPIE panel:

1. The experience of providing or receiving care remotely. For example, how the decision to switch to remote consultations was made, the purpose and types of remote appointments participated in, the modality employed (video or telephone), technical issues, communication, choice of location and the perceived benefits and challenges of consulting remotely.
2. The clinical and/or therapeutic effectiveness of remote consultations. For example, the level of care and support provided or received, the perceived effective-

ness of remote consultations and their impact on the development of therapeutic patient-clinician relationships.
3. Looking to the future of remote consultations. How remote consultations have evolved since the start of the pandemic and how they could be done differently. The potential for combining remote and face-to-face appointments as a means of confirming the future effectiveness of remote consultations and thoughts on what might improve the experience for patients and clinicians.

Recruitment of participants from groups b and c was successful. However, we were less successful in recruiting participants from groups a and d. That is, we found it more difficult to recruit primary care mental health patients and clinicians within secondary care cardiology services (see Strengths and weaknesses of the study).

Between February and March 2022, we conducted 34 interviews (see Results for breakdown of participants). Interviews were held via Microsoft Teams or telephone. One researcher (CC) conducted all interviews, and participants could choose to be interviewed via Microsoft Teams or telephone.

Interviews lasted an average of 34 min (range 17-51 min). All interviews were audio recorded and transcribed verbatim by a third-party transcription service; transcripts were not returned to the participants for confirmation or comments and no repeat interviews were undertaken. Each participant was compensated with a £20 gift voucher.

Data analysis

We recognised that an interpretative approach to data analysis would be needed to uncover, explain and understand the meanings individuals ascribe to the experience of remote consultations.

The notion of remote consultations as a particular form of healthcare interaction framed the analytical process, which was guided by a social constructionist view that knowledge expressed through social collaboration is never detached from context or cultural influences.[19 20] From a constructionist perspective, what is 'real', 'true' or 'moral' is a matter of social agreement born within culture and history and dependent on social relationships, which nurture vocabularies, assumptions and theories about the world.[16 21] We can never know what is universally 'true', 'false', 'right' or 'wrong'; we can only know stories about 'true', 'false', 'right' or 'wrong' as we construct our interpretations of the social world against a backdrop of shared understandings, practices, language, etc.[21 22] We, therefore, acknowledged the 'reality' of remote consultations as a phenomenon perceived and experienced by individuals and socially produced (jointly constructed) through interaction, relationships and language.

Interview data were subjected to qualitative thematic analysis following guidance provided by Braun and Clarke.[23] Analysis was undertaken by a four-member research team (CC, FAS, NR and KH). Analysts were both male and female, of diverse ages; two (CC and NR) are clinicians by training, one (NR) has experience of in-person primary care and cardiology consultations.

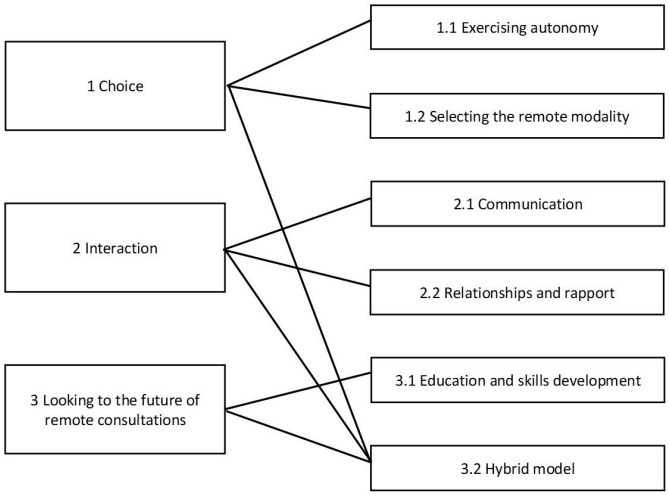

Figure 1 Coding tree detailing superordinate and subordinate themes. Relationships between the superordinate and subordinate themes are indicated in the connecting lines between themes.

Data from within different groups were analysed together. In the process of data analysis, we looked for similarities and differences within themes and across specialities/groups.

First, members of the team familiarised themselves with the data by reading all the transcripts, noting their immediate responses and insights. By a process of 'open coding' parts of transcripts relevant to the study aims were highlighted and given initial non-specific codes. This was an iterative process as we repeatedly examined the data to identify similarities and differences, patterns and relationships, points of departure and convergence. Subsequently, via a process of line-by-line scrutiny of the transcripts, noting repeated phrases and issues of importance to the participant, underlying patterns were identified and more focused codes constructed. These allowed for refined themes, inductively derived from the data rather than specified in advance, to be formed. A coding tree mapping the final organising themes was produced (figure 1). Coding was also presented and discussed in study team meetings within which a range of expertise was represented. In recognition of how their own experiences may have contributed to the analysis, members of the research team adopted a self-aware analytic approach. Reflexivity was, therefore, an essential component of both the legitimisation of the study and the trustworthiness of its findings.[24]

Data collection and analysis were undertaken concurrently until data saturation was achieved, meaning that no new codes were developed in the analysis.[25] Data saturation was reached after 28 interviews. Six additional interviews were performed, spread fairly evenly across the groups, which confirmed data saturation. Consequently, the sample size of 34 was deemed to be sufficient.[26] The

coding structure was then appraised by the research team and the transcripts were reanalysed for further evidence of the identified themes.

Rigour

The need for academic rigour in qualitative research is well established.[27 28] Therefore, a range of practical and conceptual measures was employed to confirm the legitimacy of data collection and analysis and to ensure the overall dependability of the study's findings.

We employed recognised research methods and a transparent and systematic approach to data analysis.[29] Ongoing scrutiny by an experienced research team aided evaluation of the study's credibility. We undertook regular cross-checking between researchers and team debriefings at every stage of the research process.

By maintaining a detailed record of the research process and acknowledging the study's limitations, we have enabled others who may wish to apply all or part of the findings to make judgements about the degree of 'fit' or similarity to their own situations.[30]

Patient and public involvement

Patients and members of the public were involved in the design and conduct of this research. PPIE was established through PPIE Panel meetings at which the key research areas and suggestions for specific questions were discussed and agreed with a diverse group of patients - representing both primary mental healthcare and secondary cardiology services - and members of the public. PPIE members were recruited via established PPIE networks within the London region.

RESULTS

In total, 34 participants were interviewed. The range of participants' roles is shown in table 1.

The secondary care cardiology sample consisted of a heart failure specialist nurse, a community heart failure nurse, a specialist nurse-cardiology, a community heart failure nurse specialist and a physical activity specialist.

Analysis of the 34 interviews led to the identification of six subordinate themes:

- Exercising autonomy.
- Selecting the remote modality.
- Communication.
- Relationships and rapport.
- Education and skills development.
- Hybrid model.

These were organised across the following superordinate themes:

1. Choice.
2. Interaction.
3. Looking to the future of remote consultations.

A Coding tree (figure 1) illustrates how each of the subordinate themes relates to one or more of the superordinate themes. The results are presented below in accordance with this structure. Quotes from participant interviews are used to illustrate each of the themes.

Table 1 Participant groups and numbers

Role	N=34
Primary care mental health patient	5
Primary care clinician (GP)	15
Secondary care cardiology patient	9
Secondary care cardiology clinician	5

GP, general practitioner.

Superordinate theme: choice

Interviewees described how they exercised choice within remote consultations. They were asked about their involvement in the decision to switch to remote consultations and if they were able to choose between a remote and a face-to-face consultation. They were also asked if, within a remote appointment, they would prefer a video or phone call. In addition to such direct questions, the interviews elicited a range of responses relating to the exercise of individual or professional autonomy in relation to remote consultations.

From all participant groups, there was evidence of a perceived lack of influence on the decision to switch to remote appointments. The choice of modality (telephone or video) was largely left to clinicians who either exercised their personal preference or employed the modality mandated by their service.

Exercising autonomy

Patients and clinicians were asked to describe their involvement in the decision to switch from face-to-face to remote appointments and the extent to which they felt able to exercise individual or professional autonomy in relation to this. Some described how remote consultations had been made obligatory at the start of the pandemic:

> That's all that was offered; there wasn't any other option. (Primary Care Patient)

> … that's the way it was. There seemed to be no ability to say, "Actually, I don't think this is appropriate for me". (Cardiology Patient)

> … because of the restrictions in place, the surgery closed. The surgery was unable to offer (in-person) appointments. It was suggested video or telephone consultations would be appropriate during this time of the pandemic. (Primary Care Patient)

Some clinicians explained how remote consulting had been imposed on them, noting a 'top-down' decision-making process over which they had little control:

> And then suddenly at the end of March 2020 when it all kicked off…there was a very top-down decision-making that all practices in [location] have to have eConsult [a digital triage and online consultation platform] and you need to implement it - you need to put it on your websites and you need to open it

up, and you need to do it because of the pandemic. (Primary Care Clinician)

We weren't really involved, I think. I think it came down from on high, it felt like, partly from NHS England and from the partners, saying, "Well, you can't really see patients". (Primary Care Clinician)

Clinicians, particularly those working in primary care, indicated their ability to exercise professional autonomy when describing how they were able to switch from remote to face-to-face appointments if this was required:

I'm going to say, "you know what? I think, really, you need a face-to-face conversation here, just to tease out everything". (Primary Care Clinician)

When I speak to someone on the phone, that I think this really isn't okay, that I feel that they've made a mistake in their judgment and they should have asked for a face-to-face appointment, then I'll just see them. (Primary Care Clinician)

However, not all clinicians had been able to make fully autonomous choices regarding a switch in consultation mode:

One organisation I worked in … was much stricter about the amount of autonomy a clinician had about whether to invite a patient in. So, they had a system where you had to run it past another GP before you brought someone in. (Primary Care Clinician)

Selecting the remote modality

Patients and clinicians reflected on the extent to which they felt able to exercise choice regarding the modality (video or telephone) employed in a remote consultation. The choice was primarily clinician-led, and clinicians indicated that it was influenced by factors such as the availability of resources and, perhaps significantly, the perceived inefficiency of video technology. Whereas patients, when offered a choice of modality, based their preference on the relational aspects of the consultation (see Relationships and rapport).

The majority of remote consultations participants experienced were conducted via telephone, and many indicated a preference for telephone consultations over video. Clinicians - particularly in primary care - became accustomed to undertaking most remote appointments by telephone. The benefits were framed in terms of expediency and efficiency:

I am genuinely amazed at how much we can do on the phone. That surprises me and it's fantastic. When it works, people seem to be very happy. It's quite efficient. (Primary Care Clinician)

Some clinicians also pointed to the freedom to multitask while undertaking a telephone consultation:

I prefer telephone consultations at the moment because I feel that I can look things up at the same time as the patient is talking to me. I think I can do a lot more for the patient on the telephone. (Primary Care Clinician)

They're not feeling distracted because you're not giving them eye contact, so I can do some of the documenting a little bit at the same time. (Cardiology Clinician)

You can multitask when you're on the phone, you can take notes more easily because you don't have to worry about giving eye contact to someone. (Primary Care Clinician)

Some primary care clinicians reported using telephone consultations as a necessary initial starting point prior to a video appointment:

I think I wouldn't want to do video without having a talk to the patient first, I think I'd find it a bit shocking to see the patient straight away without having elicited a history and what it's for etc. first. (Primary Care Clinician)

Patients generally found that telephone consultations were acceptable, particularly for routine or follow-up appointments. However, most had not been offered a choice of modality:

No, just phone call. (Cardiology Patient)

No. On occasion I've had video consultations, but they were set as video consultations from the start. I haven't had a choice. (Primary Care Patient)

No, generally it has just been the actual video calls. (Cardiology Patient)

No. But to be honest, if I'm offered a telephone call, I would just accept it; often I don't question it, I just go with whatever's offered. (Primary Care Patient)

Limits on the choice of modality were associated with the fact that participants were reflecting on consultations when Covid restrictions applied and face-to-face meetings were not generally available.

Although telephone consultations were the most frequently used - and preferred - modality, some participants indicated that, if offered a choice, they would prefer a video consultation:

There's no comparison. A video consultation gives you all the visual inputs as well, and so you have all the audio inputs and cues. You are missing those in a telephone consultation so it's incomparable, a video and telephone consultation. (Primary Care Clinician)

I think a video appointment is probably better. I do feel that I don't know what the doctor looks like, and I'd quite like to know that. (Cardiology Patient)

The video consultation gives you far, far, more inputs which are important in your decision-making process. (Primary Care Clinician)

Some clinicians - particularly in cardiology - expressed a preference for video based on the perceived advantages to clinical diagnosis:

> … a video recording is better because you're face to face, and you can see the expression or whatever you like and the concern. (Cardiology Clinician)

> I would prefer a video consultation given the choice… because actually seeing the patient is hugely beneficial. Being able to see somebody face-to-face helps with their clinical decision making. You are then able to be a bit more trusting of your decision making. (Cardiology Clinician)

> At least I can see the patient on the video, I can see. If I do an assessment, I always ask them, "Can you press your ankle?" if there's swelling. (Cardiology Clinician)

A further advantage, from one clinician's experience, was the increased discipline engendered by a video appointment:

> I think maybe if a patient is prepared to do a video consultation they're prepped a bit more maybe, they've got their questions ready. Whereas with a face-to-face consultation the conversation tends to drift, and you start talking about other things. Sometimes it's hard to get them on track. Maybe they're prepped a bit more because they know that they've got to use this technology and they want to ask their questions. I don't know, but generally when I've undertaken video consultations it's been kept to time much better. (Cardiology Clinician)

Overall, however, video consultations had not been widely used by our participants, and it was evident that telephone consultations were employed more frequently. Indeed, for many clinicians, video offered relatively few advantages, and they cited technical difficulties and logistical challenges (of integrating video capability into organisational systems) for not making more use of video. They also discussed some of the difficulties they had encountered when attempting to undertake video consultations:

> It's very much dependent on computer speed, broadband speed, particularly, you know, in lots of workplaces you can work from home and then that depends on your home speed as well. (Primary Care Clinician)

> Video is usually frustrating because it depends on internet connection, video resolution, sound is offering buffering, delayed, it's not quite right, so video is hugely problematic. And I think, I don't know anyone who's not had any problems with it. (Primary Care Clinician)

> …the IT systems in GP practices aren't up to scratch. The computers have slowed down, the connection doesn't work, then the patient's video doesn't work, yours doesn't work, then you've wasted maybe 30 minutes trying to get it sorted and then it would've been quicker for the patient to have come down and been seen face to face. (Primary Care Clinician)

> …you can always offer video consultations, but in reality it's quite fiddly because you've got to send… You've got to text the patient a link. They've got to have a smartphone to be able to open the link and understand what you're asking them to do, so I think for some people it's fine, and for others not so fine. So, effectively, we do very few video consultations. Mostly it's telephone. (Primary Care Clinician)

Many clinicians and patients we spoke to thought patients were well-placed to choose whether consultations should take place remotely or face to face.

> I'm really happy if we were able to ask our patients in the future: "Would you prefer this, or would you prefer this?". (Cardiology Clinician)

> I think patients should have the choice….at the moment, there's no choice. (Cardiology Clinician)

Superordinate theme: interaction

The ways in which remote consulting affects the ability to communicate clearly and effectively was an important feature of participants' experience. It was evident that, compared with telephone appointments, consulting via video was perceived as having the possibility to enable clearer and more effective interaction between patients and clinicians.

Communication

The manner in which communication is enhanced or restricted was largely dependent on the modality employed. It was felt that video offers a more effective, personal means of communicating, particularly as it enables recognition of facial gestures:

> Well, in some ways, it's [video] more personal. You know, I look at your face…it's not the same as actually being with the person, but I can see something of your facial expression, your body language, and so on, as we go through and we talk and, of course, you don't get any of that on the phone. (Cardiology Clinician)

> So doing video, in some ways, because you can see the expression of somebody's face, you can see their lips moving, things like that, so that gives you more clue of the communication that's going on. From that prospect, video consultations are probably better than just plain telephone consultations. (Cardiology Clinician)

Conversely, it was acknowledged that telephone consultations impeded the recognition of physical gestures:

> I guess it's the kind of absence of, like, physical gestures. So if they're describing their pain, they can't point to something. Or if you're encouraging them to do something, you can't just kind of nod and imply

something through those physical communication gestures that you normally would. (Primary Care Clinician)

Video is probably preferable just because, obviously, you get audio so you get everything that you can from a telephone but then you also get to pick up on non-verbal cues. (Primary Care Clinician)

Mental health consultations are particularly reliant on the communication of non-verbal cues, which highlighted the value of video to these consultations:

…to have telephone-only remote consultations, I think that makes it much harder because I think, particularly for that patient group [mental health], you do rely a lot on the non-verbal cues. They're actually really important. You do need to get a sense of how fidgety someone is, how restless someone is, how kempt someone is or unkempt someone is. All these are hugely important in your assessment. Their behaviour, ability to focus, concentrate, etc. (Primary Care Clinician)

Interviewees expressed confidence in the confidential nature of remote consultations. Although it was felt that the need for both confidentiality and privacy was better served by telephone meetings:

I'm in an office with six other people, in and out, lots of toing and froing. For the most part a lot of my consultations have had to take place there. Obviously, confidentiality from that perspective is a challenge so we try fairly hard not to hold a video consultation in that environment. Clinic space is a challenge. A quiet appropriate area is a challenge. (Cardiology Clinician)

It was noted that it is easier to have a (private) telephone conversation, for example, at work, than it would be to have a video consultation:

….a lot of people engage in remote consultations when they're at work, so they'll often find a quiet room or something like that where they can take a telephone call, but they might not have the facility to do a video call in that sort of setting. So I think that's part of the issue. (Primary Care Clinician)

Across the sample, participants identified communication challenges they faced within remote consultations. Language difficulties and the use of interpreters were a particular source of frustration for some clinicians:

Language is a bit of an issue when working remotely. We haven't had huge success using a third-party language interpreting service remotely. (Cardiology Clinician)

You call the person, the person, maybe they hang up or you lose the interpreter. You call them back, it's now a different interpreter and all this stuff. What was supposed to be a 15-minute consultation can easily become a 30-minute consultation. (Primary Care Clinician)

One particular recurrent issue we had…When we had the refugee asylum seekers there were quite a few Kurdish patients, it's just getting hold of an interpreter. I think there was one patient where we had to reschedule three or four appointments just because I kept ringing, and I was on hold for 15 minutes and I just couldn't find an interpreter. (Primary Care Clinician)

Relationships and rapport

Participants described the impact of remote consultations on the development and maintenance of effective relationships between patients and clinicians. Where a choice between a face-to-face and remote appointment was possible, the relational aspects of consultations were key in patients' decision-making:

If your first contact with that person is on the telephone and then you never meet them, I don't feel like any relationship gets built. (Primary Care Patient)

It's very, very, important for me to be able to establish a relationship of trust with my cardiologist, which has been pushed to its limits, let's put it that way, because I was frightened of going into hospital. You need to see somebody, you need to look them in the eye, to be able to do that. Going back to the body language, it's very difficult to be able to do that. (Cardiology Patient)

Video consultations were thought to contribute to better relationship development:

I can think of only a few people over the last couple of years where I think we've established a proper relationship purely by phone. (Primary Care Clinician)

A video call….it's better for building rapport if you can see the patient, and sometimes the patient can be a bit disembodied on the phone. I think also the patient probably likes to be able to look their healthcare professional, if not in the eye then at least in the face. (Primary Care Clinician)

Over a telephone consultation, you don't even know what you both look like so it's awkward because then you could… If you met again you wouldn't even know if it's the same person. I think that's a very basic limitation for telephone consultations. (Primary Care Clinician)

I have a patient who has MS so it's affected her speech, she can't speak very well. When I heard her over the phone it was really difficult to understand what she was saying, and I thought she had a learning disability, and I was sort of incorrectly treating her as such. When we did a video consultation and I realized she was actually quite articulate and she told me, "Because of my MS my speech is a bit slurred." Then

actually the relationship improved. (Primary Care Clinician)

Because with the telephone, you lose the visual cues. And even with a mask, you can see happiness, you can see despair, and there's that element vulnerability or being able to elicit that almost like a trusting relationship with that person, and video sort of makes that better. (Primary Care Clinician)

The development of relationships was perceived to be linked to establishing a good rapport between clinician and patient. This, in turn, was likely to be improved if the clinician and patient had previously met face to face:

…the whole point of building a rapport, really, and a relationship, is the connection, the human connection, and it's far, far harder to do that over the phone…and I think once you've seen them, even just once, the relationship, or the strength of that rapport increases exponentially. (Primary Care Clinician)

If it's someone you know very well then I think telephone rapport is fine. I think if it's someone you don't know then I think you have to work harder with a telephone, it takes longer to establish the rapport. (Primary Care Clinician)

I genuinely feel like it's affected my care because I don't feel like we've built up a rapport at all because we've not met face to face. There have been some significant problems because of that. (Primary Care Patient)

Superordinate theme: looking to the future of remote consultations

During the period of pandemic-related restrictions, the use of remote consultations was viewed by most participants as a pragmatic necessity. However, as these restrictions eased, participants' views on the ongoing suitability of remote consultations were less clear-cut.

Education and skills development

When asked to consider the future of remote consultations, participants highlighted the need for greater acceptance of remote modalities going forward. The need for education and skills development emerged as a subordinate theme related to both patients and clinicians:

I think what really needs to happen is for a really concerted effort from probably the RCGP and NHS England, to do a real, sort of a real communications drive nationally, in terms of not just leaflets and posters, you know, a real campaign, really, to educate people as to what we do, how we do it, but also to demonstrate to them that actually their options haven't narrowed, their options have expanded… We've gone from only having face-to-faces, to now having face-to-face, telephone, video and eConsult; that's four different ways of being able to access your primary care provider. It's huge. (Primary Care Clinician)

So, I don't think there's been enough education publicly, nationally, from NHS England to teach people what the role of these consultations are, and what they are meant to be, and how patients can actually benefit from them. (Primary Care Clinician)

There needs to be more innovative thinking regarding patients who may be experiencing digital exclusion, or digital problems. (Primary Care Patient)

Clinicians described a lack of formal training regarding remote consultations:

Not in any specific way, it was more just filtered down through the practice manager of how to do it. (Primary Care Clinician)

There have been odd bits of information, like on our intranet, to teach us how to use it. Then we've mainly done in-house training between us to practice and learn how to use it. (Cardiology Clinician)

Training needs were perceived to differ by age and to be related to the perceived technical difficulty some patients encountered and that resolving technical issues should be a priority if video consultations were to be used more freely in the future:

I think for older people, and not all older people are technically challenged, but if the remote system was literally just press a button, one button, and don't do anything else, I think that would enable more people to be able to access remote appointments from their laptops or whatever. (Cardiology Patient)

Video might come in more over time if the interface becomes a bit easier to use, it is a bit slicker. If there is more demand. (Primary Care Clinician)

A key area in which clinicians indicated skills development and adaptation was in relation to increasing willingness and ability to manage risk within remote appointments:

… what a lot of us found, is that we were doing things - not, I would say blindly - but we were taking greater risks, presuming or assuming more than we would do under other circumstances, because we were having to make judgements without having the person in front of us, or being able to investigate in the same way. (Primary Care Clinician)

I think people are more comfortable with risk. I think before, maybe, we'd have to see the patient. See a child with upper respiratory symptoms, we'd have to examine them, we'd have to see them. Now some GPs feel confident doing that over the phone because a lot of what you're asking is really in the history and appropriate safety netting. So people have become more confident in doing so. (Primary Care Clinician)

Yes, it has definitely got better because it's a whole new way of working and it's a whole new way of conducting an assessment. Or where you ask your

questions, and the type of questions you ask, has changed. (Cardiology Clinician)

The framing is very negative, whereas it has to be, yes, well, reframed to demonstrate to them that remote consultations have opened up so many more opportunities and possibilities for them. (Primary Care Clinician)

Hybrid model

Participants endorsed a 'hybrid' combination of remote and face-to-face appointments as a means of consolidating remote consultations within future service delivery. This approach would mean that either mode of delivery could be facilitated according to need.

I think I prefer a hybrid because at times initially you could do with a remote and if you feel unsatisfied then you can always ask them, "Can we have a face to face?" So that you can resolve some of the issues. (Cardiology Patient)

I think a hybrid system will be the main way forward, but we have to think very carefully about access to those face-to-faces because the concern is that the very people who you want to get them, that is, the frail, the multimorbidity, the patients with dementia, you know, the people who really need to be seen, would they be able to access them? (Primary Care Clinician)

I think the way my GP offers it, is they have a call and if they feel it's necessary to see you, then they'll invite you in at a separate time at another time. So, I think that works well. (Primary Care Patient)

I think, if I was going to see my patients following their surgery, I'd like to do that face to face. Then, possibly, if I was going to see them again, I could do a telephone call, more of a chat about things. I think there's room to develop something like that for people. (Cardiology Clinician)

The adoption of a hybrid approach that is responsive to need requires organisational understanding and commitment:

I think organisations need to understand the need to offer a variation in the type of remote consultation and ensure that they have face-to-face access as well…. Not all organisations appreciate the absolute requirement to offer the full breadth of consultations. (Primary Care Clinician)

DISCUSSION

Principal findings

The results offer an insight into the perceptions and experiences of those who participated in remote healthcare consultations from the start of the pandemic. They demonstrate that a range of factors have influenced the experiences of both clinicians and patients and indicate shifts in the norms of professional practice and clinician-patient relationships which may assist decision-making about the future use of remote consultations. Although initial expectations were that participants from primary care mental health and secondary care cardiology would differ in accordance with the care setting, few distinguishable differences were evident from the data.

When participants discussed the use of remote consultations during the pandemic, it was clear that pragmatic concerns for safety were most influential on their experiences. However, moving beyond the pandemic, positive features such as expediency and functionality, plus negative perceptions of the impact that remote consulting may have on the relational aspects of a healthcare consultation, were similarly influential.

Key findings relate to choice, the manner in which communication is either enhanced or impeded and the perceptions of patients and clinicians regarding the future of remote consulting. They also show that the advantages of remote consultations relate primarily to efficiency and that the disadvantages relate to the lessening of interpersonal contact and in the relational aspects of the patient–clinician relationship.

Telephone was the most frequently used modality, but it is clear that video consultations offer specific advantages, such as the recognition of non-verbal cues, but that the technical challenges impede their common use. For example, cardiology staff in our sample (specialist cardiology nurses and a physical activity specialist) expressed a preference for video over telephone consultations, although in practice the use of video was significantly restricted by challenges of technology and access to appropriate space and equipment. In primary care, video consultations were rarely used, clinicians cited technical frustrations and minimal perceived advantages. Although clinicians reported that issues can be effectively addressed by telephone consultation, they acknowledged the importance of having the capacity to rapidly convert to a face-to-face appointment.

Our study indicates acceptance of remote consultations by both patients and clinicians. Participants were generally supportive of the implementation of remote consultations as part of future healthcare delivery. It was acknowledged that remote appointments impede the relational aspects of a consultation and that rapport between clinician and patient was likely to be improved if the clinician and patient had previously met face-to-face. Both patients and clinicians accepted remote consultations as part of a hybrid model of care delivery as it retains the embodied, relational aspects of a 'traditional' face-to-face approach.

Most clinicians had not received any formal training on how to deliver remote consultations, and those who had reported training that was limited to how to use the technology. However, patients and clinicians have developed skills in consulting remotely through practical experience. They have had to adapt quickly to remote consultations and to manage privacy, confidentiality and clinical

decision-making in that context, despite limited access to any formal training or support.

Strengths and weaknesses of the study

We have identified characteristics of remote consultations that affect both adult patients' and clinicians' acceptance of them. Previous studies have examined patients' and clinicians' experiences of remote consultations, but this is one of the first to conceptualise remote consultations as discrete healthcare interactions rather than as a substitute for in-person, face-to-face consultations. We employed a rigorous and methodical approach to this study, which we believe has yielded meaningful and useful results and provides credibility.

We undertook an in-depth exploration of the perceptions and experiences of patients and clinicians across care delivery specialisms. We have successfully identified factors that influenced participants' experience, and our findings may contribute to decision-making about the future use of remote consultations.

However, we acknowledge that this is a relatively small qualitative study, and we anticipate that the issues raised in our study will be further explored in future research inquiry. One of the limitations of our study was the sampling strategy, which did not adequately ensure recruitment of sufficient primary care mental health patients or secondary care cardiology clinicians. We therefore recognise that our sample was somewhat skewed, which resulted in the experiences of primary care clinicians being particularly prominent in our findings, and we do not, therefore, claim that our data reached saturation of information from across the range of our sample groups, although we did achieve saturation of themes in relation to the aims of the study. This was partially due to the difficulties of recruiting in the pandemic amidst lockdowns.

Findings in the broader research context

The pandemic-related increase in remote consultations, which coincided with an NHS commitment to 'digitally enabled' healthcare,[31] generated significant scholarly activity prompting a rapid expansion in associated research, evaluation, guidance and commentary.[32–35]

Previous work investigating patients' and clinicians' experiences of remote consultations has considered the impact of remote consultations on patients and healthcare staff.[36–40] The impact of remote consultations on personalised care[41] and safeguarding[12] has also been explored.

Our findings indicate shifts in the norms of professional practice and clinician-patient relationships which reflect the findings of others in relation to the radical and evolving changes in ways of working during the pandemic when the implications for the future organisation of general practice were highlighted in the adoption of 'new' ways of working.[42 43]

Reflecting our recognition of a sense of pragmatic acceptance of remote consultations among patients and clinicians, other studies have focused on the transitory, pandemic-imposed nature of remote consultations and whether they may (or should) become a more permanent feature of healthcare delivery.[42 44]

Our finding that rapport between clinician and patient was likely to be improved if the clinician and patient had previously met face to face is reflected in the wider literature. Payne *et al*, for example, note that remote modalities can interfere with communicative tasks such as rapport building and establishing a therapeutic relationship.[45] Mann *et al* report that establishing rapport and trust over the telephone, when visual cues are lacking, and video, while providing a better approximation to face to face, is still inferior to face-to-face meetings in interactional terms.[41]

As in our study, it has been reported that remote appointments are valued by both patients and clinicians for their convenience.[46] For clinicians, they yield efficiency gains in terms of prioritisation and flexibility and in relation to the effectiveness of 'simpler' consultations such as repeat prescriptions and medication reviews.[36 47 48]

The relational aspects of remote consultations have also been explored and, as our findings indicate, some healthcare staff report that a loss of face-to-face contact makes remote interactions too 'transactional' and that a reduction in observational information - particularly via telephone as the most commonly used remote modality - can lead to uncertainty and possible misdiagnosis.[12 35 36] As we found, a balance between remote and face-to-face consultations has been advocated.[47 48]

The advantages of remote consultations to patients have been reported, and our findings reflect those of others in that it has been found that patients value remote appointments for the reduction in travel and time, improved accessibility to healthcare and shorter length of consultations.[34 49]

However, it has also been reported that patients have expressed privacy concerns and found that therapeutic relationships are more easily maintained remotely when they have previously met their clinician in-person.[46 50 51] This is clearly indicated in our own findings.

The issue of access to remote healthcare consultations, especially when technology is required, intersects with several social justice concerns which were not highlighted in our findings. For example, the 'digital divide' highlights how access to appropriate technology may be a significant barrier.[4 52] Many low-income communities, rural populations, elderly individuals and those with limited digital literacy may struggle to access the necessary tools (smartphones, computers or high-speed internet) for remote consultations. Remote consultation for individuals lacking capacity has been explored.[53] Also, the use of interpreters may be needed when cultural and linguistic barriers prevent non-English speakers or those with different cultural backgrounds from fully participating in remote consultations.[54]

As reflected in our findings, the need for additional training to provide remote consultations safely and

effectively, plus the requirement for adequate infrastructure to optimise remote consulting, has been noted.[55–57]

Acceptability and accessibility of remote consultations for different groups

We did not identify clear differences in acceptability of remote consultations across the care settings under study, although language and certain health conditions were described as hindering communication and relationship building. A recent systematic review on experiences of remote consultation in UK primary care for patients with mental health conditions found that acceptability can be context-dependent and influenced by several factors including specific conditions, comorbidities, clinician-patient relationships and the consultation's purpose.[58] The review also found that the type of remote consultation, including the use of technology, can impact on acceptability.

A qualitative service evaluation of clinicians (nurses, healthcare assistants, psychology, occupational therapy, social workers, psychotherapists, psychiatrists and administrative staff) from 10 community mental health teams in an NHS trust explored the technology theme in further detail.[59] Clinicians reported how technology could exacerbate anxiety, frustration or attachment problems among some mental health patients. Moreover, accessibility per se may be reduced and inequalities worsen, for example, where patients with paranoia refuse, or patients with intellectual disabilities are not supported to be able to use remote consultations.

The impression that it is harder to build therapeutic relationships with some patients over video (such as with those suffering from trauma) had also resulted in frequent cancellations of trauma-informed care over the pandemic. Whereas appropriate care would not necessarily reach groups that may be able to hide their symptoms over the telephone or even over video consultations (eg, in self-harm, eating disorder).[59]

Also in line with our findings, rheumatology and cardiology clinicians and patients in a general hospital in England agreed that regular and routine follow-up appointments of stable conditions would be acceptable remotely (and they may also be following specific procedures such as catheter ablation for arrhythmia in which symptoms guide long-term management).[60 61] However, not so for initial appointments. A common factor was setting the appropriate parameters for the consultations, where patients were concerned with finding the right words to describe their conditions and believed that symptoms would be more easily detected in a face-to-face consultation, while clinicians expressed a concern for 'breaking bad news' particularly over the telephone before they had met the patients.

A review of guiding themes for equitable and effective delivery in cardiology concluded that consultation modality needs to be discussed individually with and informed by the patient's specific personal characteristics (eg, language barriers, confidence with technology, internet access) and preferences.[61]

Candidacy

In recent years, the concept of a candidacy framework that helps to explain how individuals perceive and navigate their eligibility or 'right' to access healthcare services has been explored.[62] Candidacy refers to an individual patient's sense of whether they are entitled to receive certain health services, whether they are worthy or if their condition is serious enough, possibly leading them to delay or avoid seeking care. An individual's assessment of the entitlement may be based on perceived social and cultural expectations. Sinnott *et al* discuss how access to appointments in primary care is subject to a range of socioeconomic and institutional influences that may create socially patterned barriers to access for some.[63] The notion of such entitlement did not arise within our interview data other than when patients referred to a desire to not 'waste the doctor's time' within a primary care appointment. Such concern was not directly related to the remote modality employed.

Implications for clinicians and policy-makers

Although participants (particularly patients) demonstrated a lack of influence in the switch to remote consultations and a lack of choice in the remote modality employed, the extent to which there was acceptance of remote consultations by both patients and clinicians amounts to more than pragmatic recognition of their enforced nature during and immediately beyond the pandemic. An impression conveyed by interviewees across the sampled groups was an acknowledgement of remote consultations as a discrete form of healthcare interaction both currently and in the future.

However, challenges with the implementation of remote consultations still exist. Neither patients nor clinicians in our sample had been adequately prepared for remote consulting, and it is apparent that, due to their initial expedient nature, remote consulting has not been satisfactorily planned or structured with full consideration given to the end user (patient or clinician) or practice setting. There is a need to consolidate the informal learning and adaptation that has taken place by patients and clinicians since the start of the pandemic and, looking forward, ensure that training needs are effectively identified and implemented.

Remote consultations highlight the 'digital divide', that is, the gap between those with ready access to digital resources (computers/smart phones/the internet) and those without. It is worth noting that our participants were mostly recruited via email and social media and that interviews were all conducted remotely. We, therefore, recruited a digitally literate sample. The impact of the digital divide on equality of access to healthcare requires careful consideration. Those who are unable to access services remotely are likely to be part of vulnerable

groups such as older people, homeless people and service users from lower socioeconomic backgrounds.

Looking forward, an issue in terms of organisational planning might be how to navigate a model which allowed integration of remote and face-to-face consultations within the same practice or clinic. This implies a need for an appropriate infrastructure that will enable 'seamless' shifting between the two types of consultation as and when needs arise. We also suggest that remote healthcare delivery would be enhanced through training, for both staff and patients, on the most effective way in which to consult remotely.

Future research

Further research is needed to explore the collective experiences of the individual sample groups identified in this study.

CONCLUSIONS

The qualitative data collected and analysed in this study offer an insight into the perceptions and experiences of those who have participated in remote healthcare consultations since the start of the pandemic and beyond. They demonstrate that a range of factors influence these experiences.

Our study demonstrates pragmatic acceptance of remote 'routine' consultations by both patients and clinicians and, looking forward, a preference for a balanced 'hybrid model' of remote and face-to-face appointments. The recognition of a need to consolidate and build on the informal learning and adaptation that has taken place during the emergence of remote consulting as a distinct method of healthcare delivery will assist future decision-making in this area.

In looking forward, we sought to conceptualise remote consultations as discrete interactions and an established feature of contemporary healthcare delivery. We recognised their potential to improve the quality of care that patients receive and to increase the role satisfaction of clinicians.

There is substantial room for improvement in the development and implementation of remote consultations. This study has contributed to the ongoing explanation of this method of consulting, and hopefully our findings will assist the identification of ways in which the process of remote appointments may be enhanced - to the benefit of both patients and clinicians.

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