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Research Article

Patients' experiences with remote consultations in primary care during the COVID-19 pandemic: a qualitative study of this alternative to in-person care

Experiências dos pacientes com as consultas remotas na atenção primária durante a pandemia de covid-19: estudo qualitativo sobre essa alternativa ao atendimento presencial

Experiencias de los pacientes con las consultas remotas en la atención primaria durante la pandemia de COVID-19: un estudio cualitativo sobre esta alternativa a la atención presencial

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Abstract

Introduction: Teleconsultation was abruptly introduced in Brazil as an alternative to in-person care during the COVID-19 pandemic. **Objective:** We sought to understand how patients perceive remote consultations—whether they consider them comparable to face-to-face encounters or merely an exceptional measure imposed by the pandemic. **Methods:** This qualitative study used video interviews guided by a semi-structured script with patients from primary care in Florianópolis. Patients who had undergone remote consultations with the same physicians conducting the study were invited to participate. We inquired about previous experiences with telehealth, technical aspects, feelings about teleconsultation, comparisons with in-person visits, and future perspectives. The interviews were recorded, transcribed, and analyzed using conventional content analysis. **Results:** Remote consultations and other virtual interactions with the primary care service were well received, showing quality comparable to in-person care and no significant technical limitations. This tool appears to be enduring and promising, though not suitable for all conditions or demands. According to patients, it is up to the health care professional to decide whether in-person or remote care is more appropriate at the time of consultation. Patients tend to prefer remote modalities for punctual issues and in-person visits for more complex conditions requiring physical examination. Inspection—possible through video—was not considered a physical examination. We observed that there is a conventional "consultation process" consisting of a trigger (a problem or complaint), followed by dialogue between doctor and patient, physical examination, complementary tests, and management. When all these components are present, and in this order, the interaction is unanimously interpreted as a "consultation." When one of these four components is absent, the interaction is not always perceived as a "consultation," and the management provided is often interpreted merely as guidance or "triage." **Conclusions:** Remote consultations were well evaluated and tend to remain as a complement to in-person care, especially for simple demands. However, they do not replace in-person consultations in situations that require physical examination or more complex assessment. The notion of a "consultation" remains linked to a traditional process, and interactions that do not include all of its elements are not always recognized as such by patients. Thus, teleconsultation appears to be a promising tool, provided that it is used with clear clinical criteria and accompanied by adequate communication between professional and user.

Keywords: Remote consultation; Primary health care; Patient satisfaction; Telemedicine; Family practice.

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Resumo

Introdução: A teleconsulta foi introduzida repentinamente no Brasil como alternativa ao atendimento presencial durante a pandemia de covid-19. **Objetivo:** Buscamos saber como os pacientes percebem as consultas remotas e se as consideram comparáveis ao atendimento presencial ou apenas uma ferramenta de caráter excepcional imposta pelo cenário pandêmico. **Método:** Pesquisa qualitativa com entrevistas por vídeo guiadas por roteiro semiestruturado com pacientes na atenção primária de Florianópolis. Pacientes consultados remotamente pelos próprios médicos pesquisadores foram convidados a participar. Questionamos sobre experiências prévias com teleatendimento, aspectos técnicos, sentimentos sobre a teleconsulta, comparações com o atendimento presencial e perspectivas futuras. As entrevistas foram gravadas, transcritas e apreciadas por análise de conteúdo convencional. **Resultados:** As consultas remotas e outras interações virtuais com o serviço de atenção primária foram bem recebidas, com qualidade comparável ao presencial e sem problemas técnicos limitantes. Essa ferramenta parece ser duradoura e promissora, mas não para qualquer condição ou demanda, cabendo ao profissional de saúde, na opinião dos pacientes, decidir entre a modalidade presencial ou remota no momento do atendimento. Os pacientes tendem a preferir o atendimento remoto para questões mais pontuais e o presencial para questões complexas e que demandam exame físico. A inspeção, possível por vídeo, não foi considerada um exame físico. Notamos que é convencional a existência de um "processo de consulta" composto por um disparador (problema ou queixa), seguido por um diálogo entre médico e paciente, exame físico, exame complementar e uma conduta. Quando todos os itens estão presentes, e nesta ordem, a interpretação é unanimemente de que houve uma "consulta". Quando um desses quatro itens está ausente, a interação nem sempre é vista como "consulta", e a conduta informada ao paciente muitas vezes foi interpretada como orientação isolada ou "triagem". **Conclusões:** As consultas remotas foram bem avaliadas e tendem a permanecer como complemento ao cuidado presencial, sobretudo para demandas simples. Contudo, não substituem a consulta presencial em situações que exigem exame físico ou avaliação mais complexa. A noção de "consulta" permanece vinculada a um processo tradicional, e interações que não incluem todos os seus elementos nem sempre são reconhecidas como tal pelos pacientes. Assim, a teleconsulta se mostra uma ferramenta promissora, desde que utilizada com critérios clínicos claros e acompanhada de comunicação adequada entre profissional e usuário.

Palavras-chave: Consulta remota; Atenção primária à saúde; Satisfação do paciente; Telemedicina; Medicina de família e comunidade.

Resumen

Introducción: La teleconsulta fue introducida de manera repentina en Brasil como una alternativa a la atención presencial durante la pandemia de COVID-19. **Objetivo:** Buscamos comprender cómo los pacientes perciben las consultas remotas y si las consideran comparables a la atención presencial o simplemente una herramienta excepcional impuesta por la pandemia. **Métodos:** Estudio cualitativo con entrevistas por video guiadas por un guion semiestructurado con pacientes de atención primaria en Florianópolis. Los pacientes que fueron atendidos de forma remota por los propios médicos investigadores fueron invitados a participar. Se indagó sobre experiencias previas con la teleatención, aspectos técnicos, sentimientos acerca de la teleconsulta, comparaciones con la atención presencial y perspectivas futuras. Las entrevistas fueron grabadas, transcritas y analizadas mediante análisis de contenido convencional. **Resultados:** Las consultas remotas y otras interacciones virtuales con el servicio de atención primaria fueron bien recibidas, con una calidad comparable a la atención presencial y sin problemas técnicos relevantes. Esta herramienta parece ser duradera y prometedora, aunque no adecuada para cualquier condición o demanda. Según los pacientes, corresponde al profesional de salud decidir, en el momento de la atención, entre la modalidad presencial o la remota. Los pacientes tienden a preferir las modalidades remotas para cuestiones puntuales y la atención presencial para casos más complejos que requieren examen físico. La inspección, posible mediante video, no fue considerada un examen físico. Observamos que existe un "proceso de consulta" convencional compuesto por un desencadenante (problema o queja), seguido por un diálogo entre médico y paciente, examen físico, examen complementario y conducta. Cuando todos estos elementos están presentes y en este orden, la interacción se interpreta unánimemente como una "consulta". Cuando falta alguno de estos cuatro elementos, la interacción no siempre es vista como una "consulta", y la conducta informada al paciente suele interpretarse como una orientación aislada o un "triaje". **Conclusiones:** Las consultas remotas fueron bien evaluadas y tienden a permanecer como un complemento a la atención presencial, especialmente para demandas simples. Sin embargo, no reemplazan la consulta presencial en situaciones que requieren examen físico o una evaluación más compleja. La noción de "consulta" sigue vinculada a un proceso tradicional, y las interacciones que no incluyen todos sus elementos no siempre son reconocidas como tal por los pacientes. Así, la teleconsulta se muestra como una herramienta prometedora, siempre que se utilice con criterios clínicos claros y acompañada de una comunicación adecuada entre el profesional y el usuario.

Palabras clave: Consulta remota; Atención primaria de salud; Satisfacción del paciente; Telemedicina; Medicina familiar y comunitaria.

INTRODUCTION

Remote consultations have the potential to increase patient autonomy; reduce consultation time and travel costs for patients and health care professionals; and improve the quality of care.[1-3] However, this modality also presents limitations. Physical touch is lost, negatively impacting social dimensions, such as the absence of an initial handshake and the loss of touch during the welcoming process.[4] In addition, there is the loss of the physical examination, which is a determining factor

in building the doctor-patient relationship and is often necessary for diagnosis.[5,6] According to Iona Heath, without the bond that touch creates, it is not possible to begin the healing process.[4] Privacy can also be compromised when the patient consults in an unprotected location, often with family members or colleagues nearby.[4] Remote consultations can also delay or prevent diagnoses, considering the limitations of the physical examination and the difficulty for the doctor to perceive subtle cues offered by the patient during the consultation.[4,7]

The COVID-19 pandemic, experienced from March 2020 until the completion of this work, marked the regulation of telemedicine in Brazil. In March 2020, the Federal Council of Medicine recognized the possibility and ethical nature of remote consultations, "on an exceptional basis and for the duration of the fight against the spread of COVID-19."[1] Municipal decrees mandated reduced circulation and advised restrictions on people, including in health care facilities.[8] Despite the recommendation to prioritize remote care, primary care units were not prepared for this. Health care professionals and patients did not receive training, there was no pilot project, and, to date, there is no official platform to carry it out. Suddenly, the demand for remote consultations, previously non-existent, became massive when the Municipal Government of Florianópolis, Santa Catarina, in internal communication, advised the cancellation of in-person medical and nursing consultations, with the exception of situations of greater risk of clinical and social vulnerability; and the government of the state of Santa Catarina recommended reducing services to patients with flu-like symptoms, with urgency or emergency.[9]

Although remote consultations are recommended as a modality for containing and overcoming the pandemic and present potential benefits, we will not understand their scope and functionality until we know the perception of those most affected, namely the patients. Our objective was to understand patients' experiences with remote consultations, what motivated them to choose this modality and what limitations they encountered, how they evaluate and compare them to in-person consultations, and whether they consider remote consultations promising or perceive them as an exceptional tool imposed by the pandemic.

METHODS

This qualitative research involved in-depth interviews guided by a semi-structured script, with conventional content analysis of patients' experiences with remote consultations, which in our study included text messaging, telephone calls, and video calls.[10] Researcher training in qualitative interviewing and data analysis was provided through the courses Qualitative Research Methods: Conversational Interviewing and Qualitative Research Methods: Data Coding and Analysis, conducted in 2021 by the Massachusetts Institute of Technology's open online course program on edX.

Our population comprises the catchment area of the Estreito Family Health Units (UBSF) and Family Health Team (eSF) 330 of the Saco Grande UBSF.

The study sample was selected by convenience based on the prior definition of the following groups: over 60 years old; between 18 and 25 years old; between 25 and 60 years old; parents who consulted on behalf of their children; and pregnant women. All were invited by one of the two doctors and researchers and were able to discuss the research and our motivations during the invitation process.

After their appointments, we invited patients who had already had a remote consultation, attended by the researcher physician Monique Thurm Valério (MTV) or the researcher physician Donavan de Souza Lucio (DSL) at the Estreito and Saco Grande UBSFs, respectively, and who fit into the groups listed for the

research. We made sequential invitations in person and via text message until theoretical data saturation was reached.

The participants were interviewed by MTV via video call, with audio recording and subsequent transcription using Transkriptor[11] and review by both researchers. The semi-structured interview script we used is available in open access.[12]

Our expectation was that opinions would diverge mainly according to age, with greater resistance to remote consultations among older people. We expected convergent opinions between people seeking consultations for themselves and those seeking consultations for their children.

Because of prior knowledge of the population and socioeconomic data, we did not expect significant difficulties regarding access to the internet or electronic devices. According to 2010 data from the Human Development Atlas in Brazil, the Human Development Units (HDUs) that comprise the coverage area of the Estreito Family Health Unit have a Municipal Human Development Index (MHDI) between 0.845 and 0.902 and per capita incomes ranging from R$ 1,721 to R$ 2,779.[13] The HDU that comprises the coverage area of eSF 330 has an MHDI of 0.807 and a per capita income of R$ 1,008.[13] For comparison purposes, Florianópolis has an MHDI of 0.847 and a per capita income of R$ 2,097.[13]

The interviews were conducted in October and November 2021 and lasted from 9 to 30 minutes. We began the analysis after the 4th interview and judged that saturation was reached after the 11th. We completed the data analysis in January 2022. Study participants were not involved in any phases other than the interview. No interviews had to be redone, nor did we need to contact any participant again. We did not present the transcripts to the participants for comments and/or corrections. Participants were not invited to the research presentation.

Initially, we analyzed three interviews and created codes and definitions in the Taguette[14] application, then separately coded the remaining transcripts and compared them to check for convergences and divergences. There were no significant discrepancies between the codings. In the analysis, we organized the content into five themes, through which we structured the results.[10] The codes and themes were inductive.

The project was approved by the Research Ethics Committee of the Santa Catarina State Department of Health, under CAAE No. 49615321.8.0000.0115.

RESULTS

We interviewed 11 people out of the 27 invited. Those who declined participation cited scheduling conflicts for data collection; some did not respond with a reason for not participating; and two did not attend the scheduled interview, even after accepting the informed consent form. Four people participated from the group over 60 years old, three between 18 and 25 years old, two between 25 and 60 years old, two from the group “parents who consulted for their children’s benefit,” and no pregnant women. The majority were female (64%), aged between 19 and 61 years (with an average of 37.5 years and a median of 36), and 82% were from the Estreito Family Health Unit. The codes, definitions, and frequencies are detailed below in Chart 1.

In addition to consultations, many people discussed other processes carried out remotely, such as scheduling appointments, requesting prescription renewals, asking questions about how the service works, and inquiring about the availability of supplies. Therefore, we define virtual interactions as any non-face-to-face contact between the patient and the service or health care professionals.

Chart 1. Codes, definitions and frequencies obtained from content analysis.

Code	Definition	Sum
Comparative evaluation	Comparison between in-person and remote consultations	121
Reasons for	Reasons for choosing teleconsultation or in-person consultation	70
Virtual evaluation	Evaluation of remote interactions	57
Scope	Scope of services at the health center	52
Difficulties	Difficulties with interaction that did not involve technical problems	50
Scheduling process	Interaction for scheduling appointments	49
Virtual experiences	Previous experiences with telemedicine	38
Time	Mention of time saved, gained, or lost	37
Flexibility	Tools used by interviewees to deal with obstacles or difficulties	35
Consultation interpretation	Interpretation of a consultation that differed from the authors' expectations	31
Facilities	Mention of aspects that facilitated a particular process (remote or in-person)	30
Consultation process	Classic process that generally includes: complaint, anamnesis, physical examination, and treatment plan	26
Technicians	Technical aspects or problems with the internet or electronic devices	24
In-person evaluation	Evaluation of the health care service during an in-person interaction	13
Suggestions	Suggestions for service improvement after an active question from the interviewer	13
Overall evaluation	Overall evaluation of the health service, not requested by the interviewer	12
Location	Location where the teleconsultation took place	12
Third parties	Interaction motivated by the interest of third parties (sons or daughters)	11
Need help?	Need for assistance to perform the teleconsultation	8
Public versus private	Spontaneous comparison between public and private services	7

Scope and overall perspective of primary care

When asked about the services used at the family health unit before the pandemic, all respondents mentioned clinical consultations. Some patients actively brought up dental consultations. Services such as vaccinations, procedures, and pharmacy services were rarely mentioned without being specifically asked about.

Comparisons between remote and in-person services emerged, some expected by us, such as the potential time savings, and others unexpected, such as one interviewee's expectation that all initial consultations should be remote.

The family health units did not receive negative criticism but rather praise for both their effectiveness and the time it takes to access services. There were also comparisons with private health care services, which did not appear to be superior in terms of remote access.

After the introduction of a digital form for requesting appointments, patients reported primarily using virtual modality for scheduling, mentioning the time savings this way. No patient reported using telephone calls for scheduling appointments.

Choosing the type of consultation

The interviewees cited the following reasons for choosing the remote modality: initiative of health care professionals or the service; specific clinical questions; showing test results; pain that prevents travel; a diagnosis already recognized by the patient; and referral to specialist physicians.

Among the reasons that would motivate seeking in-person service and a preference for this modality, the following were mentioned: physical examination (being the most frequently discussed topic, raised in all interviews); and more complex or serious clinical situations. Such situations included functional impairment or high-intensity pain; assessment of children's behavior; and people with communication difficulties. In addition to these, there was the fear that remote consultations may limit the collection of important information:

> *"But I also had a time when lymph nodes were found in my body. If it weren't for this in-person contact, if it had been a teleconsultation, I wouldn't have found this, nor would the doctor have found it" (Woman, between 18 and 25 years old).*

Virtual interaction experiences between patients and health care professionals: advantages, difficulties, problems, and how to deal with them

Remote consultations were well received, and most considered the quality of virtual care comparable to in-person care. No one had experienced this modality before the COVID-19 pandemic.

All interviews and consultations took place either at the patients' homes or workplaces. One interviewee was inside their vehicle, but in the workplace parking lot. Privacy did not appear as a difficulty of remote care in any of the interviews.

There was apprehension regarding the remote modality when it was used for the evaluation of a child. The interviewee who expressed this feeling believed that a diagnostic error that occurred during a video consultation for her child would not have happened in an in-person consultation. The in-person consultation, in turn, was remembered positively for not having technical problems and for the convenience of receiving requests for examinations, prescriptions, or medications immediately after the consultation.

Overcoming technical problems requires some technological proficiency. Some interviewees pointed out that older people might have difficulty with the technology needed to initiate or maintain remote consultations. This difficulty was reported by only one participant, from the group over 60 years old, and was resolved with the help of a family member, without hindering access.

Throughout the interviews, we were able to witness the technical problems experienced in remote interactions. Some interviewees made adjustments at the beginning of the interview when they noticed connection failures—moving closer to the modem—or problems with the microphone or speaker audio—mitigated by using headphones or switching from a cell phone to a computer.

The addition of virtual scheduling for remote and in-person consultations was always treated positively. Only one interviewee, from the group over 60 years old, reported needing help to manage it. The perceived benefits, according to the interviewees, were: reduced waiting time; predictability of the appointment slot and time; and the convenience of having the consultation at home or at work. This tool mitigated some difficulties encountered with exclusively in-person access. These included: unnecessary time expenditure; travel to the health center; lack of parking at the health center; having to be absent from work; and having to leave children under someone else's supervision. In short, as reported by one of the interviewees: remote scheduling can be done at home or at work and provides a sense of predictability for those who can arrange time off from work.

About the process of a medical consultation

In our inquiries about how remote consultations took place and what the patient's experience was like, we noticed that it is conventional to have a "consultation process" composed of a trigger, translated as a problem or complaint, followed by: a dialogue between doctor and patient; a physical examination; complementary tests; and a course of action.

When all these items were present, in the order mentioned, the interpretation was unanimous that a consultation took place. When one of these items was absent, the interaction was not always seen as a consultation, and the course of action communicated to the patient was often interpreted as isolated advice or screening.

Although moving directly from dialogue to complementary tests, omitting the physical examination, was a process commonly expected by the patient, this format was also not presented as a "consultation" by some:

> *"There are also those problems that you have to deal with in person, but you can only get the final result after the exam, right? So you ended up going in person for nothing, so to speak." (Man, between 25 and 60 years old).*

Some interviewees interpreted it as "triage" when no physical examination was performed and no complementary tests were requested during the consultation, even though the complaint, dialogue, and treatment were present. In some cases, even when there was an inspection (visual examination of the patient), the interviewee did not consider themselves to have been examined.

Some interviewees treated the clarification of a clinical doubt sometimes as a consultation, sometimes as triage. The process that includes renewing a prescription for continuous medication—checking the prescription renewal request, searching for data in the medical record, the renewal itself, and sending it to the patient—was not considered a consultation by any of the interviewees. Even monitoring (which includes symptom research and guidance) after confirmation of COVID-19, via telephone call with a doctor or nurse, was not considered a consultation.

We also noticed a fluctuation in the interpretation of what constitutes a consultation during the interview. At the beginning of the interview, many patients did not consider themselves to have been consulted, but after the interview some seemed to change their minds and even considered an exchange of text messages as clinical care.

Suggestions and perspectives for the future

According to all interviewees, remote interactions between healthcare services and patients will continue after the end of the pandemic.

All interviewees reported being satisfied with remote appointment scheduling, and most with remote consultations; with only one interviewee dissatisfied with the outcome and conduct of a video consultation. Everyone believed that remote care will be maintained, with differing opinions regarding its scope and for which situations. Most believed that a hybrid approach should be maintained, combining remote and in-person access, with remote access primarily for scheduling appointments, clarifying specific questions, and consultations of lower complexity.

All interviewees believe that the healthcare professional providing the service should decide between in-person or remote care based on the clinical condition.

One suggested correction for a flaw in the health care professionals' approach was to provide objective guidance on the outcome of the remote consultation, especially in those conducted asynchronously, as sometimes more than one professional from the family health strategy team interacts with the patient via text, which can lead to confusion.

DISCUSSION

According to our data, remote consultations and other virtual interactions with primary care services were well received and are here to stay, although not suitable for all conditions or demands, nor for everyone. Their main limitation, in the opinion of the participants, was the lack of physical contact. The limitation of the physical examination was also pointed out in other studies, both by patients[2,15] and by health care professionals.[3,16]

Patient satisfaction with video consultations is high in all primary care studies we found, even in rural contexts.[2,17-20] However, health care professionals' evaluations of video consultations are mixed.[3,20,21] Other virtual interactions, such as scheduling appointments and requesting prescription renewals, are also considered more efficient by patients.[19]

Data on the evaluation of other remote consultation modalities are scarce. In a qualitative study with family physicians or nurses and patients, both found telephone consultations only suitable for brief issues, simple problems, or for specific information about a problem already under follow-up.[22] Telephone consultations are inferior to video consultations, according to another qualitative study conducted with doctors and nurses.[23]

We clarify that we interpreted the satisfaction of the interviewees with remote consultations and other virtual interactions as a positive, individual affective response, without the use of a scale for quantification.[12]

The scope of remote consultations is well described by a qualitative study that analyzed the perceptions of family physicians regarding video consultations during the COVID-19 pandemic.[21] These are suitable and effective for patients already known to the physician, can optimize the clinical workflow, and are more focused and limited to one problem per consultation; however, they limit the perception of valuable non-verbal cues, which are evident in in-person consultations.[21] Another cross-sectional study reaches similar conclusions.[24]

A study that evaluated more than 137,000 video consultations observed that the main difficulties in completing a consultation are technical ones.[25] About 10% of video consultations were converted to telephone consultations, and the main factors associated with this were the clinician's discomfort with the technology, as well as the patient's advanced age.[25]

According to a study that evaluated the factors influencing patients' choice between in-person, video, or telephone consultations, patients over 65 years old are less likely to choose remote consultations compared to those aged 18 to 44, and people with easy access to the internet are more likely to choose video consultations.[26] Another interesting result, which aligns with the opinion of one of our interviewees, is that patients whose clinic had paid parking were more likely to opt for a remote consultation than patients whose clinics had free parking. [26]

Throughout the interviews, we encountered unexpected opinions, such as the idea that the first consultation should always be remote, despite considering the lack of a physical examination a limitation.

Although this idea was raised by influential figures such as Matt Hancock (UK Secretary of State for Health from 2018 to 2021), who suggested during the pandemic that all consultations in the UK should be virtual,[7] we believe the opposite: that it would be better for the first contact between doctor and patient to be in person. We agree with Heath that touch is important from newborns to the older adult, especially when words are powerless.[4] In Brazil, we did not have such a recommendation, and remote care can be used to complement access.

We noticed a contradiction in the preference for a consultation modality. Some patients expressed a clear preference for in-person consultations throughout the interview, but at the end, when actively asked which modality they would choose for their consultations, they chose remote consultations. We questioned whether this was because of bias from speaking with the doctor remotely at that moment or an attempt to "guess" what the interviewer supposedly wanted to hear. We are not certain if anything during the interview may have influenced this phenomenon, but we believe it may have been the interview process itself, in which we asked the patient to think critically about the service they used.

A curious event for the authors was the non-participation of pregnant women in the interview: none of the eight who accepted the invitation actually participated. Some agreed to participate and then missed the interview or did not respond when scheduling; others did not even respond to the request. We assume this was because of the fact that they belong to one of the groups with guaranteed in-person access and are less dependent on remote consultations, and they possibly have less willingness or tolerance for interactions with health care professionals since they already frequently access the service during prenatal care. We believe that this fact, added to having only 2 participants in each of the "over 60 years old" and "parents who consult for their children's benefit" groups, is a limitation of the study.

Some patients have the idea that a doctor could attend to a much larger number of patients if they were "triaged" remotely by the professional who will attend to them.

> *"Sometimes, people who don't need an in-person appointment go there, you know? Something that a minor ailment could be resolved with remote medical advice. And a person who really needs an in-person consultation can't get one because there are people there who didn't need to be there, you know?" (Man, between 25 and 60 years old).*

We assume this is due to the disregard for preparing the equipment prior to the consultation and filling out medical records, prescriptions, and forms after the consultation: moments that are easily perceived by patients in the waiting room. The flexibility brought about by the introduction of remote consultations also has this limitation: it is another modality, and while the professional is providing remote care, they cannot provide in-person care—and vice versa.

However, a quasi-experimental study that compared the duration of in-person consultations with those by telephone or video found that remote consultations are shorter.[3] In-person consultations, with an average duration of 9.6 minutes, were, on average, 3.7 minutes longer than video consultations and 4.1 minutes longer than telephone consultations.[3] Only consultations with patients already under follow-up were evaluated, and it is not clear whether the complete consultation duration, including record-keeping and other activities such as prescriptions, requests for tests, and referrals, was included in the calculation.[3]

Remote consultations are a well-accepted tool by patients and useful for assessment, care, and treatment, and may have mitigated the lack of access to healthcare during the COVID-19 pandemic.[1] However, the opinions of users without internet access or devices for remote consultations were not

captured in our research, and this may be the segment of the population most affected by the syndemic.[4] Fortunately, for patients who do not have access to this tool, spontaneous demand and in-person care continue to be part of our service portfolio in Florianópolis.

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CONFLICT OF INTERESTS

nothing to declare.

AUTHORS' CONTRIBUTIONS

MTV: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Visualization, Writing – original draft, Writing – review & editing. DSL: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Visualization, Writing – original draft, Writing – review & editing.

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