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Research Article

Patients' perceptions of remote care in municipal primary health care

Percepções de pacientes sobre o atendimento remoto na atenção primária de cidade

Percepciones de los pacientes sobre la consulta remota en atención primaria en ciudad

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Abstract

Introduction: Remote care consists in the model health professionals and patients exchange information through electronic devices on health-related issues. This form of care has considerably increased, mainly because it was an attempt to prevent the spread of the new coronavirus (COVID-19). **Objective:** To understand the perception of users from different population groups about remote care provided in primary health care in the city of Florianópolis (state of Santa Catarina, Brazil). **Methods:** Qualitative research, in which patients remotely contacted by researchers themselves were invited to participate in an in-depth interview about previous remote care, according to groups that could, from the researchers' perspective, present different opinions. The interviews were recorded after obtaining patient's consent, with subsequent transcription and conventional content analysis. **Results:** Remote consultations and virtual interactions with the primary care service were well received, with quality comparable to face-to-face appointments, without limiting technical problems. This tool seems to be long-lasting and promising, but not for any condition or demand, and it is up to the health professional, in the patients' opinion, to decide between face-to-face or remote care at the time of care. Patients tend to prefer remote modalities for more specific issues and face-to-face modalities for complex issues that require physical examination. Medical inspection, made possible by video, was not considered a physical examination. We noticed there is a conventional consultation process, consisting of a trigger (problem or a complaint) and followed by: 1) dialogue between physician and patient; 2) physical examination; 3) complementary examination; and 4) conduct. When all items are present, and in that order, there is a unanimous interpretation that a consultation took place. When one of these items is absent, the interaction is not always seen as a consultation and the conduct informed to the patient has often been interpreted as isolated guidance or screening. **Conclusions:** Despite being a useful tool in expanding the forms of access to health care, the interpretation of consultation in remote care may be discordant between health professionals and patients. This can be related both to the virtual format and to the necessary lack of physical touch inherent in all modalities. We did not gather the opinion of users who do not have access to the Internet or other devices. Fortunately, for patients who do not have access to this tool, spontaneous demand and face-to-face care continue to be part of the services provided in Florianópolis.

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

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Resumo

Introdução: O atendimento remoto é a forma de troca de informações entre profissional da saúde e paciente por meio de dispositivos eletrônicos sobre questões relacionadas à saúde. Essa forma de cuidado aumentou consideravelmente nos últimos meses, sobretudo por ter sido uma tentativa de impedimento de disseminação do vírus da COVID-19. **Objetivo:** Entender a percepção de usuários de diferentes grupos populacionais sobre os atendimentos remotos realizados na atenção primária de Florianópolis (SC). **Métodos:** Pesquisa qualitativa, na qual os pacientes consultados remotamente pelos pesquisadores foram convidados a participar de entrevista em profundidade sobre o atendimento remoto prévio, de acordo com grupos que poderiam, na opinião dos pesquisadores, apresentar diferentes opiniões. As entrevistas foram gravadas após consentimento, com posterior transcrição e análise de conteúdo convencional. **Resultados:** As consultas remotas e as interações virtuais com o serviço de atenção primária foram bem recebidas, com qualidade comparável à das consultas presenciais, sem problemas técnicos limitantes. A ferramenta virtual parece ser duradoura e promissora, mas não para qualquer condição ou demanda, cabendo ao profissional de saúde, na opinião dos pacientes, decidir entre o presencial ou o remoto no momento do atendimento. Os pacientes tendem a preferir a modalidade remota para questões mais pontuais e a 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 de um disparador (problema ou uma queixa), seguido de: um diálogo entre médico e paciente; exame físico; exame complementar; e conduta. Quando todos os itens estão presentes e nessa ordem, a interpretação é unanimemente de que houve uma consulta. Quando um desses 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:** Apesar de o virtual ser uma ferramenta útil na ampliação das formas de acesso a cuidados em saúde, a interpretação de consulta no atendimento remoto pode ser discordante entre profissional de saúde e paciente. Isso pode estar relacionado tanto com o formato virtual quanto com a necessária falta do toque físico, que todas as modalidades trazem. A opinião de usuários que não têm acesso à internet, ou a dispositivos, não foi captada. Felizmente, para os pacientes que não têm acesso a essa ferramenta, a demanda espontânea e o atendimento presencial continuam fazendo parte da carteira de serviços em Florianópolis.

Palavras-chave: Consulta remota; Atenção primária à saúde; Satisfação do paciente; Políticas de esaúde; Telemedicina; Medicina de Família e Comunidade.

Resumen

Introducción: La atención remota es una forma de intercambio de información entre profesionales de la salud y pacientes a través de dispositivos electrónicos sobre temas relacionados con la salud. Esta forma de atención se ha incrementado considerablemente en los últimos meses, principalmente porque fue un intento de evitar la propagación del virus Covid-19. **Objetivo:** Comprender la percepción de los usuarios de diferentes grupos de población sobre la atención a distancia proporcionada en la atención primaria en Florianópolis. **Métodos:** Investigación cualitativa, en la que los pacientes consultados a distancia por los propios investigadores fueron invitados a participar en una entrevista en profundidad sobre la atención remota previa, según grupos que pudieran, a juicio de los investigadores, presentar opiniones diferentes. Las entrevistas fueron grabadas previo consentimiento, con posterior transcripción y análisis de contenido convencional. **Resultados:** Las consultas remotas y las interacciones virtuales con el servicio de atención primaria fueron bien recibidas, con una calidad comparable a las consultas presenciales, sin limitar los problemas técnicos. Esta herramienta parece duradera y prometedora, pero no para cualquier condición o demanda, y corresponde al profesional de la salud, en opinión de los pacientes, decidir entre la atención presencial o remota en el momento de la atención. Los pacientes tienden a preferir las modalidades remotas para preguntas más específicas y las modalidades presenciales para preguntas complejas que requieren un examen físico. La inspección, posible por video, no se consideró un examen físico. Señalamos que es convencional la existencia de un "proceso de consulta" consistente en un disparador (problema o queja), seguido de: 1) un diálogo entre médico y paciente; 2) examen físico; 3) examen complementario; y 4) conducta, cuando están presentes todos los ítems, y en ese orden, se interpreta por unanimidad que hubo "consulta". Cuando uno de estos ítems está ausente, la interacción no siempre es vista como una "consulta" y la conducta informada al paciente muchas veces ha sido interpretada como una orientación aislada o "triaje". **Conclusiones:** A pesar de ser una herramienta útil para ampliar las formas de acceso a la atención en salud, la interpretación de "consulta" en la atención a distancia puede ser discordante entre los profesionales de la salud y los pacientes. Esto puede estar relacionado tanto con el formato virtual como con la necesaria falta de toque físico que traen todas las modalidades. No se captó la opinión de los usuarios que no tienen acceso a internet o dispositivos. Afortunadamente, para los pacientes que no tienen acceso a esta herramienta, la demanda espontánea y la atención presencial siguen siendo parte de nuestra cartera de servicios en Florianópolis.

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

INTRODUCTION

Teleconsultation (or telecare) is the way information is exchanged between health professionals and patients through electronic devices and virtual platforms, with the aim of providing patient-centered care.[1] It is part of the larger set known as telehealth, which covers other related terms, including: teleconsulting, telediagnosis, telemonitoring, tele-education.[2]

Although previous studies consider that telemedicine emerged at the end of the 20th century, this is still a relatively new activity for part of the population and health professionals, not in temporal terms, but rather because it faces challenges of technical, legal, ethical, regulatory, and cultural nature.[3]

The new coronavirus (COVID-19) pandemic, experienced from March 2020 to the moment we wrote this article, was a milestone for teleconsultation in Brazil, as it changed the context of standardization of its use. In a letter dated March 2020, the Brazilian Federal Council of Medicine recognized the possibility and ethicality of the use of teleconsultation "in an exceptional basis and while the battle to combat the COVID-19 infection lasts."[2]

Conditions for remote care, already well established, include: wound care, prenatal genetic counseling, family planning, cardiovascular care, and home care.[1] However, as telemedicine is a recent field in health, there are few Brazilian studies on how the population, according to its culture and particular needs, perceives this innovation.

According to previous research, teleconsultation has the potential to increase access to health and patient's autonomy and to reduce transportation-related impairments, in addition to reducing care time, travel costs of patients and health professionals, and improving the quality of care.[1,2]

Conversely, it is worth emphasizing that such modality of care also has limitations. There is no physical touch, and telemedicine impairs social dimensions, such as lack of the initial handshake and the loss of touch at the moment of welcoming,[4] in addition to the loss of physical examination, which is a determining factor in the development of the relationship between physician and patient and an often necessary part for diagnosis.[5,6] According to Iona Heath,[4] without the bond created by touch, it is not possible to initiate the healing process. Privacy can also be impaired when the patient has the consultation in an unprotected place, often with relatives or close peers. Telecare can be potentially harmful for patients and professionals, considering that the lack of possibility to examine the patient and observe signs given by them during the consultation may delay or prevent diagnoses.[4,7]

Although teleconsultations are recommended as a modality for the containment and overcoming of the pandemic and have potential benefits, we will not understand its scope or functionality until we know the perception of the main subjects involved in this interaction: patients. Would they feel sufficiently satisfied, listened to, and understood to the point that the therapeutic process starts and ends remotely?

It remains to be questioned whether patients perceive virtual consultations, in their various modalities, as satisfactory, comparable to face-to-face care, or just an exceptional tool imposed by the pandemic.

Our objectives with the present study were: to know patients' experience with teleconsultation and their overall assessment of satisfaction with this mean of communication, their preferences between modalities (video, voice, and text), how they compare remote consultations with face-to-face consultations, whether they prefer, disregard, or do not distinguish between face-to-face and remote care. In addition, to understand whether patients consider teleconsultation a promising modality, with viability after the pandemic and the normal return to face-to-face medical services, or if they perceive it as a momentary tool, with important limitations regarding the establishment of bonds or other flaws.

METHODS

Study design

This is a qualitative research, with in-depth interviews and conventional content analysis.[8] It was inspired by the qualitative research "Patient perceptions of telehealth primary care video visits,"[1]

but the scope of the services studied in the present research was expanded, adding other forms of telecare, besides the videoconsultation, addressed in the aforementioned article, such as telephone calls and text messages.

Sample

Due to national ethical reasons related to the ethics committee, a list to compose the sample could not be obtained. Patients who were included in the groups considered for the research were invited by the researchers to participate in the investigation after care provided by the physician and researcher MMM or the physician and researcher DDD in the family health centers EEE and SSS, respectively. Patients from different groups were invited to participate after teleconsultation or face-to-face appointments who had a record of telecare, in order to ensure sufficient diversity of experiences. Sequential invitations were made until reaching the theoretical saturation of data, for one patient from each of the following groups:

- patients older than 60 years;
- those aged between 18 and 25 years (young adults);
- those aged between 25 and 60 years;
- parents who made an appointment due to their children.

Data collection and analysis

After reading the Informed Consent Form and having agreed to participate in the study, participants were interviewed with in-depth questions[9] by the interviewer MMM in the video calling modality, with recording and subsequent transcription[9] by MMM and review by DDD.

In the video call, via telephone application, open-ended questions were asked concerning the patient's impressions about the consultation and the potential of this form of care. The questions addressed previous experiences with video calling, technical problems with the appointment, and future prospects.

MMM and DDD separately codified[10] transcripts considered more complex according to the interviewer and, subsequently, compared them for discussion and elaboration of codes and definitions, which were evaluated by conventional content analysis.[8]

Ethical considerations

The study project was submitted to approval by the Ethics Committee on Research Involving Human Beings of the State Department of Health of Santa Catarina, under Certificate of Presentation for Ethical Consideration No. 49615321.8.0000.0115. The ethical and scientific precepts provided for in Resolution No. 466/12 of the National Health Council regarding research involving human beings were respected.

As this is a survey, a copy of the Informed Consent Form, which must be signed by the participants for this study, was sent to the Ethics Committee. The identification in the transcripts was coded, without possible identification in case of data leakage. No minor patients were interviewed. Access to the collected information was allowed solely and exclusively to the researchers involved. The risk of involuntary and unintentional breach of confidentiality on the participants' data was assumed in the event of loss or theft of the electronic devices that store the data used for the research with subsequent breach of the passwords

of personal use. It should be noted that the risk was minimal and, in order to reduce it and guarantee the fundamental right to privacy, no data were gathered or results were published that allow the direct identification of the patient. The confidentiality of the data and their secrecy were ensured by all research participants, and the disclosure of results has no nominal record.

RESULTS

We interviewed 11 people out of 27 individuals invited to participate in the research. Most were women, aged between 18 and 25 years. There were four participants in the group of young adults, aged between 18 and 25 years; three, in the group of those aged between 25 and 60 years; two, in the group of individuals older than 60 years of age; two parents who made an appointment due to their children; and no pregnant woman.

Scope and overall evaluation of primary health care

When asked about the services used in the family health center before the pandemic, all participants answered clinical consultations. Some patients actively reported dental consultation. Services, such as vaccines, procedures, and pharmacy, were rarely mentioned spontaneously.

There were comparisons between remote and face-to-face care, some expected by us, as the possible advantage over time, and other unexpected ones, such as one patient's expectation that the entire first consultation would be remote. In addition, there was an apparent divergence between the physician and the patient in the understanding of the definition of clinical consultation.

The family health centers did not receive negative criticism. They were praised by the interviewed population regarding the problem-solving capacity concerning the time for access. There was even comparison with the private health service, which does not seem to be superior in terms of remote access.

The search for the health service before the access restrictions that occurred in the first half of 2020 resulting from the pandemic consisted of attending the health center in person. No patient reported they used the telephone for scheduling consultations. After including a digital form for scheduling consultations, the patients reported using the virtual modality for doing so, reporting to gain time.

Choice of the consultation modality

The interviewees mentioned the following as reasons for the remote modality: initiative of health professionals or the service during the contact restrictions of the pandemic; specific clinical doubts; show test results; pain that makes traveling to consultation unfeasible; diagnosis acknowledged by patients themselves; referral to specialist of topics not covered by the family doctor.

Among the reasons that would motivate the search for face-to-face care and preference for this modality, the following were mentioned: physical examination (the most addressed topic, reported in all interviews); more complex and severe clinical statuses, which according to the patients are functional impairment or very severe pain; assessment of children's behavior; and people with communication difficulties. In addition, patients fear that remote consultation limits the collection of important information: "*Lymph nodes were once found in my body, if it were not for this contact, if it were through teleconsultation, I wouldn't find it out, nor would the doctor*."

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

Remote consultation, which in our research included the modalities of text messages, telephone calls, and video calls, has good acceptance among the interviewed patients, and most consider the quality of remote care comparable to the quality of face-to-face care. None of them had experienced this form of consultation before the COVID-19 pandemic.

All interviews and consultations took place either in the patients' residence or at the workplace. One interviewee had a consultation inside his vehicle, but in the parking lot of the workplace. Privacy was not mentioned as a remote care difficulty in any interview.

Respondents prefer face-to-face consultation for clinical complaints, usually mentioning the possibility of physical examination in this modality, and no one considered the medical inspection made possible by video as physical examination.

There was concern about remote consultation when scheduling it for assessing a child. The interviewee who mentioned this feeling believes that a diagnostic failure made in a video consultation with her child would not have happened in a face-to-face appointment.

Overcoming technical issues requires some dexterity with technology. We raised the possibility, by examples of family members, that older people could have difficulties with technology to initiate or maintain remote consultations. This difficulty was reported by only one participant in the group of respondents aged 60 years or older, and it was resolved with the help of a family member, without harm to the access.

Throughout the interviews, we were able to experience the technical issues experienced in remote interactions. Some of the interviewees made adjustments early in the interview by noticing a connection failure, getting nearer to the modem, or problems with the audio (microphone or speaker), using a headset or switching from the phone to the computer.

The addition of virtual scheduling was positively reported by the all the participants. Only one interviewee reported the need for help to manage the tools used. The gains, in the interviewees' perception, are the reduced waiting time; the predictability of the availability and time for consultation; and the flexibility of the scheduling location, which can be done from home or at work.

The process of virtual scheduling for face-to-face consultations and the remote consultation itself overcame some difficulties exclusively encountered with face-to-face access. The reported difficulties were: unnecessary waste of time; traveling to the health center; no parking lot in the health center; having to be absent from work; leaving the children under the care of another person.

That is, as reported by one of the interviewees: remote scheduling can be done from home or at work and gives the feeling of predictability to those who can reach an agreement concerning absences from work.

The face-to-face consultation was positively reported, because it did not present technical issues and the practicality of picking up the requested tests, the medical prescriptions, or even medications already prescribed at the time of the consultation.

On the medical consultation process

When inquiring how the teleconsultation took place and what the patient experience was, we noticed that, conventionally, there is a consultation process consisting of a trigger, that is, an issue or a complaint, followed by:

- dialogue between physician and patient;
- physical examination;
- complementary examination;
- conduct.

When all these items are present and in that order, it is unanimously interpreted that there was a consultation. When one of these items is absent, the interaction is not always seen as a consultation, and the conduct was often interpreted by the patient as isolated guidance or screening.

Although skipping from dialogue to complementary examination was a process commonly expected by the patient, this was not perceived as a consultation by some: "*There's also this kind of issue, when you have a face-to-face appointment but you can only get the final results after the test, right? So you ended up having a face-to-face consultation for nothing, so to speak*."

Some interviewees understood the consultation as screening when there was no physical examination or complementary examination, although complaint, dialogue, and conduct were present. In some cases, although having the medical inspection (which we understand as a modality of physical examination), interviewees deemed they were not examined.

The interpretation of consultation is not always cohesive. Some interviewees perceived the clarification of a clinical doubt either as a consultation or as screening.

The process that includes the search for data in the medical records and renewal and forwarding of medical prescriptions was neither considered as part of consultation by the interviewees. Even monitoring (which includes symptom search and guidance) after confirmation of COVID-19, via telephone call with physician or nurse, was not considered as consultation.

Suggestions and perspectives for the future

All interviewees are satisfied with the remote appointment schedules, and only one patient reported being dissatisfied with the outcome and conduct of the remote consultation, which in this case was by video call. Furthermore, everyone considered the remote modality as a long-lasting tool, with different opinions regarding the scope and situations. Most think that hybrid access — remote and face-to-face — should be maintained, the remote being primarily for scheduling appointments, clarification of specific doubts, and consultations of less complexity.

Anyhow, the interviewees believe that the health professional should decide between face-to-face or remote care in the face of a clinical condition.

A suggestion for correcting mistakes made by health professionals is to give clear guidance on the outcome of the remote consultation, especially those that are performed asynchronously, because sometimes more than one health professional interacts by text with the patient, and this can cause some confusion.

All respondents believe that the remote interaction between the health service and patients will remain after the end of the pandemic.

DISCUSSION

Teleconsultations and virtual interactions with the primary healthcare service were well received and came to stay, but not for any condition or demand and not for everyone. Its main limitation, in the

patients' opinion, is the lack of physical contact, an idea corroborated by Iona Heath,[4] who believes that the lack of physical examination impairs the establishment of the physician-patient bond and may delay or prevent diagnoses.

Throughout the interviews, we approached unexpected ideas, such as the fact that some patients believe that the first consultation should always be remote, despite considering the lack of physical examination a limitation. Although such an idea has been considered by influential managers such as Matthew Hancock, Secretary of State for Health of the United Kingdom from 2018 to 2021, who suggested that all consultations in the UK should be virtual during the pandemic,[7] we think the opposite: it is better that the first contact between physician and patient is face-to-face. We corroborate Heath,[4] who states that touch reaches newborns and older people, especially when words are helpless. In Brazil, we did not have such a recommendation, and telecare could be used to complement access. Now, with a greater perception of its risks and benefits, we can focus on its proper use.

In addition, the interpretation of what consists in a consultation is often unclear to the interviewees, and we noticed that some questions made patients change their opinion about the service used. Before the interview, many patients did not consider that they have had a consultation; after the interview, some seemed to change their mind and even considered an exchange of text messages as clinical care.

We noticed a contradiction in the preference for the type of consultation. Some patients mentioned during the entire interview a clear preference for face-to-face consultation, but at the end of the interview, when actively questioned which modality they would choose to have a consultation, they reported remote care. We questioned whether there was bias because they were talking to the doctor remotely at that time or an attempt to correctly respond what the interviewer intended to hear. We do not know if there was anything during the interview that might have influenced this phenomenon, but we believe that it may have been the process of the interview itself, in which we asked patients to critically think about the service they used.

Another surprise was the nonparticipation of pregnant women in the interview. In the study design, they consisted in a group, but none of the eight pregnant women who accepted the invitation effectively participated in the study. Some agreed to participate in the investigation and missed the interview or did not respond to the schedule, and others did not even respond to the request. We believe that this may be a study limitation, in addition to the fact that groups of individuals over 60 years and parents who have made consultations due to their children have only two participants each.

Some patients reported the idea that a physician would be able to see much more patients if they were screened by the very professional who provides care remotely:

> *Yeah, sometimes people who don't need face-to-face care go there, you know? They complain about some pain and it's something a remote doctor's guidance would solve. And a person who really needs face-to-face care can't get the consultation, 'cause there are people who don't need to be there but they are, you know?*

We assume that this is due to the disregard of the preparation of the equipment prior to the consultation and the filling of medical records, prescriptions, and forms after the consultation, moments that are easily perceived by the patients who are in the waiting room. The flexibility enabled by the introduction of remote consultation also has this limitation: it is another modality, and while the professional provides remote care, they cannot provide face-to-face care, and vice versa.

Remote interaction is a useful tool for assessment, care, and treatment, it greatly reduced health impacts during the COVID-19 pandemic[2], but it is a tool that can increase the socioeconomic gap existing in Brazil. The opinion of users who do not have access to the Internet or devices for teleconsultation was not gathered in our research, and this is perhaps the population most deprived of health care, because it was the most affected by the pandemic, or syndemic, if we take this aspect into account.[4] Fortunately, for patients who do not have access to this tool, spontaneous demand and face-to-face care continue to be part of the services provided in Florianópolis.

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

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

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