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Older Adults' Experiences with Remote Care for Specialized Health Service During the COVID-19 Pandemic: A Descriptive Qualitative Study

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Article

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Résumé

La pandémie de Covid-19 a exigé l'adoption rapide de services de télésanté. Cette étude qualitative descriptive était conçue pour mieux comprendre l'expérience des personnes âgées qui ont eu recours à des services de santé spécialisés à distance (rendez-vous téléphoniques ou en vidéoconférence) pendant la pandémie. Vingt-et-une personnes âgées de 65 ans et plus (8 hommes et 13 femmes) habitant dans l'Est du Canada ont participé à une entrevue téléphonique semi-structurée. Les données recueillies ont été traitées à l'aide d'une méthode d'analyse qualitative de contenu. La grande majorité des répondants se sont déclarés généralement satisfaits de leurs expériences de soins de santé spécialisés à distance. Les avantages de la télésanté pour des soins spécialisés comprennent la commodité, la sécurité en période de pandémie, le confort, l'efficacité et la facilité de consultation. Les inconvénients comprennent une communication moins efficace, un sentiment de dépersonnalisation ou de désincarnation, un manque de relation humaine et le désir d'être rassuré par un examen physique. Il est important pour les professionnels de la santé de comprendre les inconvénients des consultations à distance pour les personnes âgées, afin de les atténuer.

Abstract

The coronavirus disease (COVID-19) pandemic necessitated a rapid uptake of remote health care services. This qualitative descriptive study was designed to gain an understanding of older adults' experiences of remote care (telephone or online video conference appointments) for specialized health services during the COVID-19 pandemic. Twenty-one older adults (ages 65 years and older; 8 men and 13 women) living in eastern Canada participated in a semi-structured telephone interview. Data were analysed using qualitative content analysis. The vast majority of older adults were overall satisfied with their remote experiences of specialist care. Advantages to remote care for specialized services included convenience, safety during the pandemic, comfort, efficiency, and ease of visit. Disadvantages included communication not as effective, feeling depersonalized or disembodied, missing the human relationship, and wanting reassurance of physical assessment. It is important that health professionals understand the disadvantages for older adults of remote care visits in order to mitigate them.

Introduction

The shortage of primary care providers and difficulty in accessing timely, specialized health services have created a situation where emergency departments often serve as the first access to timely care. One solution to increased wait times, delays in receiving health services, and the overuse of emergency departments has been the expanding use of remote care. In the past, remote care was often referred to as *telemedicine*; it is the use of communication and information technologies in the provision of clinical care where the patient and health care provider are in different locations (Hailey, Ohinmaa, & Roine, 2013). The use of telemedicine (also now referred to as *telehealth* or *telecare*) has developed rapidly and has been identified as an innovative solution to transform the way that care is delivered in the community to improve patient health outcomes, including reduced hospital admissions (Landers et al., 2016). Advantages for patients are increased flexibility, autonomy, and minimized use of time and resources, whereas benefits for health care providers include increased efficiency, time released for medical assessments, less crowded waiting rooms, and more precise communication in the triage process (Flodgren, Rachas, Farmer, Inzitari, & Shepperd, 2015; Zandbelt, deKanter, & Ubbink, 2016).

Satisfaction with remote health care visits for primary care services and health outcomes has been reported in the literature. For example, researchers found that patient–clinician engagement in remote visits was comparable with in-person visits (Rose et al., 2021). A 2015 Cochrane

systematic review was conducted to examine the impact of telehealth involving remote monitoring or videoconferencing compared with in-person or telephone visits for chronic conditions, including diabetes and congestive heart failure (Flodgren et al., 2015). This review found similar health outcomes for patients with these conditions (Flodgren et al.). Similarly, researchers whose studies included participants with mental health and substance use issues reported no between-group differences for therapy delivered in-person compared with videoconferencing (Flodgren et al.).

The coronavirus disease (COVID-19) pandemic necessitated a rapid uptake of remote health care services in most developed countries in the world. Substituting in-person health services with remote health care services in the form of video (e.g., Webex or Zoom) or telephone has also been a solution to the challenges precipitated by the COVID-19 pandemic because it prevents the spread of the virus between patient and health care provider (Elkbuli, Ehrlich, & McKenney, 2020). Since the beginning of the pandemic, the use of telehealth has facilitated the remote triage of patients, rapid access to information, routine follow-up care, remote diagnosis, and remote care of patients. The implementation of this care delivery approach has helped reduce demand for emergency services and has improved access for some patients (Mann, Chen, Chunara, Testa, & Nov, 2020; Primary Care Collaborative, 2020). For example, in Quebec, Canada, from January to April 2020, more than 80 per cent of physicians practising in university-affiliated family medicine groups reported conducting telephone consultations, and 3 per cent reported conducting video consultations (Breton et al., 2021). Patient and health care provider satisfaction as well as the benefits and challenges associated with the provision of geriatric clinics during the COVID-19 pandemic have been explored. A rapid review of academic databases found that cost-effectiveness, transportation savings, and improved wait times were reported benefits, whereas hearing impairment, technological challenges, and lack of physical exam were reported challenges (Murphy et al., 2020).

In the area of mental health services during the pandemic, telehealth has also increased. Further, researchers reported that benefits to patients (both older adults and youth) included lack of disruption of service provision and a decreased rate of "no-shows" for appointments, and they eased transportation challenges; yet were limiting for patients in residential "dead zones" (without Internet and cell phone reception) (Svistova, Harris, Fogarty, Kulp, & Lee, 2022).

In the delivery of care for older patients with disabilities during the COVID-19 pandemic, the availability of flexible modes of delivery has also been noted as a benefit. A recent study indicated that when physicians and geriatricians accommodated for patient disabilities, offered flexibility with modes of telehealth delivery, and included caregivers in providing remote care, they were effective in reducing barriers to telehealth use (Chen et al., 2022).

While remote care has allowed health care providers to continue caring for patients throughout the COVID-19 pandemic, certain factors (e.g., cognitive impairment, clinical frailty, social isolation, completion of less formal education) could prevent older adults from accessing remote care (Keränen et al., 2017). Health care providers gain information from physical assessment and mental status examination, components that are not readily accessible by telephone or by participating in video conference assessments. Furthermore, participation in videoconferencing requires access to and knowledge of web-based technology (e.g., Zoom) (Wosik et al., 2020), which may place some older adults at a severe disadvantage.

The concept of aging in place has become increasingly dominant in gerontological literature over the past 5 decades due to the explosion of the number of older adults. Distinct challenges have arisen as a result of the COVID-19 pandemic that require aging-service providers to support older adults who are aging in place in new ways (Greer et al., 2023). Despite this, the importance of proximity and services to foster health and well-being for older adults to age in place has been noted in the literature as an important area for future research (Bigonnesse & Chaudhury, 2022).

Although some research has been done on the use of remote technologies in primary health care, no research has been done on older adults' experiences of remote care for specialized health services during the COVID-19 pandemic. The use of technology as a replacement for in-person consultation with a specialist has often been necessary during the COVID-19 pandemic, leaving patients with no choice but to use these mediums if they wish to receive care. The aim of our study is to gain an understanding of older adults' experiences of remote care (telephone or online video conference appointments) for specialized health services during the COVID-19 pandemic.

Methods

A qualitative descriptive method was used to answer the research question: What are the experiences of older adults who have received specialized health care through a remote appointment(s) during the COVID-19 pandemic? For the purposes of this study, we used the term *remote* appointments to include appointments via the telephone or online video conferences (e.g., Zoom). A semi-structured interview guide was used. All interviews were conducted by telephone between January and May 2022.

Qualitative description is a research design that aims to describe how individuals experience phenomena that are not well understood (Kim, Sefcik, & Bradway, 2017; Neergaard, Olesen, Andersen, & Sondergaard, 2009). Although all forms of qualitative analysis require a level of interpretation, qualitative description involves less interpretation compared to other qualitative approaches, and the goal is a description of the patterns found in the data (Sandelowski, 2010). Qualitative description is used widely in health and nursing research to generate new knowledge by enabling participants' own descriptions to be reported without substantial modification (Polit & Beck, 2018). By staying true to participants' own words, qualitative description enables researchers to report findings in a clear and logical way, in everyday language (Sandelowski). This level of interpretation enabled the researchers to showcase participants' own descriptions of what remote care meant to them without unduly transforming them.

Study Setting, Participants, and Sampling

The study took place in an eastern province of Canada. Information about the study was distributed via poster at various associations for older adults and by public service announcements in social media and local radio stations. Participants were recruited purposively based on two criteria: (a) being 65 years of age and older, and (b) having received remote care (telephone or online video conference) from a specialist during the COVID 19 pandemic. Twenty-one individuals ages 65 and over (8 men and 13 women) agreed to participate. They represented older adults living in both urban (n = 12) and rural (n = 9) areas of the province. Seven of the older

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adults were between 65 and 69 years of age, nine were between 70 and 74 years of age, and five were 75 years of age and older (see Table 1). All the older adults had a remote appointment(s) with a specialist by telephone, although two also had a video, Internet appointment. Areas of specialty visits were cardiology, dermatology, endocrinology, gastroenterology, internal medicine, neurology, oncology, orthopedics, radiology, respirology, rheumatology, surgery, urology, and psychiatry. Eight of the older adults had remote appointments with more than one specialist.

Ethical Approval

This study was approved by the Health Research Ethics Authority of Newfoundland and Labrador. Ethical considerations included describing any risks and inconveniences in participating in the study, freedom to withdraw from the study without repercussion, and methods to ensure confidentiality and anonymity. Participants were provided resources for psychological supports, if needed. We obtained verbal consent for audiotaping the telephone interview. Participants received either oral or written information about the study purpose and procedure and provided oral consent (via audio recording) before the interviews began.

Data Collection

The data were collected via semi-structured interviews by the third author, using an interview guide that included prompts to facilitate discussions. Participants were asked to talk about a time that they consulted a specialist for care using either the telephone or online video conference since the start of the COVID-19 pandemic. They were then asked to describe those experiences and how they felt about them, that is, whether they considered it was a positive or negative experience. They were then asked what advice they would give other older adults who require remote consultations for the first time as well as suggestions for health care providers who provide remote consultations with older adults. Lastly, they were asked what recommendations they would offer to the Newfoundland and Labrador health authorities for assisting older adults with remote consultations with a health care provider. All the interviews took place by telephone (audio-recorded and transcribed). The interviews lasted between 45 and 60 minutes each and were audiotaped and transcribed verbatim. All interviews were transcribed by the third author.

Data Analysis

We used qualitative content analysis for this study. Qualitative content analysis is a research approach for the description and interpretation of textual data, using a systematic process of coding. The final product of data analysis is the identification of categories, themes, and patterns (Lindgren, Lundman, & Graneheim, 2020).

Table 1. Participant demographic information

Age (Years)	Gender	Urban	Rural
65–69	5 Females 2 Males	6	1
70–74	6 Females 3 Males	4	5
75 and over	2 Females 3 Males	2	3

Qualitative content analysis is used in studies that aim to describe a phenomenon where existing research and theory are limited (Colorafi & Evans, 2016). This approach fit our study well. Content analysis is the most common form of analysis used in qualitative description (Sandelowski, 2010) and involves a systematic reduction of data into coded units that are clustered into categories according to shared characteristics (Milne & Oberle, 2005).

The data were organized manually and analysed, using constant comparison by the first and second authors. Constant comparison is a process where all the data relevant to each category are identified and examined, in which each item is checked or compared with the rest of the data to establish analytical categories, or themes. The key point about this process is that it is inclusive; categories are added to reflect as many of the nuances in the data as possible (Pope, Ziebland, & Mays, 2000).

We followed the 5-point checklist of criteria for a good thematic analysis as outlined by Braun and Clarke (2006) that included: (1) data were transcribed verbatim; (2) the coding process was thorough, inclusive, and comprehensive; (3) data were analysed and made sense of through meetings, discussion, and consensus of the researchers; (4) adequate time was allotted for reflection and discussion of all phases of the analysis; and (5) the researchers were actively involved in all stages of the research process (Braun & Clarke).

Rigour

Numerous strategies contributed to the scientific rigour of this qualitative descriptive study. To enhance clarity, these strategies have been organized according to the framework proposed by Whittemore, Chase, and Mandle (2001): (a) authenticity, or attention to the voices of participants; (b) credibility, a reflection of how believable results are; (c) criticality, the critical appraisal of every decision made throughout the research process; and (d) integrity, demonstrated by ongoing reflection and self-criticality of the researcher (Whittemore et al.). The credibility of a qualitative study is a factor of strategies to promote authenticity and the ability to remain true to the phenomenon under study, whereas the integrity is a reflection of its criticality, or the attention paid to each and every research-related decision.

Results

All but three of the older adults were generally positive about their experiences of seeing a specialist remotely and believed their needs were met, and some volunteered the information that they would like the option of remote or onsite appointments in the future. The context of the three older adults who did not like the remote appointments is useful in understanding why they would have preferred an onsite appointment.

Context of Older Adults Who Were Not Satisfied with Remote Appointment

One of the older adults (Participant #3) who was not satisfied with remote appointments was diagnosed with cancer. While she had seen the oncologist and surgeon in-person prior to surgery, the follow-up appointments with the oncologist and radiologist were done remotely. She was told the cancer stage in a phone appointment, and she believed there would have been an opportunity to ask more questions if the appointment had been onsite. The participant

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also would have liked to see the oncologist's expression when presenting the information about the stage of the cancer. She also had wanted to have a physical exam following the surgery. This participant thinks remote appointments should be for issues such as prescription renewals but not for persons who are newly diagnosed with a major illness:

> …I was just diagnosed and I had to be told what stage I was at and all that over the phone and I found that would have been better in person. If I had gone in I would have been able to ask more questions and see their expressions and everything. (Participant #3)

Another older adult (Participant #5) who was not satisfied with remote appointments had finished treatments for cancer several months before the start of the COVID-19 pandemic. This participant wanted a physical exam to verify that the surgical site was normal, and for the human interaction:

> So she (surgeon) asked how I was, if there were any complaints. Having only had it one time I didn't know what was not normal so it was very unsatisfying…. So if I have nothing to report who knows nothing about what I should be reporting. I felt dismissed. (Participant #5)

The remaining older adult (Participant #18) who was not satisfied with a remote appointment saw a psychiatrist. The participant missed seeing not only the facial expression but also the body language of the specialist. The participant also had concerns about confidentiality, not only because someone may be in the hospital room with the psychiatrist but also because someone in the participant's home may be able to hear:

> Because there is nothing like the in-person kind of thing and when you're talking over the phone again, you still have some privacy issues and there are some things that you prefer to have said completely in private. (Participant #18)

Nineteen of the 21 participants were satisfied overall with their remote experience of specialist care. Although they were satisfied overall, participants' experiences were described as both advantageous and disadvantageous.

Advantages of Remote Care

We identified five categories of advantages that the older adults experienced from remote appointments with specialists during the COVID-19 pandemic: convenience, safety during the pandemic, comfort, efficiency, and ease of visit.

Convenience

The older adults spoke of a variety of conveniences of remote visits: They did not have to go outside, deal with the weather, find parking, ask someone to drive them, deal with their wheelchair, nor wait in the specialist's office:

> It was more convenient because I didn't have to travel to [name of city] for the appointment itself. (Participant #19)

> I don't have to go clear the car. I don't have to go out in the snow. I don't have to sit in a doctor's office and wait. (Participant #8)

> I'm in a wheelchair so it's difficult for me to get in…. You should have the option [of remote or onsite visits]. (Participant #12)

Older adults appreciated the conveniences of saving time, saving the costs of transportation, being able to have other appointments or do other things on the same day, and being able to be in a different location at the time of their specialist's appointment:

> The wait time in his office was often 3 to 4 hours or longer. What I experienced in the virtual care from him, the same doctor was a 10-minute phone call. Everything was fine. He had received my bloodwork. We went through a list of symptoms, blah blah blah, all that kind of thing and it was perfect. I found it really an improvement over actually going in person. (Participant #15)

> You're not waiting in an office anymore for anything. They tell you a time that they're going to call like you did this morning, very punctual, not too often are they above or below that time. Over the years I've been going to doctor's offices and I've been sitting there for 2 or 3 hours before you see the doctor. Even though you had an appointment for 11 [o'clock] you might not get in to see him until 1 or 2 [o'clock]. (Participant #4)

> I find that it's better because I'm sitting at home and I'm doing things or watching TV or whatever whereas when you're in the hospital when you're there, you're sitting there and you're waiting around. (Participant #11)

> You can be anywhere in [province] basically. (Participant #9)

Safety during the pandemic

The older adults appreciated that they did not need to cancel their appointment because of the pandemic. Virtual care meant that they did not have to put themselves and/or accompanying persons at risk of contracting COVID-19 when sitting in a waiting room with others and by seeing the physician in person:

> It was much better during the COVID [pandemic] than having to go and sit in a waiting room with a whole bunch of other people even though you and they were masked. (Participant #16)

> When you're there, you're sitting there and you're waiting around with all these other people who are also waiting. So there is more of a chance of picking up things as well breathing in and breathing out, that type of thing. (Participant #11)

Comfort

Some older adults felt more comfortable on the phone or on a web conference than they did when meeting a specialist in person. They liked the comfort of having the appointment in their own home. They also liked the fact that the physician had more time to spend with them during the appointment:

> For me, it was positive. It's nice to be able to sit in my home and go through that with ease and feel comfortable, yeah, for sure. I liked it…. I think I might have felt less self-conscious. It created a little space, I suppose. (Participant #13)

> He [specialist] even said that something he's noticed that when appointments are not in person he actually has more time with each patient…. And I sensed that as well. He really took a lot more time than I would have anticipated and I really appreciated it especially when it was our first meeting. Like he had read my whole chart which totally startled me. (Participant #2)

Efficiency

Older adults who had an appointment for follow-up purposes or who had an appointment that did not require a physical examination felt the process was more efficient:

> I thought it was a very efficient way of doing it because basically they were just giving me the results of tests or CTs that were done or

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bloodwork or whatever. So they were just giving me the feedback of the results. So I didn't feel that an office visit was necessary and I thought the phone call was quite good. (Participant #16)

Ease of visit

Older adults with hearing loss said they put the phone on speaker and could more easily hear the specialist. Others found they could more easily have someone attend their appointment with them either by putting the phone on speaker or by setting up a conference call:

I'm not a very good phone person…. Sometimes that [hearing difficulties] makes it difficult to talk on the phone…. I put him on speaker phone. (Participant #12)

So my brother … is very ill with brain cancer. His wife and him asked me to be an advocate to help them as we've navigated the past two years of his illness…. But it was very difficult for him to absorb, my brother to absorb and his wife to take it all in. So they included me in Zoom meetings with specialists…. And I was able to see the head of the palliative team, the doctor and my brother and his wife in hospital at [hospital] and I'm at my home here in [town]. So it was a 3-way Zoom meeting. And he went through all the things to help my brother and his wife…. And I was able to take notes and be the advocate. (Participant #15)

Disadvantages of Remote Care

While almost all participants were satisfied overall with their remote appointment with a specialist, they did identify disadvantages of remote appointments. We identified four categories of disadvantages that the older adults experienced from remote visits with specialists during the COVID-19 pandemic: communication not as effective, feeling depersonalized or disembodied, missing the human relationship, and wanting reassurance of a physical assessment.

Communication not as effective

Examples of ineffective communication included not being able to see the specialist's facial expression or know what the specialist looked like. Some participants noted that a web meeting would have been preferred for this reason. Some spoke of not being able to see the specialist's body language and that this challenged communication. One older adult felt the specialist could have provided more reassurances if it had been an in-person appointment:

If I had gone in I would have been able to ask more questions and see their expressions and everything. But even before I got the call from the oncologist I had to look her up on the internet to see if I could find a picture so I could picture in my mind who was on the other side of the phone. (Participant #3)

There's a lot to be said with regards to in-person with regards to the personal visual physical language that may not be spoken but certainly can be seen and with the telephone of course, that's entirely lacking. Through a video it's apparently there but not quite right. (Participant #18)

I don't feel it was rushed. But at the end of 5 minutes, like I mentioned to you I felt like I wanted him to stay on and talk to me a little bit longer but that was just to reassure me that everything was going to be alright. (Participant #17)

Other examples of issues with communication included the older adults feeling rushed or dismissed that the specialist spoke more and listened less in the phone meeting than they would have in person, and that the specialist spoke less professionally on the phone:

I felt dismissed. Like they're doing these appointments because they're scheduled to do them and really, they don't need to. And I'm sure that's not it, but I don't know. [same participant later in interview] …you feel like you're taking up their time and that's partly because you're not getting feedback physically. You're not getting reaction. I could be talking to a computer. (Participant #5)

And it seems like on the phone it's like they want to talk more…. You know I'm on the phone so they can listen to me…. But it seems like to me they want to talk more and they talk and they got all the answers and you just hang up and that's it! And you're no farther ahead than when you started. (Participant #6)

I had questions after I left the call. I think I would have thought of them much easier if I was in an office setting. And I also wondered, where was he while he was talking to me? Like this is a professional interaction and if he was in his office, he'd be wearing a white jacket and probably a stethoscope across his neck and he'd be behind the desk or he'd be sitting next to me or something. But I wondered. He could be anywhere. He could be out for a walk. [laughing] He could be in the bath. He could be anywhere! That seemed to matter to me because I wanted it to be a professional interaction. (Participant #17)

Some older adults also had difficulty hearing and were no longer able to supplement hearing with lip reading in a phone meeting. One found that the specialist spoke too fast, and the participant was unable to process information. For another older adult participant, communication was hindered in the remote meeting because the participant was concerned about privacy; the participant wondered whether someone was with the specialist and was also concerned whether someone else living in the home was able to hear the private conversation:

I'm a little bit hard of hearing. So yes, I found it difficult to listen to them. You know I can't see them now, so now I can't even hear them very well. Do you know what I mean? [same participant later in interview] … people got a tendency to talk on and talk fast and when you're older you know I got to really pay full attention and be able to see what they're saying and hear what they're saying in order to get it because it's just too difficult, you know. My computer in my brain has slowed up and if they talk fast I don't get what they're saying and after you ask them to repeat it a couple of times, you still don't understand it and then you move on. So you don't get your needs met. (Participant #6)

When you're talking over the phone again, you still have some privacy issues and there are some things that you prefer to have said completely in private regardless if there's somebody in the building or in the room. And that kind of thing just wasn't there, that feeling with regards to being open, the openness was not there. (Participant #18)

Feeling depersonalized or disembodied

Some older adults disliked what happened during the remote appointments with specialists because they felt depersonalized or disembodied. For example, one older adult claimed feeling more nervous on the phone than if the appointment had been in the physician's office. The older adult also did not know whether there was a time limit for the phone appointment and whether the physician was multi-tasking during the phone conversation. The older adult felt depersonalized and unimportant in the process:

On the phone, I'm always kind of nervous because again it's disembodied and I'm trying to visualize who I'm speaking with. So not physically comfortable, no. I am quite aware that I'm taking up their time which is kind of different if you have a face-to-face appointment because you know at least in those circumstances you know you have a 15-minute

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> appointment or a 30-minute appointment because I will ask. So you know that and if you go over, well you go over, what odds. But you know she's not looking at or he's not looking at his charts on his computer of other people looking at his next appointment. There's a whole lot going on. You don't know how much they're paying attention to you…. You can't see their faces. You can't register what they're registering although I got to say they don't register much on their faces. I think that's their training. But at least you know they're not looking at someone else's chart. You know that they're listening and if they're making notes, they're making notes about you. (Participant #5)

Missing the human relationship

Some older adults preferred in-person appointments because of the missed social interaction, and others missed the loss of the development of a relationship with the specialist:

> So for a lot of seniors – we live alone and if we're in lockdown that's our only contact. I have an appointment with a GP or not a GP. I don't have a GP but a licensed nurse in the clinic coming up and I've asked if I can meet rather than do it on the phone. It's important to me…. And I was thinking about it when I go to see her now tomorrow, I'll explain to her that this is a part of my mental health in my visit to her. She's my treatment! [laugh]. (Participant #5)

Some older adults said that while they were okay with a remote appointment for minor issues, they would not want to be given a major diagnosis in a remote meeting. One older adult referenced an occasion that was not with a specialist during COVID-19 but with the family physician, saying:

> I had a quick phone call from a family doctor about a year prior to this to tell me the result of my diagnosis of my chest, a cytology test. And she blurted out that I had papillary thyroid cancer on the phone. And I went hysterical! So that was a quick experience with a family doctor and I know that's not part of this interview. But that was shocking! That was terrible! It was awful! [later in interview] I was at home by myself at the time and I dropped the phone and started to scream! I was so hysterical! My husband came home and he thought someone had died in the family. He couldn't figure out what was wrong with me. It was awful! It was awful! I do not believe a bad diagnosis should be given over the phone or in any virtual environment. (Participant #17)

Some older adults said that if this had been the first time they met with the specialist or if they did not already have an established relationship with the specialist, they would have wanted the appointment in person:

> Because I had been established with them, in terms of communication and was satisfied with the interaction that I was having with them, then it was no trouble at all…. But I'm of the opinion that initial contacts and that kind of stuff, my comfort level is established because of the personal contacts…. I'm not sure that I would have had the same comfort level although I may very well have, but my comfort level had been established prior to the virtual appointment that I had. (Participant #19)

> If they're sort of initial visits, I think face-to-face is necessary because I think the doctor can judge a lot by the look on your face or the look of your eyes. So in my case, if he asked me how I'm feeling and he's looking me in the eye when he's doing that to see my facial expressions and response and things of that nature. And sometimes he can just tell by your appearance whether you're looking well or not. I mean I've got terminal cancer. (Participant #16)

Wanting reassurance of a physical assessment

The older adults spoke of wanting a physical examination, such as a surgical site checked or a blood pressure taken, to feel reassured:

> So she asked how I was, if there were any complaints. Having only had it one time I didn't know what was not normal so it was very unsatisfying. I had a surgeon who is supposed to be looking and checking as I realized later for any lumps or things that might show up on the side where I had the mastectomy. And I said, no everything seems fine and she said, okay, fine. (Participant #5)

> I think I would prefer an in-person visit this time if possible…. Now because it's been wintertime I'm not getting the exercise that I would like because I can't go out in the cold up until recently. So I would probably like to have her listen to my chest and talk to her about the exercising and that like I feel like I'm a little bit out of breath. (Participant #20)

One of these older adults went on and noted that if something was wrong and the specialist said the older adult was fine, that older adult would not have felt reassured in the absence of a physical examination:

> But if I had a virtual first time visit which they said, okay that's it. We're not going to see you anymore, I probably wouldn't have been happy with that because if you know something is wrong, and they don't do anything, that's where the problem lies because you know your own body. (Participant #20)

Suggestions for Remote Appointments with Physicians

The older adults made suggestions for physicians or other health professionals, as well as for other older adults, for remote appointments. Their suggestions for physicians and other health professionals were categorized as ones to improve communication and ones to improve the quality of the appointment, as shown in Table 2.

A few of the suggestions for remote appointments with physicians were for other older adults. The participants recommended that other older adults could go online prior to the appointment to see their physician's photo, to help them visualize the physician. They also recommended that older adults stay focused during the appointment and to list their questions prior to the appointment. Further, they suggested bringing a relative or friend to the appointment, who could later confirm what the physician said.

Discussion

For the majority of older adults in this study, the advantages of seeing a specialist remotely outweighed the disadvantages. While one of the categories, "safety during pandemic," was related to the timing of the older adults' appointments, the other categories of advantages – "convenience," "ease of visit," "efficiency," and "comfort" – are likely to continue being advantages for this age group and all age groups, post-pandemic. Given the vulnerability of older adults to other infections such as the flu, pneumonia, and antibiotic resistant bacteria, the safety of remote appointments will likely also continue to be seen as an advantage post-pandemic. This has implications for health care providers and organizations because there will be demand from patients for remote appointments.

This study with older adults during the pandemic identified five categories of advantages of seeing specialists remotely during the

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Table 2. Suggestions for health professionals for remote appointments

To Improve Communication	• Use web instead of phone to enable seeing face/nonverbal. • Encourage MD not to talk fast. • Encourage MD to read chart prior to meeting. • Encourage MD to be patient and give extra time. • Encourage MD not to talk most of the time, or talk more than they would in person.
To Improve Quality of Appointment	• If web used, provide patients with education on using the computer technology. • Provide a definite time rather than a time range for the appointment. • Provide patients with a web centre where those without computers could connect for a web appointment. • If web appointment, MD could copy information in chat feature. • Use remote meetings only for follow-up appointments. • After appointment, someone from the physician's office could make a follow-up call to the patient to check whether information discussed was understood. • Provide patient with a choice of phone or web appointment. • Inform patient whether anyone is or is not in the room with the MD.

pandemic. Other research on patient experience of remote care prior to the pandemic and including younger adults found similar advantages to convenience, ease, efficiency, and comfort. For example, a recent scoping review identified key factors that contributed to facilitating e-health engagement by older adults that included individual, extrinsic, technological, relational, and environmental factors (Wilson, Heinsch, Betts, Booth, & Kay-Lambkin, 2021). These factors include convenience, availability, ease of use, accessibility to specialists, and ability to incorporate in daily routines (not having to leave home to access health care services) (Wilson et al.).

The advantages of remote appointments may be particularly appreciated by older adults who may have more challenges with their mobility and with driving. In addition, an inclusion criterion for this study was the older adults had an appointment during the pandemic. Given the higher risk of older adults for serious morbidity and mortality from COVID-19, it is no surprise that they spoke of the advantage of remote appointments in keeping them safe during the pandemic, which is similar to what other researchers have found (Iyer et al., 2021).

The advantages of remote appointments with specialists were particularly appreciated by the older adults who had already developed a relationship with the specialist or were having follow-up appointments for a non-life-threatening health condition. For these older adults, the advantages far outweighed the disadvantages, and they recognized the value of continuing with remote appointments in the future. For some older adults, when the specialist was not known and/or the appointment was for an emerging, threatening illness, the remote appointment led to feeling depersonalized or disembodied, wanting a human relationship or wanting reassurance from a physical examination. Similar results have been found where drawbacks for remote health care delivery for older, chronically ill adults showed challenges in delivering and discussing "bad news" or difficult diagnoses or prognoses (Ladin et al., 2021). This has implications for which appointment modality patients may want post-pandemic, not only for appointments with specialists but also for primary health care appointments. Some individuals may always prefer in-person appointments, for example, for the human relationship. Others may prefer remote appointments for routine or follow-up appointments, whereas others may feel comfortable with remote appointments for all instances.

This study with older adults during the pandemic identified four categories of disadvantages of seeing specialists remotely during the pandemic: "communication not as effective," "feeling depersonalized or disembodied," "missing the human relationship," and "wanting reassurance of a physical assessment." Other research on patient experience of remote care prior to the pandemic and including older adults found similar disadvantages, for example, challenges related to impairments in hearing, sight, memory, and fine motor control (Green & Joyce, 2022; Kalicki, Moody, Franzosa, Gliatto, & Ornstein, 2021; Ladin et al., 2021; Mao et al., 2022; Murphy et al., 2020; Wilson et al., 2021), lack of personal human contact (Baim-Lance et al., 2022; Chan, O'Riordan, & Appireddy, 2021; Mao et al.; Wilson et al.), fear and dislike of technology (Baim-Lance et al.; Chan et al.; Mao et al.; Wilson et al.), technological difficulties and lack of access (equipment and Internet service) (Ladin et al.; Murphy et al.; Wilson et al.), and inexperience (Wilson et al.).

Of interest, the ease of having others participate in an appointment was seen as both an advantage and a disadvantage. It was advantageous to have family members or support persons able to participate even if they were not at the same location. However, it was disadvantageous in that the older adult wasn't certain whether others were present in the physician's background or whether others in their home could hear what they said to the physician. This lack of privacy hindered the openness of communication and is similar to the finding in other studies, that privacy concerns were problematic for older adults (Baim-Lance et al., 2022; Wilson et al., 2021).

Remote appointments for older adults as well as other age groups existed long before the pandemic but were primarily utilized for persons living in regions that were distant from an urban centre and/or who were unable to attend in person for reasons such as mobility challenges. The use of remote appointments during the pandemic and the advantages experienced are anticipated to lead to a continued and growing use of remote appointments. The suggestions for health professionals for remote appointments shown in Table 2, as well as the categories of disadvantages of remote appointments that the older adults provided in this study, provide important information for health professionals who interact with patients remotely. The findings of this study have an important implication for the curricula of health care professionals, which should include education on building relationships and communicating in remote meetings.

Limitations

One study limitation is that only two of the participants used video appointments, whereas the rest used the telephone for their remote appointment. It is possible that the older adults would not have

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experienced all of the disadvantages of their remote appointment if they had had video, Internet appointments. However, even with a video appointment, one older adult spoke about how there was a loss of being able to read body language, which hindered the interactions. Another limitation is the one-time data collection because participants were not followed over time to learn whether they maintain their views about remote care.

Conclusion

The findings of this study add to the growing literature on patients' experiences of remote care by focusing on the experience of older adults who had remote appointments with specialists during the pandemic. While the majority of older adults preferred remote appointments because of the advantages, including a lower risk of contracting COVID-19, there were individuals who, because of their health conditions or need for a human relationship or physical assessment, wanted an onsite visit. Moving forward, the advantages of remote appointments experienced during the pandemic will likely result in pressure for remote visits to be offered, and therefore it is important that health professionals understand the disadvantages of these visits in order to mitigate them. Future research can determine whether the findings would be the same if there was not a pandemic. A quantitative study could identify whether the advantages and disadvantages of remote appointments differed with increasing age.

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