Background/Aims
Since the COVID-19 pandemic started, there have been changes in clinical practice to limit transmission, such as switching from face-to-face to remote consultations. Although there was some evidence of efficacy for remote consultations before the pandemic, the implications of a more widespread provision are unclear. We aimed to study the influence of technical factors on remote consultations in our experience during the pandemic.

Methods
Clinicians were asked to complete a data collection form after each remote consultation for information on technology used (video vs phone); technical problems encountered; discharge and subsequent appointment status; and technical aspects of the consultation itself using 11-point numerical rating scales (NRS) including Time Adequate, Relevant History, Physical Exam, Management Plan, and Communication Quality scales. Data were collated in a Microsoft Access 2010 database, and analysed in SPSS version 25. For dichotomous variables, Mann-Whitney U tests were used to compare means, and Chi-square tests to compare proportions. Spearman correlations were used to describe strength of association amongst NRS. Odds ratios were used to describe strengths of association of variables to subsequent appointment status.

Results
Of 285 forms valid for analysis, 48 (16.8%) had video consultations. 259 forms had technical problems data recorded, with 48 (18.5%) experiencing a technical problem. Video patients were significantly younger (mean 49.3 vs 61.3 years, \( P < 0.001 \)), had higher scores on Physical Exam scale (mean 4.0 vs 2.6, \( P < 0.001 \)), but had no significant difference on Management Plan scale (7.3 vs 7.2). Those with technical problems were more common among video than phone consultations (33.3% vs 15.4%, \( P = 0.005 \)), had lower scores on Time Adequate scale (7.7 vs 8.7, \( P < 0.001 \)) and Communication Quality scale (7.1 vs 8.4, \( P < 0.001 \)), but had no significant difference on Management Plan scale (7.3 vs 7.2). The strongest correlations of Management Plan scale were with Communication Quality scale (\( R = 0.64, P < 0.001 \)), and Relevant History scale (\( R = 0.63, P < 0.001 \)). Of the NRS, a 1-point reduction in scores on Management Plan scale was the strongest predictor of subsequent face-to-face appointment request (Odds Ratio 1.88, 95% CI 1.58-2.24), and this remained an independent predictor in multivariate analysis (adjusted OR 1.90, 1.57-2.31).

Conclusion
Video patients were younger suggesting a preference for video over phone amongst younger patients. Although technical problems were more common with video than with phone consultations, having a video consultation or a technical problem had no significant impact on the management plan. However, scoring lower on the Management Plan scale was the strongest predictor of, and independently associated with requesting a subsequent face-to-face appointment. Further studies might help refine the selection of clinical contexts and technologies deployed to improve outcomes with remote consultations.

Disclosure
S. Vasireddy: None. S. Wig: None. M. Hannides: None.