

ORIGINAL ARTICLE

PATIENT SATISFACTION WITH TELECONSULTATION DURING COVID-19 PANDEMIC: A DESCRIPTIVE STUDY FOR MENTAL HEALTH CARE IN MALAYSIA

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ABSTRACT

The recent novel coronavirus disease 2019 (COVID-19) outbreak has led health care providers to shift rapidly from on-site consultation towards teleconsultation. However, knowledge about patient satisfaction with teleconsultation, particularly for mental health care, is limited and demands further investigation. This study aimed to evaluate patient satisfaction with teleconsultation in mental health care during the COVID-19 pandemic. The study also aimed to identify the leading contributing factors to patient satisfaction with teleconsultation. A convenience sampling method was employed. An online survey was conducted between June 8 and August 3, 2020. A 14-item questionnaire was used to assess the patient's level of satisfaction in four domains of satisfaction. A total of 106 questionnaires were received. Respondents reported a high level of satisfaction with teleconsultation. The convenience of not having to travel to the health center for consultation was the leading contributing factor to patient satisfaction with teleconsultation. However, patients reported that they were least satisfied with teleconsultation because they could not express their feelings deeply to the provider. The current study provides preliminary evidence that teleconsultation may be a satisfactory mode of communication during the COVID-19 pandemic for mental health care in Malaysia. Most importantly, consultation in mental health care should carry on to be performed remotely to prevent the spread of infectious disease. Future research is warranted to provide a better understanding of other factors contributing to patient satisfaction with teleconsultation and ways to improve them.

Keywords: COVID-19, pandemic, teleconsultation, mental health, patient satisfaction, Malaysia

INTRODUCTION

In December 2019, the world was alarmed by the outbreak of novel coronavirus disease 2019 (COVID-19)¹. Since its emergence in China, this unforeseen disease has continued to sweep across nations in a matter of months². The World Health Organization (WHO) reported that more than 100 countries became rapidly infected with the virus³, leading to the declaration of a global pandemic in January 2020⁴. The most afflicted countries have implemented quarantine in an attempt to curb the spread of the disease. Additionally, to help minimize the risk of infections, governments have temporarily suspended the operation of public services and private businesses. However, critical services such as health care continue to operate under the standard operating procedure (SOP) guideline. One of the practices under this procedure is to avoid close contact through implementing social-distancing measures. In adhering to the SOP, many health care providers have adopted a wider public e-mental health approach⁵. This approach involves using virtual modes of communication, such as telephone calls or video conferencing, for consultation purposes.

The terms *telehealth* and *telemedicine* are commonly used to describe remote communication between a health care provider and a patient using distance technology⁶. These terms are broad and may lead to misconceptions: for example, *telehealth* can be used to refer to any health care services (including non-clinical services) that are performed remotely, while *telemedicine* refers only to remote clinical services. In this paper, we use the term *teleconsultation* to describe an interactive consultation that is performed remotely between mental health care providers and the patients⁷. On the other hand, we used the term *on-site consultation* to indicate that the consultation was performed in person at the health center. In comparison to on-site consultation, teleconsultation has the advantage of restricting viral transmission during a disease outbreak. The challenge with teleconsultation is that it is a relatively new approach, particularly for mental health care in Malaysia⁸. In the current situation of crisis, less is known about patient satisfaction with teleconsultation, as patients may have difficulty adapting both physically and mentally to

this sudden shift in ways of consultation. It is worth noting that there are multiple definitions of satisfaction⁹. Here patient satisfaction refers to how well the teleconsultation matches a patient's expectations⁷.

Therefore, the current study aimed to evaluate patient satisfaction with teleconsultation during the COVID-19 pandemic, specifically for mental health care in Malaysia. This is crucial because satisfaction with health care is an important quality indicator in mental health care¹⁰. Furthermore, little is known about patient satisfaction with teleconsultation in Malaysia, which should be a concern considering that teleconsultation may well outlast the pandemic^{11,12}. This study is also important as there has been a concerning report regarding the increasing number of mental distress during the COVID-19 pandemic¹³. Therefore, identifying the needs and managing expectations of those who are desperately requiring professional help is warranted to prepare mental health care providers to fulfill this unprecedented challenge. This study also aimed to investigate the leading contributing factors to patient satisfaction with teleconsultation. In this study, comparisons were made using an independent sample t-test and the Chi-square test for goodness of fit. A *p*-value of less than 0.05 was considered statistically significant. Although several studies have assessed patient satisfaction with teleconsultation during the COVID-19 pandemic¹⁴⁻¹⁷, none have been done in Malaysia. To the best of our knowledge, this is the first study to assess patient satisfaction with teleconsultation among mental health patients in Malaysia during the pandemic.

METHODS

Participants

Participants included in this study were individuals with mental illness across Malaysia. Inclusion criteria were (1) clinically-diagnosed mental health patients; (2) treatment had been changed from on-site consultation to teleconsultation; and (3) shift in ways of consultation was due to the COVID-19 pandemic. Exclusion criteria were (1) self-diagnosed mental illness and (2) patients who did not have teleconsultation during the study's period. A convenience sampling method was employed. Respondent's involvement in this study was voluntary and completing the questionnaire implied a respondent's consent. No incentive was given to the respondents for their participation. Ethics approval was not required for this study as the World Health Organization (WHO) stated that any surveillance studies performed during an emergency outbreak are exempted from ethical review and oversight¹⁸. The population size was unknown, as there have been no previous studies in Malaysia to the best of our knowledge. Therefore, the sample size was calculated using

the formula of cross-sectional studies with a 95% confidence level, the margin of error was set at 5%, and the population size was infinite. From the calculation, a total of 385 respondents were required.

Materials

The researchers developed a 14-item questionnaire based on previous relevant studies to identify factors contributing to patient satisfaction with teleconsultation. The questionnaire was created in English and the Malay language using Google forms. Respondents could choose to answer using any of the two language versions, but not both. The questionnaire was posted online on social media platforms associated with mental health in Malaysia between June 8 and August 3, 2020. These platforms were: (i) Anxiety Disorder Malaysia and (ii) Malaysia Depression and Anxiety Support Group. We also contacted the administrators of other social media platforms to increase the reach of the questionnaires, but we did not receive any reply from them. An online survey is an effective way of reaching a targeted study population during a disease outbreak as people are spending more time online during the pandemic¹⁸⁻¹⁹.

The questionnaire was divided into three main sections. In the first section, basic demographic information was obtained. The demographic data included age, gender, and type of mental health conditions. However, the questionnaire did not include personal details such as full name, contact number, home address, and e-mail address to ensure total anonymity and to maximize the number of responses. The second section of the questionnaire obtained information related to the consultation received by the participants (e.g., with whom they had their consultation and how the teleconsultation was performed). All possible responses in the first and second sections were presented as a drop-down menu (except for age). If a response was not listed in the drop-down menu, respondents could provide additional comments in a free-text box. They may also provide multiple responses.

In the third section of the questionnaire, we collected information regarding the patient's level of satisfaction with teleconsultation. The potential determinants of satisfaction with care were identified from a review of the relevant literature^{6,7,20-22}. From this literature search, we identified four domains of satisfaction: (i) communication and rapport, (ii) clinical assessment, (iii) convenience, and (iv) equipment or technical issues. Respondents were also asked about their overall level of satisfaction with teleconsultation using a five-point Likert scale ranging from "strongly not satisfied" (1) to "very satisfied" (5).

Statistical analysis

All statistical analyses were performed using IBM Statistical Package for Social Sciences (IBM SPSS, Armonk, NY) version 21 software. Count data were expressed as frequency and percentage. Data normality for age was evaluated using the Shapiro-Wilk test ($p > .05$). An independent samples t-test ($p < .05$, two-tailed, 95% CI) was used to compare the mean age between the male and female respondents. A Chi-square for goodness of fit ($p < .05$, two-tailed) was used to evaluate whether there were statistical differences in the level of satisfaction (within-group).

RESULTS

Demographic Data

A total of 106 respondents completed the questionnaire. The sample comprised of 31 males (29.2%) and 75 females (70.8%). The respondents aged between 25 and 49 years (mean age = 34.92 years; SD = ± 5.51 years). A non-significant Shapiro-Wilk test ($p > .05$) confirmed that age, in both genders, was normally distributed (male: $W = .958$, $p = .264$ and female: $W = .971$, $p = .086$). The independent t-test was not statistically significant [$t(104) = .256$, $p = .799$, two-tailed, Cohen's $d = .05$], indicating that mean age was not statistically different between gender. For details of these results, see Table 1 below.

Table 1: Demographic data of respondents (N = 106)

Variables	Descriptive statistics		Independent t-test
Gender	Male	Female	NA
Sample size, n	31 (29.2%)	75 (70.8%)	NA
Age in years (mean $\pm$ SD)	35.13 $\pm$ 6.24	34.83 $\pm$ 5.22	$p = .799$
20-29 years old	7 (6.6%)	13 (12.3%)	NA
30-39 years old	18 (17.0%)	45 (42.5%)	NA
40-49 years old	6 (5.6%)	17 (16.0%)	NA

Mental disorders

The mental disorders profiles of respondents are summarized in Table 2. The majority of respondents had anxiety (34.9%) and followed by

depression (20.8%). This result was not surprising considering that the questionnaire was posted on social media platforms that are related primarily to anxiety and depression.

Table 2: Types of mental disorders

Types of mental disorders	Male	Female	Total
Anxiety	4 (3.8%)	33 (31.1%)	37 (34.9%)
Depression	8 (7.6%)	14 (13.2%)	22 (20.8%)
Obsessive-compulsive disorder	6 (5.6%)	8 (7.6%)	14 (13.2%)
Bipolar disorder	3 (2.8%)	7 (6.6%)	10 (9.4%)
Schizophrenia	1 (0.9%)	6 (5.7%)	7 (6.6%)
Autism spectrum disorder	6 (5.7%)	0 (0.0%)	6 (5.7%)
Post-traumatic stress disorder	1 (0.9%)	4 (3.8%)	5 (4.7%)
Eating disorder	0 (0.0%)	3 (2.8%)	3 (2.8%)
Attention-deficit hyperactivity disorder	2 (1.9%)	0 (0.0%)	2 (1.9%)

Health care providers and modes of communication

The results showed that 78 respondents (73.6%) were consulted by psychiatrists, while 19 respondents (17.9%) had their consultation with psychologists. Only nine respondents (8.5%) reported consulting medical doctors. The results also showed that 90 respondents (84.9%) had their teleconsultation over the phone. The remaining 16 respondents (15.1%) were consulted using videoconferencing.

Level of satisfaction with teleconsultation

The results in Table 3 showed that the majority of respondents reported a high level of satisfaction with teleconsultation ($n = 52$; 49.1%), although some reported dissatisfaction with teleconsultation ($n = 36$; 34.0%). The chi-square test for goodness of fit was statistically significant [$\chi^2 (4, N = 106) = 29.28$, $p < .001$], indicating that there were statistically significant differences in the level of satisfaction. As an index of effect size, Cohen's w was 0.53, which can be considered large.

Table 3: Level of satisfaction with teleconsultation

Level of satisfaction	Descriptive statistics	Chi-square test of contingencies	
	Frequency (%)	Expected N	Residual
Very satisfied	22 (20.8%)	21.2	0.8
Satisfied	30 (28.3%)	21.2	8.8
Neutral	18 (16.9%)	21.2	-3.2
Not satisfied	34 (32.1%)	21.2	12.8
Strongly not satisfied	2 (1.9%)	21.2	-19.2

Determinants of satisfaction with teleconsultation

Respondents were required to indicate the factors that contributed to their level of satisfaction with teleconsultation. They may provide additional comments if the factor is not listed in the questionnaire. The results are tabulated in Table 4.

DISCUSSION

The main finding of this study was that the majority of respondents were satisfied with teleconsultation. The result showed that not having to travel to the health center for consultation was the leading contributing factor to the level of satisfaction with teleconsultation

(86.8%). Previous studies on patient satisfaction with health care services have associated waiting times with the level of satisfaction^{23,23}. In line with these studies, we investigated whether waiting to see the health care providers influenced patient satisfaction with teleconsultation. The result showed that a majority of respondents were satisfied with teleconsultation because they did not have to wait to see the provider (58.5%). This finding indicates that most patients did not like waiting to see the provider. Together, these findings show that convenience is an important determinant of satisfaction with teleconsultation in mental health care²⁴.

Table 4: Determinants of satisfaction with teleconsultation

Domain	Item	Statement	Frequency (%)
Communication and rapport	1	My privacy and confidentiality are more protected during the teleconsultation	58 (54.7%)
	2	I feel less nervous during the teleconsultation	12 (11.3%)
	3	Teleconsultation is not new for me and I am used to it	6 (5.7%)
Clinical assessment	4	I was confident that the doctor could assess my condition via teleconsultation as if I was there	22 (20.8%)
	5	I could express my feelings more deeply to the doctor via teleconsultation	3 (2.8%)
	6	I am more comfortable talking to the doctor via teleconsultation	17 (16.0%)
Convenience	7	I do not have to travel to the hospital/clinic for consultation	92 (86.8%)
	8	I save money from not traveling to the hospital/clinic for consultation	16 (15.1%)
	9	I do not have to wait to see the doctor	62 (58.5%)
	10	I can avoid seeing other people	55 (51.9%)
	11	I can avoid myself and prevent others from contracting infectious diseases	48 (45.3%)
Equipment or technical issues	12	I have the proper communication devices for teleconsultation	26 (24.5%)
	13	My internet connection or mobile network coverage is good	28 (26.4%)
	14	I experienced no technical difficulties during the teleconsultation	31 (29.2%)

Apart from that, the respondents were satisfied with teleconsultation because their privacy and confidentiality were more protected (54.7%). Teleconsultation also prevented them from seeing other people (51.9%). Some, but not all,

individuals with mental health conditions are typically known to be emotionally-withdrawn and often enjoy the feeling of being alone^{25,26}. However, it is not known whether a person's personality is associated with the level of

satisfaction with teleconsultation. Concerning this, our finding suggests that personality could affect satisfaction with care.

Also, due to the disease outbreak, we were interested to see whether patient satisfaction with teleconsultation was associated with disease prevention. The result showed that respondents were satisfied with teleconsultation because they could avoid contact with others and prevent others from contracting infectious diseases (45.3%). This finding indicates that patients were aware of the importance of disease prevention, and thus, this factor contributed to their level of satisfaction with teleconsultation.

It is worthy to note that teleconsultation involved the use of telecommunication devices and services. Therefore, equipment or technical issues may be a determinant of patient satisfaction. The results showed that a minority of respondents were satisfied with teleconsultation because they did not experience technical problems during it (29.2%), they had suitable communication devices (24.5%), and a good internet connection or mobile network coverage (26.4%). Taken together, these low percentages in the number of responses indicate that the equipment or technical issues were not firmly attributed to patient satisfaction with teleconsultation.

Respondents were also asked if their satisfaction was attributed to the level of confidence they had in their interaction with the provider. Our findings indicated that only a minority of the respondents were satisfied with teleconsultation because they were confident that the provider could assess their conditions online as if they were physically there (20.8%). This may be due to a lack of physical contact and decreased non-verbal communication⁷. Also, in mental health care, it is important for the patients to feel comfortable talking about their problems to the provider²⁷. In relation to this, we found that only a few respondents were comfortable talking to the provider via teleconsultation (16.0%). A possible explanation for this is that teleconsultation may be less patient-centered than in-person interaction²⁸.

The COVID-19 pandemic has caused a global financial crisis that affected almost every household²⁹. Therefore, we were interested to see if finance was a factor associated with patient satisfaction with teleconsultation. A minority of respondents reported that the opportunity to save money from not having to travel to the health center for consultation was not a major determinant of satisfaction with teleconsultation (15.1%). These low percentages indicated that financial factor does not contribute strongly to satisfaction with teleconsultation. The study also assessed if satisfaction was associated with how well the patients could express their feelings

during the consultation. The result showed that feeling less nervous did not contribute strongly to patient satisfaction with teleconsultation (11.3%). Similarly, only a few respondents were satisfied with teleconsultation because they were familiar with it (5.7%) and felt that they could express their feelings deeply to the provider via teleconsultation (2.8%). None of the respondents gave additional comments (0.0%).

This study has several limitations that deserve comments. One of the challenges with satisfaction studies is to find a standardized set of questions that apply to all solutions⁷. This is because the term satisfaction is not defined in most studies, and in those that did, the definition of satisfaction varies considerably⁷. Our first shortcoming was related to the reliability and validity of the questionnaire used in this study. Additionally, we did not attempt to assess the repeatability of our questionnaire. A reason for this is because we want to gain data as recently as the pandemic began to reveal early insights regarding the shift in ways of consultation. Nonetheless, we believed that this shortcoming did not affect the result of this study, as the questions in our questionnaire were adopted from the review of the relevant literature^{6,7,20-22}, where the questions have already been validated. Still, the questionnaire introduced here should be regarded as a preliminary version of an instrument for evaluating patient satisfaction with teleconsultation. The questionnaire, however, offers general insight into patient satisfaction with teleconsultation during the pandemic. Furthermore, since teleconsultation is gaining more popularity during the pandemic, future work should focus on developing a reliable and validated questionnaire to assess patient satisfaction with teleconsultation.

Secondly, as the survey was completed anonymously online to respect the respondents' confidentiality, we could not ascertain whether respondents met our selection criteria. Therefore, our results need to be viewed with caution, as there may be a possibility of selection bias. However, we tried our best to minimize this by providing a detailed description at the beginning of the questionnaire, emphasizing that the survey was explicitly intended for those clinically diagnosed with mental illness and whose treatments were changed from on-site consultation to teleconsultation due to the COVID-19 pandemic. Moreover, no incentive was given for completing the survey to minimize the potential for biased responses. Other than that, while an online survey is an effective way of reaching a targeted study population during a disease outbreak, we experienced difficulty obtaining permission from administrators of several social media platforms. Therefore, future studies should not entirely rely on posting the questionnaire on social media platforms, but they

should also consider contacting the health care providers to distribute the questionnaires.

Thirdly, because the same health care provider did not provide the consultation, we could not control the variability in the content and style of consultation between patients. Our study can be extended in future studies where the questionnaire is disseminated directly after a teleconsultation. This approach would be costly in terms of human resources and time, but it would provide richer information that could help design and review health-related policies. Additionally, to understand the impact of different health care providers on satisfaction level, future works should only recruit patients consulted by psychiatrists, psychologists, or medical doctors.

Finally, this study did not achieve the optimum sample size, and therefore, the findings should not be generalizable. One plausible reason is that we dealt with vulnerable groups of individuals, where participation from this group is typically low. However, the optimum sample size for a 14-item questionnaire ranges between 70 and 140³⁰. Therefore, we argued that the sample size of 106 was adequate for this preliminary study. Future research can shed light on other factors contributing to patient satisfaction with teleconsultation and ways to improve them in larger clinical cohorts.

CONCLUSION

Our findings showed that a majority of patients with mental health disorders were satisfied with teleconsultation. The convenience of not having to travel to the health center for consultation was the leading contributing factor to satisfaction with teleconsultation. Additionally, we showed that respondents were mostly satisfied with teleconsultation because their privacy and confidentiality were more protected. The patients were also satisfied with teleconsultation because it prevented them from seeing other people while preventing them and others from contracting infectious diseases. However, patients reported that they could not express their feelings well to the provider via teleconsultation. More importantly, this study proposed that teleconsultation may be a satisfactory mode of communication during the COVID-19 pandemic for mental health care in Malaysia. The findings of this study provide additional support for patient satisfaction with teleconsultation.

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Declarations of interest

The authors declared that they have no conflicts of interest.

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