To See or Not to See… Does Virtual Medical Encounter Harm Communication?

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Abstract

With the COVID-19 pandemic, the use of telemedicine and telehealth (telemedicine applied to health care) is becoming an important part of the tools used by medical and health care clinicians. The use of synchronous (real-time) audio-video communication (AVC) which connects physicians and patients through various technical platforms has advantages and disadvantages. The author explores how the limits associated with the use of AVC with narrow angle camera may negatively impact medical communication, depriving clinicians from non-verbal clues.

***Keywords:** Non-Verbal Communication; Telemedicine; Camera's Angle*

Virtual medical encounter, communication and interactions

I have thought medical communication for more than twenty years at our faculty of medicine. Albeit teaching of communication skills has been part of the medical curriculum for many years, I still can say to medical and surgical residents/house officers that communication problems are one of the main causes of complaints or claims against physicians [1-3].

However, physicians still tend to overestimate their capacity to communicate appropriately with their patients. It looks like physicians and patients do not have the same expectations, or that they do not evaluate the patient-physician relationship with the same parameters [4-9].

A few weeks ago, I was giving a lecture to senior residents/house officers. The lecture was about managing stress about national specialty examinations. Due to COVID-19, I had to use videoconferencing (AVC) to give the lecture which I used to give face to face. Students were attending from different parts of the city, of our province. While I was giving the lecture, I realized that I was missing something. For most part of the lecture, their camera and their microphone were off i.e. "no sight, no sound…". In fact, I was in action. But, was there an "inter-action" between the participants and I? We were engaged in a curious form of "communication." Again, something was missing during that encounter. What was the missing link? I realized that I could not identify their level of attention, I did not have the usual clues to follow their level of attention. I knew they were probably hearing me. But, were they listening to me? Were they understanding my educational messages?

Of course, at the end of the lecture we have had a discussion, but most of the time during the encounter I felt that I was deprived of many important clues, at least I was deprived of visual, non-verbal communication. A form of feedback, of "retro-action", was missing. It

made me feel uncomfortable, compared to the usual lecture conditions. The following days, I was thinking and also intrigued about some aspects of health care communication, and about telemedicine, of AVC. That lead me to write this short article about what is, for me, the impact of "seeing or not seeing" as a part of comprehensive medical communication modality.

Hearing, listening, understanding

At the basis of communication, we all know about the transmitter-receiver concept. The communication process is complex. Thus, hearing does not mean understanding. Hearing does not require attention. Hearing is more passive. It does not require action. To listen supposes a certain level of attention, a level of action, and also relates to a certain form of intent. What am I doing when I listen to someone? What is my interest? Do I listen because the other person wants me to listen to him/her? Why should I be interested to listen to that person? Is that me who wants to listen to that person? Why? What is my interest, my goal, when I choose to listen to that person?

Some authors, like Joseph DeVito [10], have defined the different stages of the process of listening i.e. receiving, understanding, remembering, evaluation, responding. Listening is action.

Roy Schwartzman [11] has described different types of listening, like listening to discriminate sounds, listening for pleasure, informational listening, critical listening, relational listening.

So, many forms of listening have been described in the health care literature. Among them, "active listening" is central to medical communication, and is often compared to passive listening.

From a clinical perspective, beyond listening there are implicit goals like understanding to interact.

At my work for thirty years as a consultant in consultation-liaison psychiatry (C-L), I learned that listening and understanding have different forms and clinical goals, have many nuances. Observing and using nuances during interactions with patients was part of my medical reality. In C-L, you have, over a very limited period of time, to try to understand what is the patient's medical condition. You have to make a formulation i.e. a synthesis of what can be understood of the patient's condition. Beside the written information mentioned in the medical chart, you must, as a consultant, identify symptoms and signs conducting to a medical diagnosis of the person's condition and propose, to the treating physician, an investigation or a treatment plan. In psychosomatic medicine, you also often have to communicate, to translate, the patient's psychological reality to your colleagues from other medical and surgical specialties.

So, to be able to quickly understand the patient's condition, you must try to optimize the encounter with the patient, to be sensitive to all forms of information shared verbally and non-verbally by the patient, during the interaction. Communication is certainly at the centre of the approach to that medical encounter, an encounter which necessitates to have established a rapport, a working alliance with the patient.

From my experience at the bedside or at my outpatient office, face to face interview seemed, at least to me, to be the best way to act clinically. The expression "face to face" may have different meanings. Here, I mean the context where there is no desk, no object, between the clinician and the patient. In a "face to face setting", I can then get a full view of the patient and the information he/she may reveals.

A previous experience with telemedicine, some of its early identified pros and cons

A little bit more than twenty years ago, I had the opportunity to participate to some virtual clinical psychiatric assessments. The patients were in another city. We were both in television studios, with the same backgrounds, the same technical equipments. The image quality was professional, the sound quality was professional. We both had access to a wall-sized screen experience. I was first impressed

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by the big screen giving an early feeling of proximity, but I felt an unexplained discomfort. I felt that there was something wrong. Something was missing, the encounter was at the same time real but also was kind of artificial. Following that experience, I discussed with colleagues also experimenting with virtual clinical psychiatric assessments. The discussion was about our impressions and observations. I realized that there was something unusual, unfamiliar with that clinical experience of AVC. As I said, I first had had a certain impression of proximity, but I did not have the same type of psychological proximity with the patient. I usually does shake my patient's hands, and I can then feel their muscular tension, something I could not get from the screen. Also, I did not feel as acutely the patient's feelings like his/her comfort or discomfort, anxiety, sadness or mistrust. More importantly, I could not verify the presence (or not) of some movement abnormalities or behavior changes. So, at the time, we proposed to introduce some solutions like, when possible, having a nurse or a technician at the patient's site, and the nurse could observe or check some of the patient's movements. We also suggested to ask the patient, during the virtual encounter, to do some movements in front of the camera. It did not solve every issue, could not replace the face to face feelings, but the idea was to try improve the experience for both parties. At least from a clinician's perspective.

COVID-19, clinical telemedicine and virtual medical assessment

Over the last twenty years, technology has evolved and has become more easily accessible. Now, more patients are familiar with computers and related technology, like the use of smartphones and webcams. With the present pandemic, many people also managed to have increased access to internet and familiarized with video conferencing.

Part of telemedicine, at least telehealth, involves processes that may be only audio, but can also be synchronous (real-time) audio-video communication (AVC) which connects physicians and patients through various technical platforms. With the COVID pandemic context, many care providing organizations and medical regulating bodies have allowed, at least temporarily, for the use of telemedicine for delivering health care. Physicians, like many other health professionals, have used telehealth, offering virtual care, doing virtual medical evaluations, or even doing virtual independent (third-party) medical assessments [12,13].

Using AVC has its advantages but also has some disadvantages. There are many documents on obstacles, technical, ethical and legal issues of telemedicine [14,15]. Discussing those issues here is beyond the scope of this article, which wants to focus on the impact of "to see or not to see" in telemedicine.

Among the advantages of AV telehealth, some groups have reported that the clinician is the one that has control over the interview. The clinician may, if needed, try to keep the interviewee focused. That may help for interaction, depending on the patient's response to the clinician's efforts. However, those attempts for what can be perceived by some patients as an empathic or benevolent attitude may be perceived as a form of harassment or intrusion, by other patients.

Among the disadvantages of AV telemedicine, as practiced nowadays, most patients use a computer with an integrated or external webcam, or use an electronic tablet, or a smartphone. Most patients sit very close to the camera. Or, people use a narrow angle camera. That limits the size of what is visually accessible (the operating field) to the clinician. So, it may take the clinician away from his emotional sensitivity. Also, it often makes it difficult to identify the patient's movement abnormalities or movement changes which may express changes in the patient's emotions, attitude, or to identify other non-verbal clues. When doing regular medical assessment or independent medical assessment, that kind of information could have even greater significance, but may be missed due to AV technical limits.

Some thoughts on the pros and cons of face to face versus virtual interventions

My first thoughts on that technical issue were that virtual medical/psychiatric encounters harm communication i.e. deprives the clinician from the clinical proximity offered by direct contact with the patient. It deprives the clinician from some changes in voice intonation, often less well captured by camera-microphones. It is also limits the clinician access to precious non-verbal visual information [16].

Then, I have given some thoughts about related issues met in clinical settings like in psychotherapy.

At the bedside, people are often in a bed and we cannot have a complete view of the patient's body which is often partly covered by bed sheets.

In the psychotherapy office, psychoanalysts were, not so long ago, defending the importance of staying behind the patient who was lying down on a couch. Seeing the patient during the session was not encouraged. The information from sight was considered like a distraction. Nowadays, the opinion about the importance of the couch has significantly changed [17].

For many clinicians, the setting of their office is done so that they sit behind a desk. It makes it easier to write notes during the encounter, but it limits the sight of the whole patient. That is why other clinicians, mostly psychiatrists and psychologists, prefer a real face-to-face setting i.e. without any object between them and the patient.

Either sitting behind a desk or sitting in a face-to-face environment, we often take notes during the interview. Taking notes may also affect our capacity to be attentive to changes in the patient's emotions or behaviours and limits our access to non-verbal clues.

So, I must admit that there are pros and cons of the different settings or technical conditions, allowing or not the clinician to have access to the sight of patient's full body.

Moreover, even in psychotherapy the issue of virtual versus face to face encounter has been the subject of different studies, some showing even more benefits for virtual encounter [18-20].

From those observations, or at least from a communication perspective, it looks like clinicians may feel uncomfortable and like myself, may react to the unfamiliarity and relative inexperience with telemedicine. As suggested by Verderber [21] clinicians may eventually have to be develop digital learning skills, and get used to it.

Adjusting to the environment of medical virtual encounters

As a mental health clinician, I identified some technical issues which may render virtual video communication more users' friendly.

We must remember that it is imperative for clinicians using telemedicine to follow the clinical and technical guidance offered by their country professional organizations [22-27].

Since the COVID pandemic, many authors have proposed tools to improve the telemedicine experience. Some companies have offered new telemedicine peripherals which could be used in collaboration with a nurse or technician at the patient's side. Christopher Brigham and his colleagues [13] have proposed to use Virtual Medical and Impairment Assessments and mention different technical tools already available which could be used by medical-surgical physicians for virtual assessments.

As a psychiatrist, I am trying to improve the visual aspects of the AV encounter. I looked at different alternatives to improve the visual experience. I suggest to patients to sit further, away from their camera. I suggest, when possible, to use a wide angle camera on a tripod (respecting sound aspects). If they use a smartphone or an electronic tablet, I suggest the use a tripod and to use an adaptor with a lens 120° wide angle. But those suggestions do not always receive the same response. Some patients are more opened and are ready to make the investment. Others do not seem to bother. Finally, I must say that may be the problem is for me, the clinician, but not for the patient.

Conclusion

There are advantages and disadvantages to AVC telemedicine. No doubt that the advances with technology, over the last twenty years, has made access to AVC more accessible for clinicians and for patients. With the COVID-19 pandemic, the use of telemedicine has been put forward, with its pros and cons. It is probable that we will learn from that accelerated use of telemedicine, that more technical advances will be proposed to improve the AVC experience. Already, some authors have proposed combining the face to face with the virtual experience [28].

As a clinician, at this time, I still favor the face to face encounter, with the accompanying quality of the experience. When I use the usual AV technology, I still miss the importance of the direct contact with the patient and the great input brought by the senses, particularly sight. At this time, for me, with the usual virtual (AV) medical encounter, not allowing to see the whole patient, harms at least in part the quality of communication. I am quite sure that that issue will be dealt and resolved with the advances in technology. for the benefits of our patients… and for us, clinicians. And, of course, I will have to make the effort and work for my brain to adjust to, who knows, some hidden feelings of the virtual environment.

Bibliography

1. Bradshaw P. "Good communication reduces risk of a complaint or claim". *British Medical Journal* 367 (2019): l6160.

2. Medical Protection. Complaints culture (2013).

3. McCreaddie M., *et al*. "Traumatic journeys; understanding the rhetoric of patients. Complaints". *BMC Health Services Research* 18 (2018): 551.

4. Fong HJ and Longnecker N. "Doctor-Patient Communication: A Review". *The Ochsner Journal* 10 (2010): 38-43.

5. Iedema R and Manidis M. "Patient-Clinician Communication: An Overview of Relevant Research and Policy Literatures". Sydney: Australian Commission on Safety and Quality in Health Care and UTS Centre for Health Communication (2013).

6. Emanuel EJ and Emanuel LL. "Four Models of the Physician-Patient Relationship". *The Journal of the American Medical Association* 267 (1992): 16.

7. Lee AV., *et al*. "What can we learn from patient dissatisfaction? An analysis of dissatisfying events at an academic medical center". *Journal of Hospital Medicine* 5.9 (2010): 514-520.

8. Krupat E., *et al*. "The practice orientations of physicians and patients: the effect of doctor-patient congruence on satisfaction". *Patient Education and Counseling* 39.1 (2000): 49-59.

9. Sofaer S and Firminger K. "Patient perceptions of the quality of health services". *Annual Review of Public Health* 26 (2005): 513-559.

10. DeVito JA. "Essential Elements of Public Speaking, 6th Edition". Pearson, New York (2017).

11. Schwartzman R. "Fundamentals of Oral Communication, 3rd edition". Kendall Hunt Publication (2016).

12. Kichloo A., *et al*. "Telemedicine, the current COVID-19 pandemic and the future: a narrative review and perspectives moving forward in the USA". *Family Medicine and Community Health* 8 (2020): e000530.

13. Brigham, C.R. *et al*. "Virtual Médical and Impairment Assessments." May/June 2020. AMA Guides Newsletter. 3-11 https://vww.ama-assn.org/system/files/2020-06/virtual-medical-impairmentassessments.pdf.

14. Canadian Medical Association. "The Future of Technology in Health and Health Care: A Primer Health Summit Backgrounder (2018)". Toronto (2019): 12-13.

15. Greenhalgh T., *et al*. "Virtual online consultations: advantages and limitations (VOCAL) study". *BMJ Open* 6 (2016): e009388.

16. Weissman SM. "Face to face: The role of vision and the smiling response". *The Psychoanalytic Study of the Child* 32 (1977): 421-450.

17. Wiener J. "The analytic setting today: using the couch or the chair?" *The Journal of Analytical Psychology* 60.4 (2015): 462-476.

18. Rees CS and Stone S. "Therapeutic Alliance in Face-to-Face Versus Video conferenced Psychotherapy". *Professional Psychology: Research and Practice* 36.6 (2005): 649-653.

19. David C., *et al*. "Effect of Telephone-Administered vs Face-to-face Cognitive Behavioral Therapy on Adherence to Therapy and Depression Outcomes Among Primary Care Patients: A Randomized Trial". *The Journal of the American Medical Association* 307.21 (2012): 2278-2285.

20. Brenna N., *et al*. "Preference for in-person psychotherapy versus digital psychotherapy options for depression: survey of adults in the U.S". npj Digital Medicine 2 (2019): 6.

21. Verderber KS., *et al*. "Communicate! 15th edition". Cengage Learning (2017).

22. General Medical Council. "Remote-consultation".

23. General Medical Council. "Regulatory approaches to telemedicine". (2020).

24. American Medical Association. "Telehealth Implementation Playbook" (2020).

25. American Medical Association. "AMA quick guide to telemedicine practice" (2020).

26. The Royal Australian College of General Practitioners. "Telehealth video consultations guide" (2019).

27. American Psychological Association. "Guidelines for the practice of telepsychology" (2020).

28. Erbe D., *et al*. "Blending Face-to-Face and Internet-Based Interventions for the Treatment of Mental Disorders in Adults: Systematic Review". *Journal of Medical Internet Research* 19.9 (2017): e306.

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