Abstract: Current videoconferencing technology has allowed for the development, acceptance and growth of telepsychiatry programs in Canada and in other countries. Questions and concerns remain about the effect of the videoconferencing context on doctor–patient communication. This paper briefly reviews factors relevant to this issue and presents two case histories that involve challenges for both telepsychiatry and in-person interviews. As demonstrated in these case histories, the encounter context of videoconferencing is only one factor in a complex and dynamic communication process. The success of a telepsychiatry interview is related more to routine communication processes than to videoconferencing technology.

Résumé : La télépsychiatrie et la communication médecin–patient : l’histoire de deux entrevues

La technologie de la vidéoconférence actuelle a permis l’élaboration, l’acceptation et la croissance de programmes de télépsychiatrie au Canada et ailleurs. Des questions et des doutes subsistent quant à l’effet du contexte de la vidéoconférence sur la communication médecin–patient. Cet article examine brièvement les facteurs relevant de cette question, et présente deux histoires de cas qui comportent des problèmes tant pour la télépsychiatrie que pour les entrevues en personne. Comme il est démontré dans ces histoires de cas, le contexte de la rencontre par vidéoconférence n’est qu’un seul facteur d’un mode de communication complexe et dynamique. Le succès d’une entrevue par télépsychiatrie a davantage trait aux modes ordinaires de communication qu’à la technologie de la vidéoconférence.

Key Words: telepsychiatry, doctor–patient communication, encounter context

How does the medium of videoconferencing affect the nature and quality of doctor–patient communications? Individuals who are approached about participating in telepsychiatry may be concerned about their comfort level and their ability to speak openly. In the same way, they may wonder about whether they will experience the “social presence” of the other person (1). Likewise, psychiatrists may question the accuracy of diagnoses, the appropriate use of recommended treatment, adherence to treatment and, ultimately, clinical outcomes. Patients may also wonder about the following: Will the interview be confidential? Will the psychiatrist really understand? Will they be treated as human beings or as depersonalized images on a television screen? In light of these concerns and their effect on doctor–patient interactions, this paper briefly discusses communication issues in telepsychiatry and presents two case histories that involve interview challenges for telepsychiatry and in-person consultations.

Telepsychiatry and doctor–patient communication have been the subjects of review in excellent articles by Dr. Donald Hilty (2) and Dr. E.A. Miller (3). Hilty’s review indicates that patient satisfaction has been extensively studied as part of telepsychiatry program evaluations. Results from post-interview questionnaires showed consistently high levels of patient satisfaction. Questions comparing patient preference for in-person interviews with telepsychiatry interviews generally indicate a nearly equivalent degree of preference, with a significant minority preferring telepsychiatry. In a prospective survey of patient preference involving pre- and post-interview questionnaires, Hilty found that patients unfamiliar with telepsychiatry chose telepsychiatry in roughly one-third of cases (29 per cent for an initial visit and 35 per cent for a followup visit) (4). After a telepsychiatry interview, 52 per cent of patients chose telepsychiatry over inpatient followup. Preference ratings for the in-person interview group were unchanged pre- and post-interview.

Miller’s detailed literature review of video consultation and communication examined 38 quantitative and qualitative studies involving surveys of providers, participants and community attitudes. Findings were divided into 23 categories describing various aspects of communication. In all but two categories, positive findings with respect to telepsychiatry outweighed negative findings: overall, there were more than three times as many positive findings. Particularly favourable results (that is, at least eight times as many positive findings) were described in the categories of general communicative efficacy, patient and provider comfort, patient–provider relationships, anxiety and (or) nervousness, miscellaneous affect and audio and video quality. Only the nonverbal behaviour and the lack
of touch categories had more negative than positive findings.

In Hilty’s review, specific measures of interview quality in the context of videoconferencing technology, including rapport (5,6) and “presence” (1,7,8), indicated that telepsychiatry was generally equivalent to—and in some cases better than—in-person interviews.

Consultant satisfaction has not been studied in the same detail, but available reports suggest that, although generally well satisfied, consultants tended to rate in-person interviews slightly higher than telepsychiatry interviews (9–11). Generally, referring physician satisfaction with telepsychiatry has been equivalent to that for in-person interviews (12).

To understand the potential advantages and disadvantages of telepsychiatry, Miller reviewed factors relevant to successful face-to-face interviews in an article subsequent to his literature review (13). He conceptualized a model in which the characteristics of the patient, of the provider and of the context of the medical encounter dynamically interacted to affect participant behaviour and, ultimately, clinical outcomes. In his review of doctor–patient communication studies, greater patient satisfaction has been associated with physician behaviour that includes more information giving, more positive affect, more social conversation, more psychosocial talk, more partnership building and more patient-oriented behaviours. Treatment adherence and, in some studies, treatment outcomes have been related to the same or similar factors. The encounter context in doctor–patient communication has been studied less than physician or patient characteristics.

In telepsychiatry, the evaluation of the videoconferencing encounter context has focused on its ability to “simulate real-time experience in terms of image and interaction” (2). Room-based videoconference systems, commonly used in telepsychiatry programs, are reliable, provide almost instantaneous signal transmission and have adequate audio and visual-image quality (14–16). Technical problems can occur, involving signal transmission delays, asynchronous audio and visual transmission, temporary disruption or loss of signal, loss of camera control (that is, zoom and pan) and disconnection; however, these are not commonly reported.

From a patient perspective, the telepsychiatry context may be viewed as inspiring (17), enjoyable (18) and less threatening (19). Patients may arrive at the interview less stressed because they have not had to deal with scheduling, planning and paying for a trip to the consultant’s office. Similarly, consultants may find telepsychiatry enjoyable; it provides a break from the usual interruptions at the office or the hospital. Consultants who become involved in telepsychiatry are likely to be innovative individuals who seek variety in their work and may deliver telepsychiatry services with a heightened sense of interest and energy.

Some authors have expressed concern that telepsychiatry may dehumanize (20) and mechanize (21) the nature of the interaction. Indeed, the interaction may be more task-oriented, but this shift in style may have benefits (22). More attention may be directed to the verbal content of the interaction by both patient and physician. This may encourage more focus on the clinical task and an enhanced sense of equanimity.

Case Histories

Ideally, both telepsychiatry and in-person interviews are provided in an environment and context that is well organized, well informed, comfortable and free of distractions—an environment with both the patient and the provider in relaxed, focused states of mind. Unfortunately, emergencies, clinical complications, staffing problems, resource limitations, administration issues, miscommunications, competing priorities, fatigue and random events represent the reality of health care. The following two cases are not typical or routine, but they did occur on consecutive days while this article was being written. They represent an opportunity to compare the two methods of service delivery in an “uncontrolled” manner.

Case History 1: Telepsychiatry and Mr. A.

The site coordinator from our program’s busiest referral centre arranged an urgent consultation for a 64-year-old married farmer whose case had been discussed with his general practitioner by telephone two days earlier. Mr. A. had a history of depression accompanied by psychotic symptoms and was relapsing with moderately severe depressive symptoms, with only a hint of paranoia. He was seen on a Thursday afternoon, a time normally reserved for the consultant’s research and administrative duties. His wife and the site telehealth coordinator, who was also a mental health nurse involved in his care, accompanied Mr. A. His first episode of depression had occurred just one year earlier in the setting of major life stressors, including illness and deaths in the family, a rough year on the farm and the tragic suicide of his son-in-law. An only child with a very responsible demeanor, he handled these issues with minimal assistance and with dedication to the point of sleep deprivation. After completing the spring farm work, he was admitted to the local hospital with depressive and paranoid symptoms. After a telepsychiatry consultation, risperidone was added to the previous treatment of paroxetine and zopiclone. He improved quickly. He was well until the following spring, when farm chores and his daughter’s pending wedding correlated with a relapse and led to the current telepsychiatry consultation. There was no other previous psychiatric illness, substance abuse or family psychiatric history.

The interview was delayed a few minutes because of technical problems and because Mr. A. was quite anxious and reluctant, despite having previously seen a different telepsychiatry consultant, with subsequent improvement. With support and encouragement, he was cooperative but
somewhat reserved and hesitant. About 10 minutes into the interview, technical problems began, probably involving the telephone lines. Both visual and audio transmission were distorted or lost, either temporarily or with a complete disconnect. Throughout these disruptions, the patient and his wife were patient and understanding and remained committed to continuing the interview. After the third complete disconnect, the consultant moved to a different videoconferencing room, hoping to have better luck with the call. As before, the patient and his wife remained understanding and cooperative. A sense of rapport was apparent, undoubtedly assisted by the presence of the site coordinator who calmly assisted with the technical problems in her usual pleasant and efficient manner. The patient and his wife responded to light-hearted comments about the technical problems. Mrs. A. provided most of the history, which seemed to be somewhat of a relief to Mr. A., who would nod and respond to questions politely but with few words and a saddened, downcast expression. Mr. A. had actually started to feel slightly better in the two days prior to this interview, which perhaps related to medication changes that had been discussed by telephone. Paroxetine was being tapered and venlafaxine added, while low-dosage risperidone was maintained. Further recommendations included slowly tapering and discontinuing the paroxetine and maintaining the other medications for the short term. Followup was arranged to assess medication requirements, to provide supportive and cognitive therapy as appropriate and to maintain careful attention to sleep patterns and stress levels. Technical problems continued in the second room, with two disconnects—one of which occurred during the discussion of diagnosis and treatment. Mr. and Mrs. A. appeared generally pleased with the interview, despite the repeated technical difficulties, and Mr. A. in particular seemed more optimistic for the future. Mr. A. completed a post-interview satisfaction questionnaire that was quite positive (Table 1).

Case History 2: Ms. B.

On a Thursday morning, a general practitioner colleague requested a psychiatric consultation at the nearby rural general hospital for Ms. B., a 37-year-old inpatient who had been admitted for treatment of a severe and chronic ulcer of the buttocks and perineal region. It had been present for 30 years and investigated by multiple consultants. One of these included a trip to an internationally renowned medical centre 20 years earlier. No clear etiology and no satisfactory treatment had been found. Ms. B. had various comorbid problems, including living common-law with an abusive alcoholic, depression for which she was on a disability pension, possible prescription drug dependence and, other than health care professionals, relatively few social supports. Three years previously, she had been admitted to the nearby psychiatric hospital and was treated by the consultant.
The request for consultation indicated no urgency; she would require care for the ulcer, which because of associated blood loss, had led to a blood transfusion. The next day, however, the general hospital staff telephoned to say that Ms. B. was packed and waiting only for her psychiatric consultation before her keenly awaited discharge. Arrangements were made for her to be seen at the general hospital at the end of that Friday afternoon.

After a busy afternoon, the consultant arrived at the general hospital, where he provides infrequent consultations. Nursing staff were quite pleasant and eager to chat. A community pharmacist known socially to the consultant stopped to say hello while passing by. Information available in the hospital file was organized differently than that at the psychiatric hospital. The medication record was also different in format. Previous psychiatric records were unavailable. The patient was seen in the small television lounge, which was unoccupied and the quietest place to go. Ms. B. was not keen to see the consultant: she felt she wasn’t “liked,” based on the previous contact, which had involved a difference of opinion over her prescriptions. The lengthy list included several medications with abuse potential. After the consultant greeted and reassured her he had no hard feelings toward her and with only a minimal recollection of her admission three years ago, the interview proceeded with relatively good rapport. Roughly 15 minutes into the interview, while discussing her history of adoption and unhappy contact with her biological mother, a co-patient knocked politely on the door and asked whether she could come in to use the telephone. Nursing staff directed her to the other available telephone. A few minutes later, an alarm sounded in the hallway and continued for several minutes. The cause was unclear but did not seem serious enough to require evacuation. Ms. B. was quite stable and asymptomatic for common psychiatric conditions. She described good efficacy and minimal side effects from her extensive list of medications. There was no direct psychiatric component to the ulcer, although the nonspecific interaction of psychological and physical health was relevant.

Consultant comments included acknowledgment of the difficult nature of her case and the extensive prescription drug use, with the option for more intensive followup and treatment, with particular regard to her need for medication. Throughout the interview, a reasonably good sense of rapport was maintained. Her primary need, however, seemed to be to complete the consultation and facilitate discharge.

Discussion

Both these interviews occurred in less-than-ideal encounter contexts. Common challenges included scheduling an urgent consultation into previously booked time slots and dealing with reluctant patients and unexpected interruptions and distractions. Compensating factors in Mr. A.’s case included the presence and support of Mr. A.’s wife and a mental health nurse who was familiar with troubleshooting the videoconferencing system. In addition, records of previous consultations were available. In Ms. B.’s case, the patient was motivated to maintain reasonable rapport to complete the interview and to obtain discharge. Despite five complete disconnects in Mr. A.’s interview, the consultant felt that the assessment, management recommendations and establishment of rapport were all accomplished in a satisfactory manner. In Ms. B.’s case, however, the consultant viewed the assessment as less productive because of the looming expeditious discharge, the less-than-complete availability of information and perhaps because of the patient’s need to maintain treatment with an extensive list of medications. In both cases, followup was an important recommendation. Mr. A. had followup with the referring general practitioner and a future telespsychiatry appointment. Ms. B. had followup through an outreach or clubhouse program, as well as with her family practitioner.

Was the outcome of each interview affected negatively by the less-than-ideal encounter contexts? In Mr. A.’s case, the outcome was likely the same as it would have been in person, despite the presence of fairly urgent symptoms and moderately frustrating technical problems. After the session, there may have been a sense of satisfaction and relief that challenging obstacles were overcome. Mr. A. and his wife commented that their anticipatory anxieties about the interview were generally relieved and that they “understood” the technical problems. They readily agreed to a further telespsychiatry appointment.

In Ms. B.’s case, a more ideal context with more available information might well have led to more time and attention being given to the issue of possible drug dependence. Whether this would change the long-term outcome is uncertain, but clearer assessment and treatment recommendations might have emerged and been available for future reference.

In Mr. A.’s case, two third-party individuals were present. The presence of third parties—whether family members, therapists or physicians—has an effect on the communications, as reviewed by Miller (23). With third parties present, more information giving generally takes place and more time is spent. Potentially negative impacts may include physicians’ providing less emotional support and patients, especially the elderly, being less assertive and expressive, raising fewer questions and participating less in shared laughter and joint decision-making. Indeed, Mr. A. participated minimally in the interview but seemed quite relieved that his wife supplied most of the history. This seemed appropriate to his care, given that without her support he might not have agreed to the interview at all. Even so, one wonders how differently he might have presented alone.

What are we to conclude from these cases and this brief review? Perhaps Cecil Wittson, the pioneer of telepsychiatry, said it best in his 1961 paper about the use of closed-circuit television for group therapy sessions:

Ratings are influenced substantially more by the therapist and the selection of group members than by the
Today’s videoconferencing technology allows for clear audiovisual transmission over long distances, and telepsychiatry is a growing method of service delivery. Patient and provider responses to telepsychiatry reflect not only technical adequacy but also the myriad factors relevant to any communication process. Ultimately, the success of a telepsychiatry interview is more a function of traditional communication processes than of technology.

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References