
Distance and proximity in clinical work

EDITORIAL

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The author has completed the ICMJE form and declares no conflicts of interest.

Digital communication works well – for everybody, always?

In this issue of the Journal of the Norwegian Medical Association, Tvetter and colleagues publish experiences from the use of video consultations at the outpatient rheumatology clinic at Diakonhjemmet Hospital [\(1\)](#). The study shows that both therapists and patients were generally satisfied with video consultations for following up patients with rheumatic diseases. However, one-quarter of the patients felt that it was problematic not to be examined, and the therapists believe that video consultations are best suited for following up patients with little comorbidity. These results concur with findings made by others [\(2–5\)](#).

Rapid technological development has made it possible to have medical consultations online [\(2\)](#). Before the COVID-19 pandemic, however, little use was made of them. The numerous barriers included the clinicians' opinion that they provided no possibility for clinical examination and building of relationships. In some countries, insurance and reimbursement schemes constituted further barriers. Infrastructure was yet another issue: concerns about data security, unequal access to and knowledge about technology, and disruption of established work processes [\(2\)](#), [\(6–8\)](#). With the anxieties caused

by the pandemic regarding physical contact, most of the barriers vanished into thin air. Patients, and not only those in sparsely populated areas, found digital access to health personnel both tempting and simple. The possibility of technological monitoring of the patients' condition in their homes is better utilised, and patients can be sorted in advance by solutions such as chatbots (*forward triage*), thereby increasing the efficiency of emergency departments (2, 6). It is reasonable to assume that when danger threatens, most people are willing to accept digital risks in order to get in touch with competent health personnel.

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While there is no lack of studies that use satisfaction as an outcome measure, or descriptions of various uses of remote digital technology (7, 9), the literature includes few detailed observations. Hammersley and colleagues compared video consultation with audio recordings of regular consultations (5). They found that on average, regular consultations lasted four minutes longer than video or telephone consultations. The patients also brought up more problems, and the doctors gave more information than when using digital aids. A physical encounter may also provide better opportunities to consider different symptoms in context. A conversation analysis study compared video consultations with matched audio recordings of regular consultations (4). Most of the consultations were uncomplicated. To the extent that technical challenges disrupted the video conversations, it turned out that both the clinician and the patient relied on common interpersonal communication strategies to resolve the situation. This is consistent with general communication theory.

As a main rule, conversations tend to be collaborative. As an unexpected effect of digital consultations in the United States, doctors have gained shocking insight into their patients' lives and living conditions (10). Remote technology may thus provide insight through a paradoxical 'proximity'. It is questionable, though, whether such a scent-free orientation to reality will entail any consequences for medical work. One of the greatest concerns associated with the digital era is that we will see greater differences in health service provision between those who can cope with and have access to the technology on the one hand and the rest of the population on the other. Overconsumption of services is expected among those who can afford them, because the services become more available or because the digital doctor orders more, and costlier tests when the patients cannot be examined physically (4–6), (10).

During the pandemic, it has become abundantly clear how much personal contact, smell, hugs, touch and warmth mean to people. Digital remote proximity may nevertheless prove efficient and able to prevent infection (7), and the future may show when the technology is helpful and when instead it is harmful. Going forward we should ask ourselves whether some of the billions that are spent on digitalisation should rather be devoted to human resources

that can be applied to old-fashioned, perhaps somewhat slower and less practical proximity. Perhaps in the end this would be more meaningful for both the service provider and the user?

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