

The symbolic affordances of a video-mediated gaze in emergency psychiatry

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Abstract

While mental illness is a significant health challenge worldwide, the availability of specialists is limited, especially in rural areas and for psychiatric emergencies. Although tele-psychiatry, via real-time videoconferencing (VC), is used to provide consultative services in areas that lack psychiatrists, there are a paucity of studies on the use of VC for psychiatric *emergencies*. We examine how VC matters for patient involvement and professional practice in the first Norwegian emergency tele-psychiatric service. Through a decentralised on-call system, psychiatrists are accessible 24/7 by telephone and VC for patients and nurses in regional psychiatry centres. Based on 29 interviews with patients, psychiatrists and nurses, this article addresses how participation is fostered by VC, and how it may change the social dynamics of therapeutic emergency encounters. We identified four contributions of the 'video-mediated gaze' in the therapeutic encounter including those of the: (1) immediacy of assessment, (2) increased transparency, (3) sense of access to the 'real' expert, and (4) fostering of the patient's 'voice' in therapeutic decisions. These VC inflections of the therapeutic encounter are a mix of the pragmatic (1 and 2) and the symbolic (3 and 4), assembling in these contexts to foster patient-centeredness. With a sociological approach to video-conferenced emergency psychiatry, the identification of symbolic affordances adds necessary nuances to the application of new technologies into fragile therapeutic communication.

Keywords

Norway; tele-psychiatry; videoconference; emergency care; psychiatry; patient involvement; qualitative study.

Introduction

As mental illness has been recognised as a notable contributor to the global burden of diseases, improving mental healthcare has become urgent worldwide. Even Western countries have been unable to provide sustainable mental health services, ensure financial and available human resources, implement adequate interventions and solve inequities and inefficiencies in the distribution of resources (Whiteford et al., 2013). Developing distributed services such as tele-psychiatry may address some of these obstacles in mental healthcare. Consequently, national health policies often include decentralisation of services through outpatient clinics and local day treatment to reduce the demand for and cost of admission in central hospital wards (Norwegian Ministry of Health and Care Services, 2008–2009). A major barrier to realising such strategies in Norwegian mental healthcare provision, which is recognised by other countries (Boydell et al., 2014), is the limited availability of mental health specialists in remote areas. There is thus the problem of capacity to penetrate the periphery, regardless of policy intentions.

One strategy to spread services more evenly and further engage the periphery of health service delivery, is the rollout of information and communication technology (ICT) to promote a cost-effective, wider distribution of services. Whether under the banner of *telemedicine*, *e-health* or *health informatics*, ICTs have in recent years transformed the mediation of and access to medical expertise (May et al., 2005; Dedding et al., 2011; Lupton and Jutel, 2015). In mental healthcare, tele-psychiatry is now utilised via real-time videoconferencing (VC) and involves the provision of advanced consultative services ‘virtually’ to previously remote locations and service contexts (Hilty et al., 2013).

As new services are funded and developed, there is a need for considered assessment of how they inflect therapeutic processes. Studies illustrate the successful use of tele-psychiatric services, by improved access to expertise and therapy, patient, carer and professional satisfaction, time efficiency and reduced need for patient travel (Hilty et al., 2013; Boydell et al., 2014). Young patients even reported that the use of VC in therapy alleviated their previous anxieties in consulting a psychiatrist (Boydell et al., 2010). Further, healthcare providers in remote communities emphasised that regular access to specialists through VC increased their knowledge and confidence in assisting patients locally (Greenberg et al. 2006).

However, video-conferenced psychiatry has been applied principally in *planned* consultations, with limited experience and research of its use in psychiatric *emergencies* (Hilty et al., 2013). Psychiatric emergencies require 24/7 health services, with situations characterised by complexity, uncertainty, limited information and the need for urgent action. Moreover, the patients have hardly met the health personnel in advance, whilst in planned video-conferenced psychiatry the actors have already established communication. Emergencies often require team decisions, for which VC may be a suitable tool when patients and psychiatrists are not co-located (Bolle et al., 2017). Within research, however, tele-psychiatry of all kinds has been examined mainly from a medical or health services perspective, concentrating on therapeutic effectiveness and specific clinical outcomes rather than issues such as patient involvement, professional practice or the personnel-patient interaction. Sociological studies have shown that ICT implemented in health-care significantly impacts on the allocation and organisation of human resources and on professional or inter-professional practice (Tjora 2000; Heath et al., 2003; Halford et al.,

2010) although limited professional involvement may have reduced potential outcomes (Tjora and Scambler, 2009). When ICT transforms and even challenges the traditional doctor-patient interaction (Broom, 2005a; Tjora et al., 2005; Andreassen et al., 2006; Dedding et al., 2011) and people's own management of their health conditions (Ziebland and Wyke, 2012; Trondsen and Tjora, 2014) sociological approaches may explore important interactional issues.

The University Hospital of North Norway established in 2011 the first videoconferencing system for decentralised psychiatric emergency care in Norway, to address the need for psychiatric expertise in rural areas. This system allows patient-provider consultations through VC whereby patients, local nurses and remote psychiatrists participate. To explore experiences with this tele-psychiatric service, we designed the current qualitative study, involved semi-structured interviews with patients, psychiatrists and nurses (Trondsen et al., 2012). Specifically, in this analysis we critically explore how VC *matters* in psychiatric emergencies for patient involvement and the dynamics of professional practice, in which more than just the physician is involved. In our previous work, we found that VC consultations were useful in exigencies characterised by uncertainty regarding the degree of illness or level of treatment, a need to clarify the severity of the patient condition, a need to build an alliance with the patient, or disagreement either between health personnel or between the patient and providers (Bolle et al., 2017). We also showed how access to VC increased patients', nurses' and psychiatrists' sense of confidence in challenging psychiatric emergencies, by strengthening patient involvement, reducing uncertainty, sharing responsibility, and providing a safety net (Trondsen et al., 2014).

In this article, we are concerned with how the triadic participation fostered by VC, in which the patient, the nurse and the doctor interact in parallel, may change the social dynamic of therapeutic encounters. As mentioned, in emergencies urgent action is needed, despite limited information, physical distance to expertise, or whether the patient and the health personnel have met before. Through specifically applying a *sociological* approach to the use of VC in psychiatric *emergencies*, we aim at exploring experiences of social interaction in which both patients, nurses, and psychiatrists are involved, and where the unstandardised nature of emergencies make this triadic negotiation more explicit. The main question we ask is therefore: how does the introduction of VC in psychiatric emergencies alter the meaning of the medical consultation.

Theoretical framework

The theoretical basis of our analysis rests on two themes: first, technology's role in the mediation of professional boundaries and second, a domestication theory on the application of technologies.

To explore the dynamics of VC, it is helpful to understand the history and dynamics of professional territory and authority (including various struggles therein). It is well documented in medical sociology that the medical profession's jurisdiction has granted extensive 'legitimate' control over health services (Freidson, 1994). Professional practice is more complex, however (Abbott, 1988); for instance, nurses have increasingly exercised

considerable autonomy in their specialist nursing practices. With ICTs being further integrated into contemporary healthcare, the negotiation of professional boundaries (Tjora 2000, Petrakaki et al., 2014) and roles between patients and providers (Broom, 2005a, 2005b; Tjora et al., 2005; Andreassen et al., 2006; Dedding et al., 2011) is being fundamentally mediated by 'non-traditional' forms of communication, often in addition to traditional face-to-face interaction. Studies have shown how the implementation of ICTs can render professional responsibilities more visible, such as in emergency coordination (Tjora, 2000) and help lines (Hanlon et al., 2005; Snelgrove, 2009).

In social studies of technology, an array of perspectives allows a nuanced understanding of the nexus between technology and practice. Particularly, these viewpoints establish an interpretive approach to understanding the ways in which technologies may have material and symbolic qualities that both lead to social changes and are socially interpreted and shaped in specific contexts and practices. From the social constructivist perspectives, popular amongst scholars engaged in science and technology studies (STS), the *interpretive flexibility* of technologies has been emphasised (Pinch and Bijker, 1987), as well as the impact on users (cf. Oudshoorn and Pinch, 2003). In our analysis, we are especially interested in how various users' applications of VC change roles and relations within the services. Theoretical works regarding *domestication* (Lie and Sørensen, 1996; Berker et al., 2005) and *affordances* (cf. Hutchby, 2001a) are particularly helpful in this field – as is apparent in the results presented in this article – since these frameworks are specifically concerned with technology-in-use, as well as discriminating between their material versus social dimensions.

The term *domestication* has been applied to the process by which artefacts are appropriated and re-embedded in a local context when put to use (Lie and Sørensen, 1996:17) or how 'wild devices' are tamed as they are adapted at home (Silverstone et al., 1992). Domestication is an inherently conservative process in the sense that consumers seek to incorporate new technologies into the patterns of their everyday lives in such a way as to maintain both the structure of their lives and their control of it (Thrall, 1982). Domestication holds the promise of functioning as a key concept in the analysis of technology in everyday life as it embraces the assumptions about the users as active parties that might act in various ways and acknowledges the systemic qualities of the process through which technology is consumed (Lie and Sørensen, 1996). The original contribution of Silverstone et al. (1992) describes domestication as a fourfold process: (1) appropriation, where an object is made physically and mentally available; (2) objectification, where the household presents its aesthetic and cognitive values, and the object is given a place; (3) incorporation, where the object is incorporated into daily routines; and (4) conversion, where the household's cultural preferences are mediated with the outside world through the incorporated artefact. Silverstone and Haddon (1996) add a fifth dimension that viewed sequentially, comes before the other four, namely, commodification, where commodities are constructed as objects of desire within an advertising and market system. From a user's perspective, this dimension represents the 'imaginative work that potential or actual customers undertake as they participate, willy-nilly, in the consumption process' (Silverstone and Haddon, 1996:63) or simply 'imagination' as suggested by Ling (2001).

While the domestication perspective has its natural home in a social constructivist paradigm (Pinch and Bijker, 1987), Hutchby (2001a:444) offers another viewpoint based on the *affordance* concept and is concerned with the 'constraining, as well as enabling,

materiality of the technology as a worldly object'. The affordance perspective focuses on how ordinary users of technology are concerned with 'what the technology can and cannot do, and what they, in their situated courses of action, can and cannot do with it' (Hutchby, 2003:586). This perspective therefore acknowledges the technical and material qualities of any artefact brought into use. Applying the affordance perspective to our analysis of VC is relevant as it includes an acceptance of technological materiality as influential in the integration of a 'VC option' into acute psychiatry.

Method

Site of research

Our study examines the introduction of a new decentralised on-call system in psychiatric emergencies, where psychiatrists are accessible 24/7 by telephone and VC for distant consultations with patients and nurses (Trondsen et al., 2012). In collaboration with the Norwegian Centre for Integrated Care and Telemedicine, a department of emergency psychiatric care at the University Hospital of North Norway established the on-call system in clinical practice in 2011. The department covers 95,000 people and consists of one acute psychiatric ward in a central hospital located in the county capital and three regional psychiatric centres (RPCs) located in towns 2.5 to 4 hours away (by car) from the central hospital. The RPCs are responsible for delivering psychiatric emergency services in their geographical areas. Each RPC has a regional acute ward with 12 beds, an ambulatory psychiatric team and outpatient services. The ambulatory team consists of nurses or similar professionals who have discretionary authority to admit patients to the regional ward in the morning, afternoon and evening. A physician should be involved to formally issue or change drug prescriptions, or admit patients to the regional ward at night. Additionally, involuntary admissions have to be requested by a physician and are only permitted in the central hospital ward.

Because of the RPCs' geographic remoteness, the department had not succeeded in recruiting psychiatrists for positions to provide regular 24-hour emergency care. The purpose of the on-call service was to overcome this challenge and ensure all patients' equal access to specialist assessment regardless of their location. Six psychiatrists were organised on a rotation scheme, and VC studios were installed in the three RPCs and in the psychiatrists' offices or homes. The psychiatrists agreed to be available for direct patient consultation by VC in collaboration with nurses at the RPCs to provide a 24/7 emergency service. Approximately 50-60 VC consultations are conducted annually, usually lasting 30-40 minutes.

Research design, recruitment and participants

This study aims to explore how different actors experience the use of VC in psychiatric emergencies, and a qualitative exploratory design was chosen. We draw on 29 semi-structured, individually interviews with patients, nurses in the three RPCs and psychiatrists involved in the on-call system. The criterion for inclusion in the study was that they had attended at least one VC consultation in a psychiatric emergency setting. Patients were

recruited by written information, delivered by the RPC. With consideration for patients' state of health, they were invited to participate in the study when they were discharged from emergency care. We recruited 29 individuals for interviews, comprising five patients (1 male and 4 females, aged 18 to 51), five psychiatrists (all males, aged 40 to 60) and 19 nurses (4 males and 15 females, aged 39 to 63). Both the patients and the nurses represented all the three RPCs. Five of the six psychiatrists involved in the on-call system were interviewed (one psychiatrist excluded as being department head and initiator of the VC service).

Interviews

The first author conducted the interviews between July 2012 and June 2013, approximately one to two years after the VC system became operational. The psychiatrists and the nurses were interviewed in their workplaces. Four patient interviews were carried out in the RPCs, while one patient preferred to be interviewed at home. Interview guides were used to structure the dialogue, simultaneously allowing the participants to rethink and explore their experiences in detail through 'grand tour questions' (Spradley, 1979). Three semi-structured interview guides were customised to patients, nurses, and psychiatrists, respectively. The guides covered topics such as expectations and experiences of using VC consultations; practical and technological issues, collaboration, trust and safety, and assumptions for use. In the interviews with the health personnel, we sought to explore clinical, professional and organisational issues, while the patient interview focused on their personal experiences. Due to a wide range of experiences with VC, the interviews lasted between 34 and 75 minutes. All interviews were digitally audio-recorded and fully transcribed.

The Regional Ethics Committee in Norway approved the study. All participants were recruited on a voluntary basis, patients providing written informed consent, while health personnel providing oral consent. The data material was depersonalised and securely handled according to the ethics committee's guidelines, excluding pertinent biographical details from quotes.

Empirical limitations

While the sample is quite representative of the various health personnel participating in the project, recruiting this particular group of patients was challenging. Patients should be recruited at an appropriate time after the emergency incident occurred so they would be in a better health condition. Considering this vulnerable group of patients, we carefully avoided being too persistent in recruiting them.

Analysis

The analysis followed a stepwise-deductive-inductive (SDI) approach (Tjora, 2019), directed towards identifying issues and themes across the empirical material, rather than focusing on individuals (Weiss, 1994). According to the SDI approach and similar to the grounded theory (Glaser and Strauss, 1967), qualitative analysis aims to inductively explore issues emerging from detailed processing of empirical data. Detailed 'empirical-close coding' is followed by

categorisation, in which idea generation and a structured volume reduction are supposed to support conceptual generalisation. First, the transcripts were coded by using HyperRESEARCH analysis software, maintaining the detailed interview contents. In total, 241 empirically close codes regarding the users' experiences were generated in this process. These codes were grouped into nine categories, of which two (named 'the impact of patient-physician communication' and 'VC for assessment of medication and [immediate] admittance') have informed the analysis in this article. A closer, theoretically informed exploration of nuances in each category, *category zooming* in our case (Halkier, 2011), focused on four aspects of the 'video-mediated gaze'.

Findings

This article aims to explore how the triadic interaction fostered by VC influences the social meaning of medical consultation. Based on our categorisation process, we have identified four analytical themes relevant to our research question concerning the video-mediated gaze in therapeutic decisions, as follows: (1) immediacy of assessment, (2) increased transparency, (3) sense of access to the 'real' expert and (4) fostering the patient's voice.

Immediacy of assessment

Both the acute ward in the central hospital and the RPCs belong to the secondary healthcare level. However, the acute central ward is more specialised, with medical expertise continuously available to handle compulsory admissions and patients with seriously acute and long-term conditions. It is a prevailing principle in Western healthcare that patients must receive proper treatment at the right level, and health personnel are expected to make this assessment. Accordingly, the RPCs are supposed to provide proper treatment at the regional level and function as potential service points for more specialised treatment in the central hospital.

In our study of the organisation of emergency psychiatric care, nurses and physicians (psychiatrists) were not co-located. A nurse performed an independent and initial assessment of a patient prior to suggesting a VC consultation with the on-call psychiatrist. When patients contacted or were referred to an RPC, they would always be met and followed up by a nurse from the ambulant psychiatric team and if appropriate, also by a nurse from the regional hospital ward. Hence, the nurses in the RPCs were gatekeepers of the patient's potential special assessment by the medical expert on-call. In our study, we found that the RPCs largely operated autonomously, but nurses regularly phoned the on-call psychiatrist. The nurses used telephone counselling in straightforward situations when further treatment or admission decisions were obvious (Trondsen et al., 2014). The VC system mainly functioned as a supplement in more challenging cases, for instance, when there were uncertainty regarding the degree of illness and the level of treatment, or disagreement between the involved persons (Bolle et al., 2017). Accordingly, the nurses played a significant role in assessing when and why a VC consultation might be indicated. The psychiatrists also had the opportunity to suggest VC for assessment if they considered it necessary.

The on-call psychiatrists expressed a 'rationality view' on the option of offering special assessment via VC. 'You choose that method of working that seems most rational, best suited for the purpose' (Doctor 4). Particularly, psychiatrists were concerned about not using VC when it was unnecessary. 'If it's kind of child's play, I don't see the point of VC' (Doctor 2). However, in some cases, special assessment through VC was considered the most appropriate means to promote efficient decision-making:

Videoconference is chosen when the clinical problem is of [a] significant degree of seriousness. Then the patient is often the best source of information. You have to talk to people to elucidate how things are (Doctor 2).

Moreover, the nurses expressed the common view that the seriousness of the patient's condition was the key factor to determine whether or not they would suggest VC with the specialist:

If it is something as simple as the patient needing sleeping pills or something like that, we [the doctor and I] talk about it on the phone. Nevertheless, if the patient is seriously ill, so that I think, a specialist should look at the person and hear him/her talk, I insist that the doctor should see the patient himself by VC (Nurse 7).

The psychiatrist's direct consultation with the patient, although through VC, allowed for a more effective, complete and nuanced clinical gaze.

However, deciding for or against VC was not straightforward; consequently, the VC option was an issue for negotiation between nurse and psychiatrist. We discovered that the nurses' position vis-à-vis the psychiatrists' changed in line with the opportunity of setting up a VC connection without too much problems. As mentioned by Nurse 7, she was ready to *insist on* the doctor seeing the patient (via VC) himself. However, this is not a novel dynamic since nurses' often subtle influence on doctors' decisions has been observed in many of the classic studies on hospitals (cf. Stein, 1967). The fact that the nurses in our study were used to phoning the psychiatrist meant that they were regularly gathering information that seemed medically relevant. They *needed to decide* what was medically relevant, mediating a 'medical gaze' through nursing practice and at the same time, rationing the 'costly' resource of physician time. Hence, choosing a VC consultation had a pragmatic dimension.

Increased transparency

Another pragmatic dimension of choosing VC as the consultation medium was its role in increasing the transparency in therapeutic assessments and decisions. Both nurses and psychiatrists in our study emphasised initiating VC consultations with patients in challenging cases that required the on-call psychiatrist to obtain more information about the patients than the nurses could express over the phone, in other words, when assessing the patients and judging the right level of treatment were not clear-cut (Trondsen et al., 2014; Bolle et al. 2017). In such a situation, the nurse and/or the physician decided that direct communication amongst the on-call psychiatrist, the patient, the nurse or other involved parties would be helpful. One of the psychiatrists said:

Some of the cases become complex simply because the patient is not involved enough, the next-of-kin are not involved enough, and that ideas, assumptions and expectations appear which are not justified or clarified. Then it is absolutely necessary to talk to people (Doctor 1).

Health personnel viewed VC as a suitable medium to increase transparency in challenging cases, involving the psychiatrist, the nurse and the patient (with a family member present if desired). One of the psychiatrists mentioned that he usually encouraged input from everyone involved, when a VC consultation was ending. 'I invite input from all of us; from the position of the doctor, from the position of the department, and how it looks [...] for the patient' (Doctor 1). Both the psychiatrists and the nurses expressed mostly positive experiences of collaboration through VC to make proper assessments and decisions about further treatment.

It seems like [these are] very confident healthcare professionals who accompany them (the patients), who are well trained on what will happen. The patient is kind of mildly expectant about there being something afoot; they do have an expectation there, and within this is the feeling that if you play your cards right, you have a unique opportunity to try to achieve something (Doctor 1).

The clinical gaze, the nurses' initial assessment and the patient's accounts are all relevant for optimal medical assessment, which are supported by the possible direct VC link amongst the patient, the nurse and the psychiatrist. However, our analysis of the interviews with the nurses revealed their experience of needing actually to 'push' the initiation of VC consultation during telephone conversations with the psychiatrists.

I confer with the doctor on the phone to start with. Then, the doctor may participate in the decision about whether VC is necessary. Sometimes I guess I argue strongly for the doctor to see the patient when I feel that I cannot express myself precisely enough by using the phone only (Nurse 8).

The nurses' interest in stressing the need for VC in front of the psychiatrist was related to their challenge in presenting an image of the patient that they believed was detailed enough for the physician to make a decision. Notably, in situations where the patient's account seemed to depart from the nurse's observations, VC gave the psychiatrist direct access to the patient (a clinical gaze), reducing the reliance on the nurse's interpretation. This brings us into a more complex discussion of what exactly an assessment is. One of the nurses said:

I think it has been much easier with VC, because it's not everything I am able to pass on to the doctors. Therefore, it is much easier when the doctor notices it as well. [...] The view of the patient is brought forward a lot more clearly, when you can see both body language and posture (Nurse 8).

As documented in previous research, nurses often contribute to the early assessment of patients (Hughes, 1977, 1988) as part of a process of negotiation with doctors (Svensson, 1996; Allen, 1997). This process is sometimes mediated by technologies (Tjora, 2000). In our study, Nurse 8 wanted the doctor to 'notice it as well', that is, to observe what the nurse had observed by means of his own direct view through VC.

The nurse's initial encounter with the patient and how she interpreted the patient's story and appearance, were important determinants of whether and potentially when the psychiatrist should be involved. In our analysis, the doctor's engagement might be mediated through the telephone with the nurse only or by VC, through which both the nurse and the patient would be directly involved. Hence, it was the nurse's discretion whether or not she would escort the doctor to the patient and if she did, whether this would happen through her own interpretation of the patient via telephone or by bringing the patient to the doctor by VC.

Having the VC as an option in any particular case changed the 'communication toolbox' of the nurses in the RPCs. The opportunity to present the patient to the psychiatrist in a matter of minutes enhanced the experience of having more specialised support available. Andreassen (2011) showed that families with children with skin diseases felt safer when they had e-mail access to the dermatology department even if the e-mail was not used. The incorporation stage of the domestication framework (cf. Silverstone and Hirsch, 1992), where the object is embodied in daily routines, may therefore not require the actual use of the object, just its potential use.

When the *VC option* is incorporated into the daily routines of emergency psychiatry in the RPCs, optional triadic and more transparent conversation is made available. This situation broadens the local nurses' scope of handling complex cases.

The sense of access to the 'real expert'

The VC consultations amongst the psychiatrist, the patient and the nurse involved more than mere pragmatism. Direct access to the specialist through the VC consultation in an acute situation also had a symbolic dimension for the patients. Offering a VC consultation directly with the psychiatrist gave them the feeling of being taken seriously, i.e. symbolising an increased concern for patients. All the patients emphasised confidence in the physician's competence and role as the expert in psychiatric assessment, as exemplified in this quote:

I am here to get help, you know, and I trust them to send me to someone [who] knows what he's doing. Hence, there is no problem trusting that. The doctor was very professional, that is something you notice. [...] I respect the doctor's position, and then I regarded what he said as worth its weight in gold (Patient 3).

The doctor's words were viewed as 'worth [their] weight in gold' *because of 'the doctor's position'*. We understand 'the position' as relating both to the doctor's expertise, acquired through long education, training and practice, and the role as gatekeeper or facilitator of any further action required to solve the patient's problems. By implementing VC for use in emergency psychiatry in the RPCs, access to this 'position' was extended. Another patient reported:

You do get expert help immediately even though there is no doctor there. I think it is a good thing, when a doctor is not present, that you can talk with him/her on VC. [...] You relax a little bit more if you can consult an expert – getting ready for how treatment is going to happen further on (Patient 4).

Gaining immediate access to expert help encouraged Patient 4 to calm down a bit since further treatment was being determined at the initial stage. The doctor's capacity through the organisational position and power to make a decision on further treatment was of real significance in an emergency where urgent action might be required. The patients' direct access to this authority or 'power' was associated with their experience of 'being taken seriously'.

That VC was helpful and calming. I understood that they took me seriously when they took such a step [to use VC] (Patient 3).

I felt I was being heard in a way that they actually treated me sincerely. It was good getting help that early, that it was somebody there who actually made an assessment (Patient 5).

The view expressed by Patient 3 – that the nurses 'took such a step' to set up VC with the physician – showed how it was experienced as an extra effort for the good of the patient. Additionally, Patient 5 conveyed the feeling of being heard. The nurses also underlined the importance for patients to have direct contact with the doctor, emphasising that patients often expressed confidence in the doctor as the expert and adding that they were calmer when they were offered access to the psychiatrist.

I think that often [the patients] can be reassured when they get to talk to a professional who knows about medication and much about the mind's health related to it. Because often they ask, even if our local staff have conversations with them every day and sometimes several times a day: 'When will I see the doctor? At what time can I speak to the psychiatrist?' Therefore, I think it says a lot about confidence. We have quite a few elderly patients. They have grown up with the view that it's the doctor [who] sort of decides everything (Nurse 7).

It is not so much the issue about not being taken seriously by the local health personnel (nurses) but being *in direct contact with the doctor* as the real expert. Nurse 8 mentions that it has to do with authority, that the patients feel that they are getting heard as soon the doctor enters the stage. Thus, the use of VC consultation has a symbolic value in affording *access to the doctor* that goes beyond the purely pragmatic requirement of referring to the psychiatrist for specialist assessment.

Fostering the patient's voice

Giving the patient an opportunity (although rarely used) to participate in a VC consultation directly with a psychiatrist symbolises an increased degree of patient engagement. Both the patients and the health personnel commented on how the VC consultation could be a basis for involving patients in discussing and assessing their situations. The patients emphasised the importance of presenting themselves in their own words *directly to the doctor* and participating in the decisions about further treatment:

If the nurses call the psychiatrist, I cannot participate in the conversation. I don't know what they are talking about, and they [...] will be kind of making a decision without me being there to answer and defend myself (Patient 4).

You get to participate yourself and take part in the discussion about what is actually going to happen to yourself (Patient 5).

In accordance with the patients' experiences, several nurses emphasised how VC worked as a medium for bringing the patient's voice into the assessment. By using the phone, the patient might not 'even be in the same room' (Nurse 8), but with VC, the 'patient's own voice is carried through to the psychiatrist' (Nurse 4).

The patient was admitted and given medication on the basis of what she told us and how she experienced things. She was well capable of mediating that herself [...]. I was somewhat just sitting beside her – it was the patient in focus, so to speak. If we had used the phone, the doctor and I would have been in focus, while the patient wouldn't have been there (Nurse 1).

Being part of the VC consultation afforded patients the possibility of taking an active role in decision making and representing themselves, being given a voice and being physically present and 'in focus'. A nurse from the RPC is always present with the patient in the VC room but mainly serves as a listener and an advocate in the consultation to let the patient express herself. One nurse referred to a patient's feedback after the VC consultation:

[The patient] said that she felt that with VC, the others were not speaking when she talked to the psychiatrist. Often, when you are sitting physically in the same room, it can get more of a buzz, that as soon it gets quiet from one, another continues without waiting for the other to finish. By VC, [the patient] felt very strongly that it was only communication between her and the doctor. The rest of us became listeners (Nurse 4).

Patients in need of acute psychiatric help are all different, as is the case when participating in VC. Some patients actively communicated their experiences and opinions during the VC consultations, while others did not, often due to their illnesses and health conditions. Still, the nurses emphasised the value of including the patient in the assessment through the VC consultation.

I believe that for the patients, if they are drawn closer to making a decision, then they get at least a feeling that they are more involved than if I only speak directly with the doctor. Then the person is in a way excluded from the conversation. In that sense, they may get a feeling that they might be allowed to express their view[s]. Therefore, for the patients, it may be important that they are allowed to be participants in the decision[s] being made (Nurse 9).

The nurses and the psychiatrists presented examples of some VC consultations that had failed for several reasons, as follows: the patient was paranoid and worried about being monitored, the patient just cut off the consultation and left the room, or he/she was just silently sitting in the VC room. However, both the nurses and the psychiatrists stressed that such situations seldom happened and that VC consultations generally worked better than

anticipated. One nurse mentioned an emergency where she considered the patient too sick to communicate with the doctor in a VC consultation, but she decided to try it anyway:

He was very tired, and I think that dealing with something new, like VC, that he knew nothing about, would be a bit of a threshold for him. Nevertheless, when he saw [the doctor] on the screen, and the doctor greeted him and was very accommodating, it was as though he lowered his shoulders and relaxed. From that point, it went really well. He thought it was a great innovation that it could be done this way, because I think he felt safe about it being a doctor who assessed him (Nurse 10).

One of the psychiatrists concluded that patients who were keen on trying VC would have a strong motivation for taking new steps to sort out their problems.

I think when one particular patient wants to conduct a VC, there is a lot of goodwill to accomplish something. It is expected, perhaps from the patients themselves that something is going to happen [...]. Those who actually sit down there [in front of a VC screen] I guess are probably a bit 'primed' for something to happen (Doctor 1).

Hence, the fact that the patients who would like to try VC have a stronger desire to find solutions partly explains VC's success in this setting. The patients are given a voice by having them present in the assessment and decision-making through VC with the psychiatrist. Although this must be regarded as an opportunity, as not all patients are able to communicate in the event of a psychiatric emergency, it enables seeing and talking directly to the doctor. Offering patients this option has a value beyond the pragmatic use of VC consultations.

Discussion: the symbolic affordances of VC

As new technologies are incorporated into daily routines, they foster changes both of a pragmatic and of a more symbolic character. The 'imagination' (Ling, 2001) of VC in psychiatric emergencies centres on finding immediate solutions to challenging cases (Trondsen et al., 2014; Bolle et al., 2017). However, our *sociological* exploration of the accounts given - especially by patients and nurses - points towards *affordances* of VC that are *symbolic*. While many cases have been assessed by using the telephone (and still are), the patients' experiences of being 'taken seriously' and thus being given a voice represent a symbolic value in relation to conversion, the fourth stage of domestication. Through VC consultation, the triadic interaction contributes to another level of collaboration to solve problems and to reduce misunderstanding.

Based on the patients', the nurses' and the psychiatrists' accounts of experiencing such interaction, we have identified four aspects of the 'video-mediated gaze', both pragmatic and symbolic. The pragmatic aspects include (1) immediacy of assessment and (2) increased transparency in therapeutic decisions. Symbolic aspects include (3) sense of access to the 'real' expert and (4) fostering the patient's voice. In Table 1, we suggest a typology of these four aspects, encompassing a pragmatic versus a symbolic dimension, as well as an authoritative versus a cooperative mode of provider-patient interaction.

Table 1

| | | VALUE OF VC CONSULTATION | |
|--|---------------|-----------------------------|--|
| MODE OF PROVIDER – PATIENT INTERACTION | | PRAGMATIC | SYMBOLIC |
| | AUTHORITATIVE | (1) immediacy of assessment | (3) sense of access to the ‘real’ expert |
| | COOPERATIVE | (2) increased transparency | (4) fostering the patient’s voice |

The former established practice of (1) a patient seeing a local nurse, (2) a nurse calling a psychiatrist and (3) a nurse facilitating action and passing on the information to a patient produces a frontstage-backstage situation (Goffman, 1959) in which the professional communication between the nurse and the physician is largely hidden from the patient. By using VC, ‘communicative transparency’ (Tjora, 2011:205) is produced amongst the three participants, facilitating a more cooperative mode of interaction (Table 1, cell 2). As suggested by Hutchby (2001b), some material qualities in phone versus VC communication offer another mode of interaction, that is, one-to-one communication on the phone versus three-way communication in VC. The triadic participation through VC affords an increased redundancy of practices to ‘fill in the gaps and glitches’ (Atkinson, 1995; Bowker and Star, 1999) for a more nuanced and cooperative assessment. As VC is fully domesticated, that is, converts the service, it does *not* imply that it is always used; rather, the VC consultation is taken for granted as a relevant and easily available option.

The health personnel in the RPCs are at the core of exploiting technological opportunities. In relation to a four-part domestication theory (Silverstone et al., 1992), they may (1) appropriate the (technical) option of VC and demonstrate competence in connecting it, (2) objectify it as a useful medium for the consultation, (3) incorporate VC as a routine option and (4) convert the service, still decentralised but now with continuous (mediated) access to medical expertise. However, these processes also depend on the two other actors in the triadic VC consultation – psychiatrists and patients. For instance, the accounts of patients and psychiatrists reported here are relevant to the second stage. VC consultations are legitimised as useful, given that patients appreciate being taken seriously, and psychiatrists value the ability to actually see patients in acute crisis. By this, patient-centred communication is increased in an emergency setting.

In many cases, the nurses in the RPCs are those who suggest using VC. This raises the question of whether the domestication process has been further adopted amongst the local personnel in RPCs or just reflects established professional roles, by which nurses encounter patients before the physicians. In his study of work in the casualty setting, Hughes (1988:9) observes that nurses collect ‘the available facts and fit them together to amount to some understanding of the course of events’. Accordingly, the introduction of VC in our study

reduces the level of resources that should be invested in an immediate specialist assessment. Does this integrate the doctor as a potential service point, and if so, in which situations should the psychiatrist 'assist' the nurses? Our analysis indicates that having a VC connection available through a quick-and-easy setup changes the negotiation between RPC nurses and more centrally located physicians. The symbolic value of being seen by the actual doctor directly without appointment on basis of emergency may be given explicit consideration.

From a sociological perspective, the utilisation of VC provides another role, status and manner of self-understanding of the patient, through the mere act of seeing and talking to the doctor, as well as being seen by him or her. In contrast to the pragmatic values of VC, which are strategically pursued by the introduction of the system, the symbolic values *evolve as affordances* of VC as the system is incorporated into actual practice. While our patient sample has been limited, the study demonstrates however that technology such as VC have great potential, and not only pragmatically. With the symbolic affordances of a video-mediated gaze in emergency psychiatry, a more patient-centred service seems attainable.

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