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Look and Listen: How the Coldness of Health Care Providers is Modifiable

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Abstract

Purpose: To explore how we can make Health Care Providers (HCP) more conscious of their gaze and to encourage HCPs to make more eye contact with their patients, making them better suited to promote meaningful lives for them, thus strengthening the patient-provider relationship.

Methods: Mixed quantitative and qualitative descriptive experimental design with narrative data analysis. 40 participants (23 HCPs and 17 chronic pain patients) viewed standardized videos depicting a patient-provider interaction in which the HCP did not look at the patient. Self-assessments and reflections were obtained.

Results: Most HCPs recognized the clinical approach in the videos as cold, whereas 41% of patients recognized it as "normal". When looking into patient's eyes, 44% of HCPs were unable to identify the patients' emotions, nor their own feelings. Powerlessness and vulnerability were emotions often felt by the HCP. Patients and HCPs agree that better addressing meaningful activities in a patient's life, as well as looking at the patient more, would positively impact patient outcomes and pain management. At the one-month follow-up, 74% of HCPs had increased the amount of eye-contact made during their encounters and paid more attention to the relational aspect of their care.

Conclusion: We succeeded in making HCPs more aware of the gaze they hold onto their patients, thus encouraging them to change their actions. We attributed the lack of eye contact and lack of focus on meaningful activities to a sense of vulnerability felt by HCPs. We believe that non-verbal communications skills should be more overtly taught in medical school.

The problem addressed in this study is the challenging relationship between the Healthcare Provider (HCP) and the Chronic Pain Patient (CPP) [1,2]. Most patients desire care centered around them, their beliefs, their emotions, their values, and their expectations. However, this knowledge brings little to no change to HCPs' practice and clinical attitude [3-5]. Interactions cannot be limited to verbal communication; it is crucial for HCPs to consider non-verbal cues [6,7]. Non-Verbal Communication (NVC) is important for deciphering a patient's emotional cues, as it reveals hidden agendas and concerns [33]. NVC accounts for around 80% of communication between individuals [35] and may override verbal communication when it contradicts verbal messages[7], highlighting the "visual" attention that should be brought to patients.

In today's clinical environment, medical interviews are monopolized by computer screens [10,11]. X-rays, laboratory results and consultant notes are displayed on screens placed right in front of

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HCP's eyes. Many clinics now offer/require that patient progress notes be directly written on the computer, leaving little time to look at patients. However, short- and long-term decreases in physical and cognitive functioning are strongly correlated with a distant behavior from therapists [13]. On the contrary, time spent looking at the patient predicts patient satisfaction [14,15].

Norwegian authors, Kari Agledahl and Pal Gulbrandsen, had a major influence on this study. They published *Courteous but not curious: how doctors' politeness masks their existential neglect* [4]. They conclude that the main shortcoming of patient-doctor encounters is the moral offence patients experience when their existential concerns are ignored. Thus, physicians potentially "undermine" patient recovery by ignoring their experiences, facial expressions, and visual gaze [21]. Philosopher Emmanuel Levinas states that the face and the gaze of others refers us to our own vulnerability, giving us the feeling of being naked. This prevents true communication with the other, a fact confirmed by latest studies in experimental psychology [6,22,23].

To look into the other's eyes means to accept to be looked at [24]. The vulnerability this may create, particularly when the patient's Chronic Pain (CP) cannot be taken away, potentially explains why HCPs would rather look at their screens [7,12,25]. To avoid such vulnerability, HCPs also talk more than they listen, cutting off their patients after 11, 13 or 17 seconds of an encounter [14,26].

When it comes to the care of CPPs, there are emotional, relational, and existential matters at stake [16,17]. Unless these issues are addressed, both the patient and the HCP will remain frustrated and unsatisfied, perpetuating a rise in health care costs. The goal is not to rid CPPs of their pain [18], but rather to promote a meaningful life for them, i.e., promote a life that is worth living despite the pain [16].

We hypothesize that greater eye contact made by HCPs will lead to richer interactions, thus leading to more satisfying clinical encounters.

Objectives

1. For the Healthcare Providers (HCP): To explore how to make the HCP conscious of their visual gaze towards their patients; to explore the emotional aspect behind eye-contact in the patient-provider relationship; and to explore vulnerability as a possible explanation for the lack of eye-contact between the HCP and their patient.

2. For the patients: To validate the importance of achieving a meaningful life and to explore their attitude toward HCPs' visual gaze (or the lack thereof).

Methods

This is an exploratory study. We used a mixed quantitative and qualitative descriptive experimental design with narrative data analysis. Standardized videos were used in an experimental session, repeated for both HCPs and CPPs, with the goal of confirming that patients desire a meaningful life despite their pain [9,16,29,30].

Participants and Recruitment

We recruited 23 HCPs (11 physicians (family practice and specialists), and 12 physiotherapists) and 17 patients suffering from CP. The mean years of clinical experience for HCPs was 13, with a median of 6 years (1-39 years). As for the CPPs, the average number of years they've had CP was 11 (3 months-30 years). The male to female ratio was 19:21. Any physician or physiotherapist was eligible, as long as they see CPPs in their usual clinical practice. It has been mainly snowball recruitment.

Instruments

Likert scales and narrative reports (verbatim) were used in this study.

Videos: The standardized research videos were designed to represent various encounters between a CPP and a physician or physiotherapist. The actors recruited often played patient roles in student OSCEs. The HCPs were not looking at the patients and purposely ignored their existential complaints.

Video 1 (90 seconds): A 43-year-old woman consulting her HCP who has been treating her CP for a long time. She conveys her feeling towards the loss of a previous meaningful life and her existential suffering.

Video 2 (263 seconds): A 25-year-old woman consulting for Complex Regional Pain Syndrome (CRPS) which is preventing her from practicing gymnastics, a central and meaningful activity in her life. The HCP remains courteous but does not delve further into the patient's concerns.

Video 3 (completed in 3 parts): A 54-year-old man consulting for CP. The HCP insists on the importance of exercising, although the patient says he has already tried.

Clip 3a (40 seconds): Audio only.

Clip 3b (40 seconds): Image only.

Clip 3c (40 seconds): Combined image and audio.

Video 4a and 4b: Video zoomed in on the eyes of two patients suffering from CP. Participants were asked to look into the eyes shown on the screen in silence for 11 seconds. They were informed that the gaze may be from one of their regular CPPs.

Procedure

Six pretest sessions were conducted with two pain specialists, a family physician, a nurse, a physical therapist, and a nursing professor. A large spectrum of answers was collected. We felt that 40 participants would provide enough content variability to meet the study's objectives.

A. For the HCPs: After an initial telephone contact made by the research assistant, the consent form was sent by email to be signed. Participants were informed that they would be filmed during the ES.

The ES was held on the Teams platform. It included some questions regarding HCPs' knowledge on CP management. HCPs then watched the videos and answered questions after each viewing. The ES lasted 30-35 minutes.

A short follow-up phone call took place one month later. Its focus was to gather information on the HCPs recollection of the ES and to determine whether they made any conscious changes in their attitude during patient encounters over the last month.

B. For patients: Identical to that of HCPs, but without a questionnaire on pain knowledge and without a follow-up call.

Video recordings served as an audio collection for the verbatim transcription. The numeric responses were compiled into an Excel document.

Analysis

We used QDA Miner (Provalis, Montreal) for the narrative analyses. The verbatims were reviewed by two different people. Codes were initially given to describe the various components of the participants' answers. Codes with similar meanings were then grouped and categorized. Ultimately, themes emerged, and codes were related to those themes. Results are presented as quotes and as percentages. Percentages represent the ratio of participants' expressing a code's theme. Every participant named many different codes inside a theme, so code percentages could add up to more than 100%.

Ethics statement: We followed the standards of the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans. We obtained the ethical approbation of our research ethical committee (CR-CHUS). No participants dropped out of the study.

Results

Three themes emerged in the participants' answers: impressions about the eye-contact displayed in the video, expectations towards HCPs, and HCPs' changes in attitude after the ES. Quotes were translated from French (French hospital in Canada). The coding tag is made of either F (female) or H (*homme* or male) and a coding number.

Emotion and Gaze Recognition

After viewing the videos, 91% of HCPs described the clinical approach of the HCP in the video as cold, whereas 41% of patients recognized it as "normal" or usual. When asked to assess the proportion of the interview in which the HCP made eye-contact with the patient, HCPs and CPPs came to similar conclusions: video 1: 37% [range 10-80%] vs 46% [range 30-80%], video 2: 28% vs 29%, video 3: 1% vs 3% respectively. These percentages decreased during the ES. This is explained by the fact that participants were not initially focusing on this aspect of the encounter but noticed it by the 3rd video.

Results after viewing videos #4a and #4b revealed different themes for CPPs and for HCPs. Patients saw sadness (35%) and pain (35%) in the eyes displayed. They described feeling a sense of understanding (53%) and a sense of wanting to help (41%). Among HCPs, 39% noticed a negative affect generally related to anger, while 44% were incapable of identifying the patients' emotions or even their own feelings. Meanwhile, 77% of CPPs were able to identify an emotion or a feeling.

A sense of vulnerability was felt by the HCPs, as one stated how "you can feel the distress in the patient's eyes a little bit, and you feel like shifting your gaze rather than maintaining the gaze of a patient who is in pain" [F51031]. The feeling of being looked at by the patient also added a certain pressure on the HCP. One "wondered if when we look into the patients' eyes, if our gaze is analysed in return" [F42040a].

The feeling of powerlessness was also an uncomfortable emotion felt by the HCP: "What did she see in me? I think she saw a doctor who was listening, who was there to help, but […] who often feels deprived or ill-equipped to help patients who are suffering with chronic pain" [H36002].

Expectations Towards the HCP

The patients' expectations were the following: to be listened to (53%), to be offered a treatment plan (53%), to be reassured (47%), to be educated (47%), to receive tips on how to resume meaningful activities (41%), to receive a positive attitude from the HCP (41%), and to have a human/individual approach (35%). One patient expressed how HCPs should "open the door differently so [that the patient in the video] can talk about her pain" [F80012].

Regarding HCPs' roles toward CPPs, answers did not differ much between the two: understand the patient (61%), personalize the interview (61%), educate the patient (61%), be positive (52%) and listen to the patient (48%).

An unexpected result was that 35% of patients wished for a physical examination to be performed by the HCP: "[A good HCP] will make me do movements… not just sit back at his desk" [H69005].

When CPPs were asked why the HCPs did not seek out the patient's perspective, powerlessness was the most frequent answer (24%) given: "[The HCP] feels helpless and doesn't have many options himself" [F26032] and "they don't know what to do with chronic pain" [F73001].

According to all participants, the importance placed on the relational component of chronic pain management should be 10/10. They all agreed that looking at the patient more would be beneficial. One patient stated that "they would feel considered like a person as a whole, in whom the physician takes

interest in [their preferred activities or the activities they can no longer participate in]" [F78009]. However, 30% of HCPs gave a justification to reduce the importance of eye-contact. Such responses were coded as "yes, but": "You can really listen to a patient well without maintaining eye-contact "[H36002] and "yes, but it's far from being essential" [H54035].

According to 88% of patients and 96% of HCPs, better addressing the meaningful activities in a patient's life could have a positive impact on patient outcomes and pain management. One CPP said that "it gives [the patient] goals, makes [the visit] more concrete, more goal-oriented" [F26032].

HCP Behavior Modification at the One-Month Follow-up

17 out of 23 HCPs said that they noted an increased importance of eye-contact during their encounters and claim to look at their patients more since the ES. Of the other 6 HCPs, 3 answered that they were already paying great attention to it. Of the 7 HCPs who answered "yes, but" during the ES, 4 changed their answer, now attributing a greater importance to eye contact.

The most frequent changes made by the HCPs were an enhanced relational component (56%), an increased amount of eye-contact (56%) and a decreased amount of time spent looking at the screen (25%). One HCP said: "I felt like I was looking at my patients a different way, […] I tried to decipher the meaning of the look my patients were giving me" [H83022].

Discussion

Our goal was to explore how we could improve the outcome of CPPs by modifying HCPs' attitude. This study is an interim one. We did not follow real patients after changes in HCPs' gaze. However, using a short 30-minute ES, we succeeded in changing HCPs' attitude, as they now make a conscious effort in maintaining greater eye-contact. Even if pain reduction is not achieved, CPPs wish to regain a meaningful life [9,16,29,30]. We believe that looking at the patient in a genuine manner is a promising approach. We postulate and confirm that a sense of vulnerability felt by HCPs could be an explanation for the lack of eye-contact made during encounters.

Vulnerability of Eye-Contact

Based on philosopher Levinas' concepts, Gulbrandsen proposed that vulnerability coming from the "threat of disease" and the "threat of being worthless" is reflected in the gaze of the eyes looking back at us. In a patient-provider relationship, this vulnerability may affect communication [21]. This could be one explanation for the "coldness" recognized by both HCPs and patients, as shown by the fact that 44% of HCPs were unable to identify the patient's emotions, nor their own feelings. By being more mindfully present, HCPs can demonstrate more empathy, thus decreasing burnout [31,36].

In healthcare, empathy is described as "a cognitive an affective attribute involving an understanding of the patient's experience and perspective" [31,32]. Therefore, it is important for the HCP to recognize their own thoughts and emotions. Hence, HCPs' inability to recognize their own emotions, combined with a lack of eye-contact, could be seen as a lack of empathy or coldness. A lack of eye contact made by HCPs may also reflect a fear of showing their vulnerability or the powerlessness they feel in reducing their patient's pain. One HCP said: "I wondered if, when we look into patients' eyes, if our gaze would be analysed in return" [F42040a]. If HCPs are unaware of this effect, it could become an important barrier in the patient-provider relationship [6,21-23]. "[Feeling] deprived or ill-equipped to help [chronic pain] patients" [H36002] (also mentioned by F26032 and F73001) may add to the HCPs' feeling of vulnerability by perpetuating the hopelessness that makes them feel vulnerable. By shifting the focus on regaining a meaningful life, HCPs could mitigate these feelings of vulnerability and powerlessness.

Expectations of Patients towards Their Healthcare Provider

An unanticipated result was the patient's expectation of a physical examination by the HCP, despite having lived with CP for 10 years. This could mean "touching me is a relational demand", as closer interpersonal distance is one of the nonverbal behaviours linked to patient satisfaction [9].

Placing importance on supporting CPPs in leading meaningful lives [9,16,29,30] guides us to advocate for better relational care. Most of our participants responded that there would be a positive impact if HCPs addressed these matters: "I would feel considered like a person as a whole" [F78009].

Looking is a central component of listening [5]: "It is very important that [the HCP] listens to what I have to say, that they look at me" [F80011]. Through the principles of affectivity and attention [6], maintaining eye contact is an element of NVC that demonstrates listening [7,11]. Eye contact generally evokes a positive affective reaction [6,19] and should thus be a central component of medical teaching [35].

Changing the Attitude of HCPs

To create a change in medical attitude, the exclusive use of factual/cognitive teaching is not enough [35]. Doing so requires an upheaval, a "panic", a disturbance (stepping out of line), an emotional turnaround [27]. We attempted to create such a discomfort in the HCP with our ES [28]. We succeeded more than expected. Most HCPs recognised having made concrete changes to their practice, such as paying more attention to relational components of their encounters, increasing eye-contact, and decreasing time spent looking at the screen. We showed that pairing cognitive and affective stimuli may be an effective approach to change HCP behavior. Even the "yes but" HCPs changed their attitude one month later. A few HCPs wondered "about [their] ability to let the emotion and information [they] want to convey show through [their] gaze" [F42040b] (also said by H83022). Therefore, there is a mutual influence regarding one's gaze onto another and another's gaze onto oneself. This bidirectionality ties back to Gulbrandsen and Levinas [21].

Conclusion

Although health care professionals were, for the most part, aware of the importance of making eye-contact, they seemed unable to interpret the look in the patient's eyes. Many were also unable to identify their own feelings. We attribute such results to the vulnerability felt by the HCP when in a situation of powerlessness. Most HCPs noted an increase in the role eye-contact makes in their clinical encounters.

HCPs paid more attention to their gaze, thus proving that their actions can be changed. Through patients' expectation of a physical examination as a relational demand, our study revealed the extent to which patients require a relational encounter with their HCP for a satisfactory visit. Patients also confirmed the importance of eye-contact and the importance of addressing meaningful activities. Finally, most HCPs said they

require additional training in chronic pain management.

Our actions reflect what we have been taught. Even though non-verbal communication is one of the most important determinants of patient satisfaction and health outcomes, it is barely taught [35]. Different approaches such as dramaturgical or cartoon techniques have been studied [34]. However, genuinely looking at patients could be an easier first NVC lesson. Looking at our patients is an essential first step to improving patient-provider relations and should therefore be included in medical faculty curriculums.

Author Statements

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Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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