

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**Is a Video Worth a Thousand Words?**

Laura Kolbe, MD, MPhil, Ryan H. Nelson, PhD, Joelle Robertson-Preidler, PhD, Olivia Schuman, PhD, and Inmaculada de Melo-Martín, PhD, MS

**Abstract**

Bodily imagery elicits strong affective responses and is highly salient, potentially altering viewers' decision making. When clinicians engage surrogates in video calls showing the patient's body, several competing ethical issues must be considered. On the one hand, surrogates may require visual information to make informed decisions, and video technology closes crucial information gaps. On the other, video technology puts an increased amount of control in the hands of clinicians over how the patient's condition is perceived. This article explores some situations that can result in manipulation due to the affective impact of bodily images and the potential for selectivity and framing. Focusing on goals of care, the paper outlines the foremost ethical considerations for clinicians and provides recommendations for clinicians on how to reduce possible manipulation when making these video calls.

**Case**

Ms K is an 80-year-old woman initially hospitalized with sepsis. Multiple hospital setbacks include kidney injury, aspiration, and heart failure. She has been hospitalized for a month, with evidence of deconditioning, malnourishment, pressure injuries, anasarca, and delirium.

While previously cognitively unimpaired, she now fluctuates between agitation and somnolence. According to her family, she never discussed her critical illness or end-of-life care preferences. They consider her a “fighter” and therefore feel uncomfortable pursuing a palliative approach. Because of COVID-related visitor restrictions, they have not seen her in person. Her clinicians think she is unlikely to survive hospitalization. If she declines further, next steps could include a percutaneous endoscopic gastrostomy tube, hemodialysis, and intensive care unit (ICU) transfer. Thinking it best for the patient, her clinicians believe that Ms K's family should opt to stop aggressive treatments and focus on comfort, although family meetings have not produced this change.

Ms K's attending physician, Dr B, has told the team that one way to “change her family's mind” would be to increase video calls to the family during times when Ms K appears

uncomfortable or distressed and during activities such as wound care, so that the family “gets it” that Ms K is “in horrible shape.” Dr B advises against video calling the family when Ms K is asleep or relaxed, since “it paints too rosy a picture,” and “they’ll just cling to unreasonable hope.”

A resident feels uncomfortable but also thinks that knowledge is power and that providing this information can’t be wrong if it results in less suffering for the patient.

### Commentary

Clinician-initiated video calls to show surrogates aspects of the patient’s body raise ethical concerns about manipulation. Visual information may improve informed decision making by conveying additional nuance lacking in verbal communication. However, because of the **salience of bodily imagery** and its affective impact on viewers, as well as the special potential for clinician selectivity and framing, video calls can be manipulative. Here we discuss how manipulation can occur and offer some recommendations so that clinicians can reduce that possibility.

### Manipulation in Health Care Decisions

Informed consent, which is considered the **primary means of respecting autonomy** in clinical medicine, requires freedom of choice. Yet choosing freely cannot mean choosing absent any outside influence, since good decision making often demands others’ input. What forms of influence are acceptable? While coercion undermines autonomous decision making and rational persuasion is compatible with it, a range exists between these extremes involving varying degrees of manipulation. Generally speaking, A manipulates B when A intentionally subverts B’s rational capacity by employing trickery, deception, pressure, or a similar tactic to get B to do what A wants.<sup>1</sup>

Viewed through the lens of autonomy, manipulation is *prima facie* wrong—that is, manipulation has the morally bad feature of failing to respect autonomy and therefore should generally be avoided. It follows that clinicians ought to refrain from manipulating patients or surrogates in the absence of (sufficiently strong) countervailing ethical considerations. Whether a given act of manipulation is justified, all things considered, will depend on the particulars of the case. But the fact that an act or practice is *potentially* manipulative is enough to warrant scrutiny.

Dr B’s actions are arguably manipulative in 2 ways. First, Dr B proposes to share images via video call that support his favored outcome and to withhold images that might lead Ms K’s family to make decisions contrary to it—which involves a kind of trickery. By focusing on decisional outcome rather than the decision-making process, Dr B appears less concerned about providing information than about guiding Ms K’s family **towards a particular decision** that Dr B favors. Second, Dr B appears to be aware that the video calls, especially when timed and framed in a certain manner, are likely to have a special affective impact on Ms K’s family—which suggests a kind of pressure. Provoking family members’ strong affective responses, such as disgust and fear, risks undermining their rational deliberation rather than promoting it.

In the following sections, we consider video visits’ affective impact and selectivity in greater detail and argue that showing a patient’s body over video calls can manipulate surrogate decision makers. Potential for manipulation escalates in busy, stressful conditions that can limit clinicians’ abilities to evaluate specific features of a situation. While manipulation can certainly be present in traditional in-person visitation, already-

accepted standards of care help mitigate that outcome. However, the rapid rise in video communication and visitation may leave clinicians feeling particularly unprepared to manage these encounters ethically.

### **Relevance of Visual Information**

Visual information, particularly from observation of the body and about effects on the body, can be crucial for surrogates' ability to make decisions, especially when other sources of information are absent or unavailable. Whenever possible, surrogates' decisions should reflect a patient's values and preferences. To achieve this goal, clinicians should provide information about the patient's condition and prognosis so that surrogates can make a substituted judgment.

However, surrogates may lack knowledge of a patient's values and preferences or of how these accord with treatment options.<sup>2</sup> Additionally, factors other than medical information—eg, surrogates' beliefs about the patient's strength of character or their own observations of the patient's physical appearance—influence surrogates' understandings of prognosis.<sup>3,4,5</sup> Unconscious bias can also lead surrogates to underestimate pain, overestimate the patient's acceptance of risk,<sup>6,7</sup> choose options that require less knowledge,<sup>2</sup> or accept default options to reduce feelings of responsibility.<sup>8</sup> Consequently, patient-surrogate agreement on medical decisions is generally poor,<sup>9,10,11</sup> suggesting that new or additional modes of information might be valuable in improving concordance.

The case of Ms K illustrates the different views health care teams and families may have about a patient's interests. The family members' perception of the patient as a fighter and their inability to observe her deteriorating condition may hinder their appreciation of her prognosis. To circumvent these issues and ensure that decisions are truly informed, surrogates may require additional visual information. Absent in-person visitation, or when bedside visits are challenging to arrange, video calls can bridge this gap. In fact, audiovisual resources have been shown to improve informed decisions about cardiopulmonary resuscitation<sup>12</sup> and ICU procedures.<sup>13</sup>

### **Affective Responses to Bodily Imagery**

Although visual information can be helpful in decision making, how this visual information is provided has ethical relevance because of the salience and affective impact of such information. Bodily imagery, in particular, has been employed to discourage various health-related choices, including by placing warnings in the form of images of rotting teeth and blackened lungs on cigarette packages to decrease smoking<sup>14</sup> and requiring the viewing of fetal ultrasound images with the intent of reducing abortions.<sup>15</sup> Such strategies assume not only that there is a preferable choice but also that images are more compelling than other forms of persuasion, such as written or verbal communication.

This last assumption is supported by various types of evidence. Theories of visual attention recognize the salience of human images, ie, the degree to which the viewed object stands out from surroundings and attracts attention.<sup>16</sup> Human body postures, particularly when in motion rather than still, and when combined with emotional facial expressions, are especially salient to human observers.<sup>17</sup> Indeed, humans struggle with tasks that require looking away from images of other humans to focus on other kinds of information.<sup>18,19</sup> Neuroscience research reveals that there are biological underpinnings to our affective and empathic responses when viewing human pain or suffering.<sup>20</sup> Mirror

neurons become active both when individuals experience or perform a certain action and when they observe another person performing or responding to a similar act—suggesting that, from a functional standpoint, the brain processes experiences involving the self and the visually observed experiences of others similarly.<sup>20</sup> Viewing another’s body in pain activates brain areas that overlap considerably with those involved in perceiving one’s own pain,<sup>21</sup> as does viewing another person’s facial expressions.<sup>22</sup>

### **Framing Images of a Patient’s Body**

The visual information in a video call has particular ethical relevance because of the degree of control that clinicians wield. Health care professionals serve as crucial intermediaries between patients and their surrogate decision makers, particularly when bedside visitation is limited and patients cannot communicate. Yet, unlike bedside visits, video calls enable clinicians to have greater control over viewing interpretations by determining when a video is used, what part of the patient’s body is visible or hidden, the incorporation or exclusion of surroundings, and the narrative that accompanies the visual transmission. As such, video calls have unique features that make it easy for them to be used in manipulative ways. A typical bedside visit, lasting several hours and involving interactions with several staff members, is a very different experience from a quick 10-minute video call that contains little contextual data and is restricted in its capacity for engagement. In addition, viewers exercise limited control over the interactive experience. Although visual imagery can activate emotion-driven decision making, visual imagery is not, as we have said, necessarily incompatible with good decision making.<sup>12,13</sup> Yet, in many cases, the control that the clinician exercises over how or when the body is shown is manipulative because a patient’s body is used as a means to the clinician’s preferred decisional outcome. In Ms K’s case, the clinical team believed her best interests were disregarded by her surrogates. However, the team’s proposed deployment of video calls was problematically selective and outcome driven. It failed to be transparent about the team’s motivation in initiating video calls and about the particular affective salience that viewing Ms K’s body might have on her family.

To avoid manipulation, we recommend that clinicians consider the following guidelines (see Table) when contemplating video calls to show the patient’s body in the context of surrogate decision making. Our practical recommendations are process focused, not outcome focused. As such, the team may never achieve the outcome that it believes is “best” for the patient, but these recommendations will help ensure that clinicians focus on upholding and promoting surrogates’ informed decision making, while avoiding some of the unique risks of video-call use.

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**Table.** How to Avoid Manipulation in Video Calls for Surrogate Decision Making

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*Normalization.* Clinicians and hospitals should standardize the use of video calls so that they provide many of the same benefits as in-person visitation. That is, video calls should be used on a regular basis in ethically uncomplicated decision making for patients who are not critically ill, as well as to support the psychosocial needs of patients and families in high-stakes, goals-of-care decision making.

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*Process.* Clinicians should primarily use video calls to inform rather than influence a decision, with a focus on the process of informed decision making rather than outcome.

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*Patient assent.* Clinicians should obtain patient assent when possible and, when known, patients' wishes about displaying their bodies via video call or displaying particular wounds or bodily areas should be respected.

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*Transparency.* Clinicians should be transparent about the purpose of showing certain features of the body (eg, "We are very concerned about your loved one's wound and want to show you, so you understand its severity.") Clinicians should also be transparent about the salience and affective impact of bodily imagery (eg, "Seeing a loved one in a state of illness or suffering is an intense experience and weighs heavily on people's minds. We want to make sure it's one part of a well-rounded decision-making process for you.")

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*Substituted judgment.* Clinicians should explain how viewing the patient's body promotes substituted judgment in line with the patient's preferences.

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*Selectivity and framing.* Clinicians should reflect on the selective use and the framing of video visits, including their choice of narrative detail and the compositional arrangement of the images of the body.

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**Laura Kolbe, MD, MPhil** is an assistant professor of medicine and assistant clinical ethicist at New York-Presbyterian/Weill Cornell Medical Center in New York City. She is also a former fellow in the Division of Medical Ethics at Weill Cornell Medicine. A hospitalist attending physician and clinical ethics consultant, she works on topics in medical ethics within the hospital setting, including health equity, clinician moral distress, and access to care.

**Ryan H. Nelson, PhD** is an assistant professor in the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston, Texas, and is a certified health care ethics consultant. His research interests include disability, psychiatry, and end-of-life decision making.

**Joelle Robertson-Preidler, PhD** is a clinical ethics fellow in the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston, Texas, where she teaches, consults, and does research on perspectives on appropriate end-of-life care and factors that influence surrogate and physician decision making.

**Olivia Schuman, PhD** is a postdoctoral clinical ethics fellow and researcher in the Center for Medical Ethics and Health Policy at Baylor College of Medicine in Houston, Texas. Her research examines ethical considerations arising from symbolic and aesthetic choices in clinic settings.

**Inmaculada de Melo-Martín, PhD, MS** is professor of medical ethics at Weill Cornell Medicine of Cornell University in New York City. Her areas of research are bioethics and philosophy of science, with a focus on evaluating ethical and epistemic questions about biomedical science and technology.

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