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Letter to the Editor: Patient and Staff Experiences with Inpatient Video Monitoring

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Patient and Staff Experiences with Inpatient Video Monitoring

We read your article ‘Remote video monitoring is another example of “dying on the machine” for critically ill patients’ with interest.¹

In this age of digital social networks, many of our daily interactions are no longer face-to-face, and social interactions are changing in ways that we don’t yet understand. Medicine has always valued compassion and a “healing touch.” As these new digital technologies change patient interactions, it is still unclear how they affect patient care.

Uchino, Uchino et. al., and Cohen review pathophysiological explanations that mediate the relationship between social support and disease outcome or death.²⁻⁴ Controlled studies on morbidity and mortality related to video monitoring have not been done. In spite of this, remote video monitoring is regularly employed in the inpatient setting at our hospital.

Our inpatient medicine team recently cared for a patient who was delirious due to alcohol withdrawal. He fell out of his hospital bed despite being monitored remotely with video surveillance. Our patient did not sustain any significant injury, but we used this event as an opportunity to explore patient and staff experiences with video monitoring.

Our patient shared his thoughts on being video monitored while delirious and during his return to baseline; his impressions varied depending on his phase of recovery. While very delirious, the patient stated that being monitored made his anxiety significantly worse. He felt compelled to lay motionless in bed saying, “if I moved a muscle I was afraid someone was going to yell at me right away.” At times he believed the video monitoring device was a staff member standing over him, watching him. As his mental status improved, the patient was angered by the presence of the camera. He felt his dignity and privacy were not being respected.

Nursing staff on the inpatient unit had mixed views on the utility of video monitoring. Some appreciated the utility for confused, high fall-risk patients who respond well to verbal reminders to ask for assistance when getting out of bed. Others felt that video monitoring can complicate care of patients who frequently try to get out of bed and don’t respond to verbal cues, requiring physical assistance from staff to stay safe. Many staff members reported increased patient anxiety during video monitoring.

It is clear from your article, the existing body of literature on the importance of social relationships in health outcomes, and our anecdotal experiences that the use of remote video monitoring may not be the boon it was promised to be. We suggest that the medical community needs to examine the potential negative impacts on patient outcomes and balance those against the potential economic and staffing benefits.

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