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Proper distance in the age of social distancing: Hepatitis C treatment, telehealth and questions of care and responsibility

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Abstract

During the COVID-19 pandemic, telehealth has played a prominent role in the treatment of hepatitis C. As part of a qualitative study on the accessibility and effectiveness of telehealth for hepatitis C treatment during this period in Australia, this article considers how health-care practitioners and patients experience and manage their proximity to each other in telehealth encounters of care. Comparisons between telehealth and in-person health-care tend to focus on measures of patient satisfaction rather than qualitative changes in treatment relationships. Media scholar Silverstone (*Digital media revisited: Theoretical and conceptual innovations in digital domains*, MIT Press, 2003) uses the term 'proper distance' to theorise how ethical relationships are mediated by technology. Drawing on this concept, we explore how patients and health-care practitioners understand telehealth as affecting distance and proximity. We find that both groups express some ambivalence about the impact of telehealth on relationships, on the one hand expecting and privileging simple, transactional relationships, and on the other hand, expressing concerns about

the loss of more intimate relationships in health care and about 'missing something' while providing health care. Given that proximity is important to the development of ethical relationships in health care, we conclude with some considerations for establishing and sustaining attentive and responsive relationships in telehealth.

KEYWORDS
COVID-19, hepatitis C, proper distance, relational ethics, responsibilities, telehealth, treatment relationships

INTRODUCTION

Telehealth refers to the delivery of health care remotely through telecommunications technology. It is increasingly used across a wide range of health-care settings. During COVID-19, telehealth has played a prominent role in the treatment of hepatitis C in Australia. Using a relational ethics theoretical approach, this article explores whether and in what ways the use of telehealth during the COVID-19 pandemic has changed patients' and health-care practitioners' experiences of treatment. Using media scholar Roger Silverstone's concept of proper distance, this article explores how telehealth affects relationships in patient-practitioner interactions in hepatitis C treatment and care. Proper distance refers to the degree of distance required to generate responsibility in an ethical relationship. As we will argue, an analysis of proper distance in telehealth for hepatitis C treatment is important for understanding what is required in the treatment relationship to produce responsible and attentive care.

Drawing on interviews undertaken as part of a qualitative study on experiences of telehealth for hepatitis C treatment during this period, we explore how patients and health-care practitioners describe relational distance and proximity in their experiences of telehealth, based on Silverstone's (2003) concept of proper distance. The analysis will be divided into three parts. While some patient participants pointed to the role of distance in generating comfort with some forms of disclosure, others expressed discomfort with speaking to those they do not know. As we will argue in the first part of the analysis, while telehealth allows hepatitis C treatment to bridge physical distance and COVID-19 restrictions, it also alters how 'proper distance' is established in health care encounters. Here, health-care practitioners and patients expressed uncertainty about relationships due to the absence of physical proximity, concerns about not being known or understood and the lack of visual information in phone telehealth. In the second part of the analysis, we analyse the elements that do help establish attentive and responsible relationships in telehealth. In the third part of the analysis, we consider how these negotiations of proper distance in telehealth shape stigma and vulnerability for patients in new ways. In concluding, we outline some considerations for better understanding treatment relationships, health-care intimacies and responsibility in the context of changing health-care modalities.

BACKGROUND

Treatment for hepatitis C has improved significantly in recent years with the introduction of direct-acting antiretroviral (DAA) medications that have far fewer side effects and much higher success rates than those of past treatments. Australia has committed to the World Health Organization's goal of elimination by 2030. However, as identified in Australia's Fifth National Hepatitis C Strategy 2018–2022 (Department of Health, 2018), widespread reforms in health-care delivery are needed to improve access to these medications and treatment uptake if Australia's elimination goal is to be met. Research on hepatitis C treatment access identifies a series of issues shaping and often impeding uptake for people who have hepatitis C. These include housing availability, geographic isolation, criminalisation of people who consume drugs, gaps in continuity of care, availability of supportive and non-judgemental health care and concern about side effects (Harris & Rhodes, 2013; Madden et al., 2018). Social stigma is also known to be a strong barrier to treatment for people living with hepatitis C (Harris & Rhodes, 2013), and telehealth has been identified as potentially able to mitigate the role of stigma as a barrier to treatment (Thompson et al., 2020).

Telehealth services are commonly presented in the literature as one way to improve access to hepatitis C treatment (Keogh et al., 2016; Schulz et al., 2020). In Australia, telehealth has been found to be successful in improving patient access to hepatitis C treatment, particularly in prison and regional or rural settings (Bradford et al., 2016; Mina et al., 2016). Telehealth has also been understood to address barriers to treatment uptake by reducing the financial, travel and other material costs associated with accessing treatment (Bradford et al., 2016; Schulz et al., 2017), providing access to specialist care without requiring attendance at tertiary hospitals (Wade et al., 2016) and by providing access to treatment in settings (e.g. prisons) without specialist clinics (Mina et al., 2016; Neuhaus et al., 2018; Papaluca et al., 2019; Taylor et al., 2018).

While studies have long shown the importance of a positive patient-practitioner relationship in treatment outcomes and attitudes to health care among people living with hepatitis C (Körner, 2010; Zickmund et al., 2004), research on patient experiences of telehealth is limited, and is mainly quantitative in methods (Bensted et al., 2021; Lepage et al., 2020; Rodrigues et al., 2021; Schulz et al., 2017, 2020). Few studies have explored in detail *how* telehealth has shaped health care for people with hepatitis C. This article explores, for the first time, the impact of telehealth on the relational ethics of health care for hepatitis C. As we will argue, the concept of proper distance shows how communications media/technologies affect relationships and, therefore, notions and practices of responsibility. In particular, this article explores telehealth's effects on distance and proximity to understand how telehealth might affect responsible health care.

PATIENT-PRACTITIONER RELATIONSHIPS IN TELEHEALTH

Comparisons between telehealth and in-person health care are common in research on telehealth for hepatitis C, but the focus often tends to be on simple measures of patient satisfaction and treatment uptake (Henry et al., 2018; Isautier et al., 2020; Orlando et al., 2019; Rose et al., 2021). This limited scope means that we still know little about *how* telehealth changes treatment relationships, particularly from a relational ethics perspective. Some research on blood-borne viruses and sexually transmissible infections (STIs) suggests that telehealth can facilitate positive relationships between health-care practitioners and patients by, for example, enabling discreet and convenient treatment for STIs (Aicken et al., 2018) or engendering feelings of safety and support

through a virtual HIV nursing intervention (Rouleau et al., 2016). Other studies, however, have found that the effects of telehealth on experiences of health care were less uniformly positive. In a study by Marent et al. (2021) on digitised follow-up in HIV care, both doctors and patients found telehealth interactions (via app, phone or video) more cursory than in-person interactions. Marent's participants said telehealth platforms did not convey non-verbal cues well and were generally too focussed on biomedical measurements. The authors also argue that the mobile platform they used narrowed the relationship to a '*highly specific role relationship*' (p. 1129, italics in original) in which specific consultation activities were prioritised over more in-depth considerations of the person and their individual needs and preferences. Similarly, in a survey of health-care practitioner perceptions of telehealth for HIV treatment, Anderson et al. (2017) found that practitioners were also concerned that telehealth 'does not allow for a comprehensive assessment of their patients' health' and worried that 'patients may not feel adequately connected to them as a provider' (2017, p. 1). Such findings suggest that telehealth creates a particular sense of distance between the practitioner and patient due to the technologically mediated nature of the relationship, an issue we explore in more detail below.

While problems relating to telehealth's lack of in-person care, such as the inability to conduct physical examinations, are noted in the literature (Marent et al., 2021; Mashru et al., 2017), the effects of such limitations on the health-care encounter are not well addressed. Cataldo et al.'s (2021) analysis of telehealth for psychotherapy is one of a few exceptions. The authors argue that physical proximity and touch are necessary for the development of trust and the therapeutic alliance in psychotherapy (2021, p. 5). Nagel et al. (2013, p. 104) also argue that visual observation and knowledge of a patient are integral to nursing practice and can be prevented or altered in telehealth consultations. Work has also been done on the impact of telehealth on patient-practitioner trust (Kiran & Verbeek, 2010) and the broader ethics of health-care technology (Kiran, 2017) in other areas. Here, though, we focus on how telehealth might affect responsibility, stigma and obligation in hepatitis C health care, after these themes emerged in analysis. Oudshoorn (2009) cautions against simplistic understandings of proximity and distance in relation to in-person or remote health care. She argues that the 'changes that take place when care moves from physical to virtual clinical encounters' cannot be understood as 'a replication of existing health-care services' (2009, p. 390). Instead, such changes bring about 'different forms of proximity' including types of immediacy and mediated intimacy. While telehealth changes the nature of health care (Oudshoorn, 2009), the implications of these changes cannot be assumed by virtue of physical distance or mediated technology. We need to understand how patients and practitioners conceptualise distance in telehealth and what this distance or proximity affords.

Scholarship on what has been termed 'telepresence' is also relevant for our understanding of the way distance is conceptualised in health care mediated by telecommunications. A concept developed in cognitive science and used in early studies of computer-mediated communication, telepresence has been defined as the 'subjective experience of being in one place or environment, even when one is physically situated in another' (Witmer & Singer, 1998) or as 'a mental state in which a user feels physically present within the computer-mediated environment' (Draper et al., 1998, in Groom et al., 2021, p. 1). According to Henry et al. (2018), health-care practitioners now must develop skills in order to 'striv[e] to achieve' telepresence. Here, telepresence is conceived as an interpersonal skill rather than mediated or produced using technology. Others adopt a more complex view of telepresence. For example, Barrett's (2017) study of telepresence among nurses engaged in teleconsultations found that participants understood presence as multi-dimensional and contingent on the medium of health-care delivery. While they do not refer to telepresence, Marent and Henwood theorise the related concept of 'co-presence' as containing

three dimensions: spatial, temporal and social (2021, p. 1124). While the concept of telepresence or 'co-presence' have been used to understand presence and proximity in health-care encounters, we suggest they are incomplete in their conceptualisation of how telehealth shapes the relational encounter because they overwhelmingly focus on experiential perception and, in so doing, background the ethical dimensions of such encounters. Telepresence approaches also tend to focus on videoconferencing rather than phone health care, the latter of which made up most encounters in our study. We also contend that proper distance and an ethical relation can be established without any sense of telepresence or co-presence.

Read together, this literature shows the complexities of building relationships in telehealth and understanding the effects of telehealth on treatment relationships. To improve our understanding of these tensions in technologically mediated health care, we make use of Silverstone's (2003, 2007) concept of proper distance to help theorise whether and if so how a sense of responsibility and proximity can be established in telehealth settings.

THEORETICAL APPROACH: PROPER DISTANCE AND RELATIONAL ETHICS

The concept of *proper distance* addresses the role of technology in mediating ethical relationships. The distance referred to in this concept is relational rather than physical. Developed to understand representation in communication media (Silverstone, 2007), it has recently been applied to mobile health (Shaw & McCosker, 2019) and is useful to understand other forms of technological mediation. According to Silverstone (2007):

> Proper distance refers to the importance of understanding the more or less precise degree of proximity required in our mediated inter-relationships if we are to create and sustain a sense of the other sufficient not just for reciprocity but for a duty of care, obligation and responsibility, as well as understanding.
>
> (Silverstone, 2007, p. 47)

In the context of mediated health care, 'proper distance' may refer to the proximity that needs to be established for a relationship in which patients feel comfortable to disclose their needs and circumstances and in which practitioners feel responsible for patients to the appropriate or 'proper' degree, all of which is socially negotiated rather than fixed.

Silverstone argues that physical distance in situations that demand social closeness creates ambivalence (2003) and that a key challenge in such situations is how to generate manageable social closeness to facilitate recognition and responsibility. For Silverstone, proper distance is central to the establishment of the moral duty that underpins and generates care. However, many relationships require some social distance (Silverstone, 2003, p. 481), and the concept of proper distance includes not being 'too close' to the other. The ambivalence generated by mediated technology comes from negotiating the appropriate proximity or distance and from 'not knowing how to act in relation to the other: how to be, how to care, how to take responsibility' (Silverstone, 2003, p. 479). 'Proper distance' needs to be renegotiated in different mediated settings. The shift of health care from in-person to telehealth settings is one such situation in which proper distance needs to be renegotiated.

Silverstone's (2007) understanding of relational ethics is heavily influenced by Levinas (1969), who sees the relational distance between subjects, as 'a crucial determinant of [...] morality' (p. 47), symbolised by the 'immediacy of the face' that 'makes the other present for us'

(Silverstone, 2007, pp. 133, 152). Levinas' contribution to relational ethics was the recognition that distance forms the conditions of responsibility by maintaining autonomy and alterity, thereby troubling the idea that distance leads to indifference (Levinas, 1969, p. 197). In this understanding of proper distance, both proximity and distance are required for an ethical relationship to be established. However, we focus on Silverstone's development of 'proper distance' as applied to technological mediation, drawing on his argument that mediation complicates our 'sense of the other' (2007, p. 47) required to establish proper distance. The idea of proper distance can therefore be productively used to understand the complex effects of telehealth technologies on ethical relationships between health-care practitioners and patients without requiring the physical or visual presence of the other. In doing so, we do not take a normative or evaluative approach to define what an ethical relationship looks like in hepatitis C care, although we assume that one should be established sufficient to provide care and take responsibility. The concept of proper distance simply acknowledges that the medium of treatment affects how this relationship can be established. Therefore, our analysis draws out tensions around distance and responsibility in hepatitis C treatment, for example, when concerns are expressed about the lack of a physical examination affecting practitioners' comfort with meeting their duty of care to patients or when patients express concern about whether practitioners are able to understand them well enough to treat them over telehealth.

While technological mediation complicates ethical relationships, Silverstone's approach does not assume that the digitally mediated health-care encounter is less able to bring about proper distance than the in-person encounter. Instead, it seeks to understand *how* phone and video technologies might change proximity or distance, such as by enabling 'instantaneity and immediacy' in ways that differ from face-to-face encounters (Silverstone, 2007, p. 119), while also interrogating how physical distance affects relational ethics. Silverstone argues that the proximity-generating and distance-generating effects of media are compatible concepts:

> The other's moral absence (or presence) is overdetermined (or undermined) by her physical absence. She is somewhere else, even if I treat her as a neighbor. Yet for us to be moral beings we have to be able to take responsibility for the other in both situations.
>
> (Silverstone, 2003, p. 481)

These considerations are also part of the practice of in-person medical treatment and are not unique to telehealth. The setup of in-person consultations can also afford ethical distance and proximity in different ways, such as through the presence or absence of a desk or counter in the clinic (Silverstone, 2007, p. 103). In this article, we first seek to understand how distance in hepatitis C telehealth care is understood and experienced by patients and practitioners. We then analyse how questions of responsibility and ethics are discussed. How do patients and practitioners adapt to changing relationships in mediated health care? A relational ethics lens sees responsibility to the other as shaped by obligations of care and reciprocity. However, we do not owe everyone everything—what we owe each other is determined in part by our ethical distance from the other, our role in their lives and the relationships that we build with others. Communications technology alters our perception of our ethical distance from others, but, as we will ask, how does this then affect the practice of hepatitis C health care in telehealth settings?

METHOD

This article draws on interview data from a qualitative study of telehealth for hepatitis C during the COVID-19 pandemic in Australia. The study sought to better understand the benefits, limitations, and effects of the use of telehealth for hepatitis C treatment during the pandemic. In this respect, the research responds to the rapid expansion of telehealth availability in Australia during the pandemic and related changes in the Medicare Benefits Schedule (MBS). The MBS comprises health services funded or subsidised by the Australian government. It was expanded to include telehealth services for a wider range of treatment types during the COVID-19 pandemic (Isautier et al., 2020; Snoswell et al., 2020).

The study is based on semi-structured interviews with 25 health-care practitioners and 15 patients with experience of hepatitis C-related telehealth care (both telephone and video, with the majority of patients [$n = 11$] experiencing telephone only care) since March 2020. Patient participants were recruited through a wide range of strategies. Recruitment flyers were shared with hepatitis organisations, community health organisations, alcohol and other drug services, needle exchange programs, tertiary hospitals, GPs, liver clinics, nurse practitioners and harm reduction services. The study was also advertised on various social media platforms. To be eligible, participants had to be aged 18 or over and have received hepatitis C care via telehealth at any point since March 2020. The 15 patient participants were recruited from urban and regional locations in Victoria ($n = 7$), New South Wales ($n = 3$) and Queensland ($n = 5$). Four participants had accessed video telehealth, of which three had accessed a combination of video and phone telehealth. The 25 health-care practitioners were recruited through key organisations, snowballing and targeted invitations. They comprised GPs ($n = 5$); specialists such as hepatologists, infectious disease specialists, sexual health clinicians or gastroenterologists ($n = 8$); nurses ($n = 8$); harm reduction workers ($n = 2$); and others involved in hepatitis C care ($n = 2$).

The semi-structured interview schedules on which the interviews were based were developed with reference to the existing literature, stakeholder consultations and study aims. Patient participant interviews explored the effects of COVID-19 on everyday life, access to telehealth, experiences of telehealth, interactions with health-care practitioners and experiences of stigma. Health-care practitioner interviews explored the effects of telehealth on professional practice, knowledge of telehealth for hepatitis C care delivery, experiences of telehealth for hepatitis C care delivery, key professional issues and telehealth access and uptake. All participants were emailed an information sheet describing the aims of the study prior to the interview and/or had the aims verbally summarised and explained at the start of the interview. All participants provided verbal audio-recorded consent at the beginning of the interview. Patient participants were reimbursed A$50 for their time and contribution to the research.

The interviews were transcribed, checked for accuracy and de-identified, with all participants' assigned pseudonyms to protect their identities. The de-identified transcripts were entered into NVivo 12 qualitative data management software. Analysis proceeded using an iterative inductive approach in which a list of codes was developed based on themes emerging from the data, current research and the aims of the study. Interview data were coded by two team members. This article focuses on relational ethics and proper distance in health-care encounters. The first author extracted the data under the code 'the effects of telehealth on treatment relationships' and read and analysed this material in light of Silverstone's concept of proper distance. Drawing on this theoretical approach, the analysis was sensitive to relational encounters in which participants described how responsibility and care were established through proximity, distance

and the sense of the other. This study obtained ethics approval from La Trobe University with Approval No: HEC20432.

ANALYSIS

Our analysis is divided into three sections. First, we explore the particular kind of proximity engendered through telehealth. We explore how the absence of physical proximity affects the establishment of proper distance in telehealth encounters. We argue that different practices or conventions in health care may need to be developed in telehealth to enable responsible action for complex health problems. In the second section, we explore how proper distance *can* be established in telehealth through frequent contact and attention. In the third section, we attend to the relationship between proper distance and stigma. We argue that the proximity specific to telehealth may be useful for managing stigma in health care settings.

Physical proximity and proper distance in telehealth

In this section, we explore how the absence of physical proximity in telehealth encounters shapes the establishment of proper distance. While telehealth has been positioned as an important way of increasing health-care access (Schulz et al., 2017, 2020), the practitioner and patient participants in our research often expressed a preference for in-person appointments, speaking about what they offered that phone or video consultations did not. Focussing first on patients, Frank, a patient from New South Wales (NSW), said:

> I'm from the old school. I really like face-to-face. I like being in the room with someone and talking to them because you get a better understanding of what's going on in the conversation. [...] It's just that whole person-to-person contact that is not there when they're on a screen or on a phone.
>
> (Frank, 64, M, NSW)

In describing how not seeing the other person shaped their experience of hepatitis C treatment, patients expressed concerns about not being understood and not knowing who they were speaking to. Magid (36, M, Victoria), for example, did not have a pre-existing relationship with his treating practitioner. As he explained, '[i]t's a bit harder [talking about personal things] over the phone and not understanding who you are talking to or who knows if you are talking to a female or a male'. David (52, M, Queensland) explained that '[t]he first couple of times speaking to someone you're still trying to figure your way and find out what sort of person they are'. At times, the lack of physical proximity contributed to uncertainty about being understood. While some patients expressed a desire to 'see' the practitioner, this did not just refer to visual recognition but was about developing a deeper understanding of and familiarity with them.

As a result of this reduced 'sense of the other' (Silverstone, 2007, p. 47), patients tended to perceive telehealth as adequate for some kinds of simple, straightforward health care but less suitable for more complex problems. For example, Cam (41, M, NSW) said he found it 'hard to explain certain issues over the telephone', while David (52, M, Queensland) thought telehealth was great for 'routine stuff [... but] face-to-face is good if you've got something going on and you need someone to really understand'. On this note, patient participants felt that a pre-existing

in-person relationship helped create familiarity and understanding in the telehealth encounter. When talking about the importance of her pre-existing relationship with her GP, Elena (39, F, Victoria) explained that it was 'a relief actually, knowing that I was going to a place where I would be kind of, not celebrated, but really well supported and really well understood'. Frank (64, M, NSW) explained that in his case he was not concerned about privacy because he 'knew' who he was 'talking to'. Read together, these accounts suggest that the proximity engendered by telehealth alone may be insufficient for in-depth understanding and responsible action for complex health problems. Instead, closer proximity, of the kind that patient participants describe being produced through in-person health care, may be required through initial in-person appointments and pre-existing health care relationships to furnish an adequate sense of social closeness and connection. However, we should note that this issue varied among participants, with some patients valuing the social distance produced through telehealth appointments. We explore this in the section on proximity and stigma below.

Our interview data also suggest that the kind of proximity specific to telehealth makes it difficult for health care practitioners to establish proper distance in the ways familiar to in-person care in trying to establish a responsible relationship with the patient. Among practitioners, the physical proximity specific to in-person appointments was understood to assist with communication, and practitioners described the non-verbal 'cues' of body language and facial expression as important in diagnosis and treatment, adding something beyond the verbal account that the patient gives. As Tim, a specialist from Queensland, explained:

> There is something [important] about laying on hands and actually seeing somebody face-to-face, what their body language is and their behaviours and things like that and picking up [...] nonverbal cues from other people in the room that you don't get on telehealth.
>
> (Tim, specialist, Queensland)

Related to this, health-care practitioners expressed concern that they may miss significant health issues in telehealth consultations because they are not able to conduct physical examinations. For example, Benjamin, a specialist from Victoria explained:

> It's just too hard sometimes when there's a lot of things going on and you really need to *see* the person and just *see* how unwell they are.
>
> (Benjamin)

In discussions of what is missing in telehealth, health-care practitioners gave the visual a particular primacy, linking visual information to their ability to offer effective health care to their patients.

Health-care practitioners also sometimes expressed a lack of trust in verbal responses. Rachel (nurse, Victoria), for example, described how challenging it was to establish her duty of care without physical proximity and examination. Describing a patient who she treated by telehealth and had complications, she explained:

> He has got a hematoma and he was clearly deteriorating, but I couldn't *see* him. He kept playing it down and really didn't want to come to hospital so we could check it out [and] I do believe 100% that if I'd actually *eyeballed* him when things started

> to go wrong, we would've actioned, made it, you know, we would've just got him to hospital sooner.
>
> (Rachel, nurse, Victoria [emphasis ours])

Likewise, Rose, a nurse in Victoria explained that:

> [Y]ou have to sort of go a little bit further and you might have to ask the same question a couple of times in a different way just to make sure you're getting the correct answers [...] because normally you can tell by *looking at them* when you're not getting a full answer.
>
> (Rose, nurse, Victoria [emphasis ours])

Here, the symbolic primacy of the visual in health care is present in the data. In commonplace medical metaphor, people are 'seen' by their health-care professionals. The primacy given to medical 'seeing' as medical 'knowing' recalls Foucault's influential account of the medical gaze (2012 [1973]), in which a physician's observation of a patient takes primacy over the voice of the patient and their own account of their experience. These accounts by practitioners suggest a concern that the mediated proximity of telehealth makes it more difficult to establish proper distance in a way that fits with established ways of doing medicine. Patients, on the other hand, explained their concerns more in terms of not being understood and less to do with not being seen or being able to be examined. These negotiations around proximity and the reduced sense of the other are sometimes managed through pre-existing health-care relationships or by approaching verbal communication differently.

In this section, our analysis has traced two mutually implicated dynamics in establishing proper distance in telehealth hepatitis C care: (1) patients struggle to communicate and be understood and (2) practitioners struggle to develop a better sense of patients and their health without physical proximity and visual information or examination. In this way, both patients and practitioners can be understood to be struggling to establish proper distance in their telehealth hepatitis C encounters. These findings suggest that health-care practitioners may need to find new ways to establish a sense of the other, as discussed further below.

Contact and attention: Establishing a sense of the other

In the previous section, we argued that both patients and practitioners are concerned about the lack of physical proximity in telehealth. The proximity specific to telehealth makes it harder for patients and practitioners to establish proper distance in their customary ways. However, while proper distance can be established with physical proximity, it can also be established in other ways. In this section, we explore how proper distance can be established in telehealth through frequent contact and attention.

As well as noting concerns about the lack of physical proximity, patients and health-care practitioners observed that telehealth appointments tended to be more perfunctory, fast or routine compared to in-person appointments. For Elena (39, F, Victoria), a patient who ordinarily had a good relationship with her general practitioner and normally felt able to chat with them, her telehealth interactions with her GP became less detailed and engaged over time:

> [I]t sometimes felt like ... not rushed but just a bit fast, you know, and so the extra, you know, maybe support or conversation that I might have got in person, maybe wasn't happening as much over the phone.
>
> (Elena, 29, F, Victoria)

Health-care practitioners also noted the same effect: that the proximity specific to telehealth made health-care consultations briefer and more cursory, with less time spent on other health concerns or general wellbeing. Belinda, a nurse from New South Wales, explained that with telehealth, 'you wouldn't have the chitchat'. Bill, another health-care practitioner explains:

> [I]nstead of going through the pleasantries and exchanging anecdotes and talking generally, it's a bit more pointed and we get onto stuff and usually we are out of there quicker.
>
> (Bill, specialist, Queensland)

Related to this, telehealth consultations were described by some health-care practitioners as more 'anonymous'. This was seen as a positive effect by some. Rose (nurse, Victoria) described a phone call as both intimate and anonymous because 'they [patients] can't be seen' and 'they're anonymous'. This suggests that some patients preferred not to be seen or to make eye contact, in the way Foucault (1990 [1978]) suggests that the screen in the confession booth enables disclosure. Lisa, a nurse from Queensland, also suggested that patients benefited from the 'anonymity' of telehealth:

> [T]hey've got that anonymity and they're safe within their own home, in their own space.
>
> (Lisa, nurse, Queensland)

Notably, telehealth consultations are not anonymous. Like in-person health care, telehealth involves the collection of personal and identifying information. These descriptions suggest that telehealth produces a particular kind of proximity in which the 'sense of the other' is complicated. Unlike an in-person encounter, in which physical proximity can produce a sense of closeness, resulting in conversation and careful attention to and consideration of wellbeing, telehealth seems to enact patients at a distance and make them seem unfamiliar. This can result in narrower health-care consultations and less detailed or extended attention. However, as we discuss below in the section on stigma, this can be an advantage if the face-to-face appointment is exposing or threatening for patients.

Some practitioners noticed the potential for distanced proximity in telehealth and made efforts to overcome this to create and sustain a stronger sense of their patients (Silverstone, 2007). The idea of repeated contact came up in interviews with health-care practitioners in their discussions of establishing rapport and closeness in telehealth care. As Josephine, a social worker in New South Wales who provided support for people in hepatitis C treatment, said:

> I felt like I needed to work a lot harder. I needed to have ... say more or give more cues to say, "I am listening" you know, "I am hearing you, I empathise with you, I know it's tough".
>
> (Josephine, social worker, NSW)

Here, active listening and repeated verbal affirmation were used to demonstrate attention and care. In line with the approach adopted in this article, we might say that these strategies were used to establish proper distance, which in turn helped sustain a sense of the patient as a whole person. Phone telehealth also had certain strengths for Josephine, who said that, while it required more verbal relational work within the encounter, also supported more regular 'checking in' later. As she explains, it was possible to call more to compensate for shorter appointments:

> The only thing I did was possibly call more often, because calling is easier to get patients to pick up the phone rather than book them in to come in, so calling again and having more 2-5 minute conversations – trying to get a few more in there, that was my strategy. If it was a short conversation, I would say to them, "I will give you a call next week to see how you are going" and I would call again.
>
> (Josephine, social worker, NSW)

While the proximity that is created through more frequent contact is different to the proximity of in-person settings, proper distance can be established in telehealth through more frequent contact and attention. Peter, a patient in Victoria, explained how his doctor rings him frequently:

> [M]y doctor now, she rings me up and says, "do you have any side effects or anything or has this happened or that happened?". She cares, she asks the questions and like one time she rang me and she goes, "oh, I'm a bloody dill, I forgot to ask you what I first rang to ask you for in the first place" and she rang me back.
>
> (Peter, 53, M, Victoria)

Phone telehealth technology entails an 'instantaneity and immediacy' (Silverstone, 2007, p. 119) that enables patients to be contacted more readily. For some, repeated calls establish a specific kind of closeness and perform attentiveness, which help build the sense of the other and establish proper distance. Thus, notwithstanding the interpersonal limits of telehealth identified here, David, a patient in Queensland, explained that over the course of several phone conversations he was 'convinced' to begin hepatitis C treatment:

> [The healthcare practitioner] was able to convince me to go in and do something about it because it really hadn't worried me much, but I realised that if I wanted to avoid liver damage and all that sort of thing, I needed to do something about it. She convinced me to go in. She did that over the phone, so she was very, very convincing about it and I went in, we did a course of it.
>
> (David, 52, M, Queensland)

Our findings suggest that while telehealth generally makes the establishment of proximity more difficult in health care, frequent contact from practitioners can help patients feel attended to and allow practitioners to sustain a sufficient sense of their patients to ensure responsible health care.

Proximity and stigma

In the previous section, we analysed the ways lack of physical proximity in telehealth and the related cursory nature of phone consultations can result in a reduced sense of the other. In this

section, we examine the ways in which this distanced proximity could be useful at times, specifically for managing stigma in health care settings. Stigma is known to be a key concern in the treatment of hepatitis C, affecting people's ability to access care and their experience of treatment when they do (Fraser & Seear, 2016; Harris, 2009; Harris & Rhodes, 2013). For some patients, this alteration in proximity from in-person care was associated with reduced concern about stigma. For example, discussing his experience of hepatitis C treatment, David (52, M, Queensland) explained:

> [The phone] puts that distance between you and the other person where, you know, you're not seeing the *look* of disapproval, you don't necessarily have the paranoid fantasy that they're looking or feeling disapproving of you'.
>
> (David, 52, M, Queensland)

Similarly, Lucy (52, F, Queensland) explained that she would feel uncomfortable in a public hospital setting because 'the stigma is there' and doing treatment by phone 'makes it a little bit more discreet, more private because you can do it at home'. In both of these responses, being seen or making eye contact was understood as potentially exposing. In the absence of physical proximity, and with a reduced sense of the other, speaking about hepatitis C was easier for some patients.

Many practitioners also agreed that patients appeared more comfortable disclosing things in telehealth settings. According to Rohan (GP, Victoria), 'people seem to tell you a lot more' over the phone. Similarly, Carol, a nurse from New South Wales, said that:

> [P]eople are maybe less reluctant [to disclose things] on a phone call than they are in a face-to-face situation, because of the distance.
>
> (Carol, nurse, NSW)

Rachel, a nurse from Victoria, recounted the words of one of her patients who explained that it was easier to discuss hepatitis C acquisition over the telephone:

> [My patient] was saying, like, having to have eye contact with somebody and explain how he's got hep C and stuff has always been a difficult conversation for him, but he found it much easier to disclose things and just be open about it [over the phone].
>
> (Rachel, nurse, Victoria)

Importantly, privacy and discretion are not fixed qualities of telehealth. As with health-care practitioners' characterisation of telehealth as anonymous, these descriptions capture the effects of a reduced sense of the other rather than the operations of the technology itself.

Such findings highlight the fluid and ambiguous nature of proper distance. Physical remoteness makes proper distance more difficult to establish but also reduces patients' exposure to potentially stigmatising words or actions by professionals. It seems, then, that relationships can be established more quickly because the amount of trust required is reduced. Patients appear to feel less exposed in telehealth settings and therefore more able to engage in conversations. This reduces the visual information that health-care practitioners are able to gather about patients but may also enable different conversations.

CONCLUSION: NEGOTIATING PROPER DISTANCE IN CHANGING HEALTH-CARE MODALITIES

In this article, we have examined how telehealth affects treatment relationships in hepatitis C, building on existing literature that focuses on patient experience and drawing on qualitative data from interviews with patients and practitioners during the COVID-19 pandemic in Australia. Overall, the argument contributes novel insights into patient experiences of telehealth for hepatitis C, raising questions about, and adding complexity to, research that emphasises the positive effects of telehealth for patients (Bensted et al., 2021; Lepage et al., 2020; Rodrigues et al., 2021; Schulz et al., 2020) by focussing on its role in treatment relationships.

In conducting this analysis, we have established how telehealth changes the establishment and experience of relationships and responsibilities in hepatitis C treatment and care. To do so, we used Silverstone's concept of 'proper distance' (2003), which allowed us to explore the effect of distance and proximity in telehealth.

Our analysis was divided into three parts. In the first part, we argued that while telehealth allows hepatitis C treatment to bridge physical distance and COVID-19 restrictions, it also alters how 'proper distance' is established in health-care encounters. Here, health-care practitioners and patients expressed uncertainty about relationships due to the absence of physical proximity, concerns about not being known or understood and a lack of visual information in phone telehealth. For practitioners, the primacy of the visual in health care emerged as a key issue, along with the difficulty of building a sense of the other through telehealth. Importantly, these data raise the possibility that the mediated proximity specific to telehealth, especially phone telehealth, impedes health-care practitioners' sense that they have enough information to provide responsible care (see also Anderson et al., 2017).

In the second part of the analysis, we discussed elements that do help establish attentive and responsible relationships in telehealth. Here, we considered the strategies health-care practitioners used to establish relationships, such as frequent contact and verbal affirmations, to demonstrate and allow listening. Such strategies compensated for the tendency for contact to feel perfunctory (as also discussed by Marent et al., 2021) with phone telehealth affording this instant and immediate contact because patients were readily contactable. In the third part, we observed that both groups talked about the capacity of social distance enacted in telehealth to increase comfort with disclosure and lessen concerns about stigma, supporting the proposition that telehealth may mitigate the problem of stigma as a barrier to treatment (Thompson et al., 2020).

Given that proper distance—the manageable social closeness that facilitates recognition and responsibility in health care (Silverstone, 2003)—is important to the development of ethical relationships in health care, we conclude with some considerations for establishing attentive and responsive relationships in telehealth for hepatitis C treatment and care. Based on the data, we note that the sense of the other developed through in-person care may encourage such relationships in later telehealth encounters. Therefore, the establishment of treatment relationships in person may aid telehealth by generating proximity and social closeness and a great sense of responsibility. However, this early physical contact is not always possible, as many people undergoing treatment for hepatitis C may not have pre-existing health-care relationships. Our analysis also suggests that practitioners can establish proper distance in other ways, such as through frequent contact or check-ins, verbal affirmations to demonstrate and allow listening and the practice of active listening rather than relying on the medical gaze. We encourage health-care practitioners to consider how telehealth affects treatment relationships and build on existing approaches to work towards proper distance in telehealth. Specifically, the concept of proper

distance can encourage practitioners to think about how the distancing effects of telehealth can encourage or necessitate changes in how they address and respond to patients so as to establish appropriate ethical relations that are responsive to each patient and their unique situation.

Our findings indicate that practitioners have to do more to establish relationships and demonstrate that they are able to address any complexities that may arise in the course of treatment. Patients felt less understood or known by practitioners and practitioners felt the absence of body language and physical examination to establish proximity and increase communication. Practitioners tended to privilege visual information and should develop additional verbal strategies to help patients feel known and understood, such as asking additional questions and checking in more frequently. These findings do, however, also suggest that telehealth has advantages for redressing stigma through an increased distance that enables disclosure and also enables a repeated contact that may help establish attentiveness.

More broadly, a relational ethics approach has significance for health sociology beyond the delivery of hepatitis C treatment. The notions of ethical distance and proximity, for example, are concepts that can be used to analyse the ethical implications of other new health-care technologies as they are constituted and negotiated by those who use them. Rather than assuming that new technologies can or should have stable effects in health care, this approach can be used to analyse their ethical implications as they are made in practice. Further, the concept of proper distance has the potential to inform research on health-care stigma in areas beyond hepatitis C. The concept, for example, can be used to analyse the practices needed to establish responsibility and non-stigmatising health-care encounters. Finally, given that compromised trust is a known issue between health-care professionals and individuals with stigmatised health conditions (see e.g. Treloar et al., 2016; Whetten et al., 2008), our approach offers a frame for understanding how new technologies can shape these dynamics and how trust can be established.

AUTHOR CONTRIBUTIONS

Frances Shaw: Conceptualization; Writing—original draft; Writing—review & editing. **Renae Fomiatti**: Conceptualization; Writing—review & editing. **Adrian Farrugia**: Writing—review & editing. **Suzanne Fraser**: Writing—review & editing.

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Research data are not shared.

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