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Caring remotely through "fitting": video consultation use in Danish general practice

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Abstract

In this study, we examine how Danish general practitioners (GPs) and general practice staff have fitted their use of video consultation to align with their conceptualisations of good care. Political stakeholders are repeatedly encouraging the use of video consultation in the healthcare sector, discursively referring to optimised use of healthcare resources, increased efficiency and flexibility for and geographical equality among patients. By the end of 2024, it will be mandatory for GPs to offer video consultations to patients in Danish general practice. This raises important questions about the implications of video consultation on the care provided in general practice. Our data consists of 30 semi-structured interviews with GPs and 132 hours of fieldwork conducted across seven clinics from August 2021 to August 2022. We analysed the data following the principles of reflexive thematic analysis and inspired by an abductive approach. Drawing on Annemarie Mol's and Jeanette Pols' conceptualisations of care and fitting, we identified common rationalisations articulated and observed in practice that highlight how fitting video consultation into the care provided in a general practice setting can enable 1) optimised use of busy patients' time), 2) optimised use of clinician and clinic resources, 3) enhanced connection of 'harder to reach' patients and 4) better work experiences for GPs and staff. Our findings demonstrate the variety of video consultation use potentials, contributing to our understanding of the implications of video consultation on the provision of care.

Introduction

In Denmark, as in many other high-income countries, new digital health technologies are increasingly shaping approaches to care (e.g., through remote consulting, monitoring, diagnostic tools, etc.), continuously raising questions about their implications for care practices and quality of care (Lupton, 2018; Ziebland et al., 2021). One digital health technology engaging healthcare professionals in thoughts and concerns regarding new ways

of providing care is the video consultation. There are multiple partially overlapping definitions of a video consultation (Osman et al., 2018; Hughes et al., 2022; Keuper et al., 2021). In this study, we refer to a video consultation as a synchronous healthcare session conducted remotely between a patient and a general practitioner (GP) or practice staff using digital audiovisual technology. Studies show that while many GPs perceive healthcare provided by video consultation to offer advantages, e.g., enhancing access to healthcare, greater flexibility and efficiency, uncertainty about appropriate use, how to maintain quality in the doctor-patient relationship and how to avoid exacerbating health inequalities if embedded in routine practice also reside among GPs (Nordtug et al., 2022; Due et al., 2021; Wanderås et al., 2023). In Denmark, as elsewhere, video consultation was introduced as a response to the Covid-19 pandemic, supplementing the other remote consultation forms (telephone- and e-consultations). Within that period, the suitability of video consultation for care delivery seemed obvious to most healthcare professionals. For example, in the context of the pandemic, many Danish GPs perceived video consultation as a helpful "crisis-tool" because the technology enabled the GPs to not only audibly but also visually interact with their patients at a distance (Lüchau et al., 2023) . Likewise, in a Norwegian general practice setting during the pandemic, video consultation was perceived by the GPs to be equally or even more suitable than face-to-face consultation for assessing the main reason for contact, even though the GPs were instructed to overlook the obvious advantage of avoiding contamination through the use of video consultation (Johnsen et al., 2021).

In the aftermath of the pandemic, however, researchers and healthcare professionals have discussed the suitability and added value of video consultation and what future role it is to play in general practice (Assing Hvidt et al., 2023). In a Danish study, based on interviews with GPs from 2021 and 2022, perceptions of the relative advantage of the technology differ significantly between the GPs, with some being keen video consultation users and others being more resistant or hesitant (non-)users (Lüchau et al., 2023). By the same token, a British study with GPs, patients and other stakeholders, concludes, based on data from 2019 to 2021, that the relative advantage of video consultation was perceived as minimal albeit with some exceptions such as out-of-hours and nursing home consultations and statuary functions (Greenhalgh et al., 2022). Thus, presently, the research evidence presents a somewhat diverse picture of the perceived suitability and added value of video consultation among healthcare professionals, in part because studies draw on differences regarding the scope of user experiences but also because suitability and added value are difficult to generalise upon. There is a need for empirical explorations and theoretical framing of those video consultation use situations which GPs and staff experience as adding further value to the care that they provide. Therefore, we ask: How have Danish GPs and general practice staff fitted their use of video consultation to align with their conceptualisations of good care?

In doing this, we are inspired by social scientists and philosophers Anne Marie Mol and Jeanette Pols' approach to studying the use of care practices and technologies. Concurring with how Løvschal-Nielsen et al. (2022: 217) understand care, who also draw on Mol, we think of care as something GPs and staff do in

practice when they "care for" and "look after" their patients. Following Mol's and Pols' lines of thought, care is a normative practice that can take many forms (Mol, 2010; Pols, 2012). Hence, while principles of care also exist on a discursive and policy level, as will be described below (i.e., the ideal of continuity of care or expectations of efficiency), understanding the impact of video consultation in care requires that we explore care as perceived and experienced by users in the context of specific situations around video consultation practices.

In wanting to challenge the widespread division of "warm" (=good) and "cold" (=bad) care, where technologies are perceived as especially cold, Pols proposed the metaphor of fitting to be used to understand care without focusing on pre-established categories and oppositions (Pols, 2012). According to Pols, how a technology is used depends on the specific context and its users (Pols, 2012). Using new technology, such as a video consultation, healthcare professionals (as well as patients) experiment with and adjust their ways of seeking and providing care (Pols, 2012). Pols has emphasised how telecare technologies shape the provision of care, describing how healthcare professionals and patients engage in the activity of fitting technologies, people and situations to meet norms of good care (2012). Norms, Pols explains, are to be understood as values (e.g., good relations, independence) and directives for what to do and who should do it (e.g., call or see a patient, prescribe medication). In essence, a good fit involves several key aspects, according to Pols. She describes how clinicians should draw on their professional experiences and clinical knowledge to best help the patient. At the same time, they must remain open and sensitive to a patient's situation which can be unpredictable and subject to change, and they must be pragmatic and accept the limitations of their control over care processes because patients also play a part (Pols, 2012). Ultimately, a good fit balances all these factors. As will be reflected throughout our findings, the GPs and staff balance these aspects in different ways according to different patients' circumstances when they work on making good fits, ultimately leading to good care.

We thus draw on the term fitting in our analysis when exploring how GPs' and staff use video consultations to align with their conceptualisations of good care. Knowledge hereof may inform the development of policies and procedures to ensure that video consultation is used in alignment with patients' and healthcare professionals' need for seeking and providing care – in other words, policies and procedures that fit the general practice setting.

Use of video consultation in Danish general practice

Regardless of the evidence on the suitability of video consultation, the use of video consultation is repeatedly encouraged by political stakeholders in Denmark based on expectations of optimised use of healthcare resources, increased efficiency and flexibility for and geographical equality among patients (Finansministeriet and Regeringen, 2022; Regeringen et al., 2022). As stipulated by the collective agreement between the Danish Health Authorities and The Danish Organisation for General Practice, it will be mandatory for all GPs to offer patients video consultations by the end of 2024 (Praktiserende Lægers Organisation, 2022b). To create

financial incentives and make video consultation easily available, video consultation software was made freely available in 2020 through the publicly developed application My Doctor, and GPs' reimbursement for a video consultation (DKK 166/EUR 22) is slightly higher than that of a physical consultation (DKK 156/EUR 21) (Praktiserende Lægers Organisation, 2023). These political decisions are likely to affect GPs' and staff's rationales for using video consultation.

General practice is commonly perceived as one of the cornerstones of the Danish healthcare system (Pedersen et al., 2012), committed to providing person-centred and longitudinal continuity of care (with most patients attending a permanent GP of their choosing (Nexoe, 2013; Frederiksen et al., 2010). In Denmark, GPs work as private contractors remunerated by the public health authorities through a mixed capitation and fee-for-service system (Rose Olsen et al., 2016). Patients can consult their GP (or staff) by attending the clinic in person or through telephone consultation, e-mail consultation or video consultation. On rare occasions, GPs visit patients in their homes (Sundheds- og Ældreministeriet, 2016; Praktiserende Lægers Organisation, 2023). General practice has been increasingly required to expand its role to take on more care demands (Oxholm et al., 2022; Rose Olsen et al., 2016). Additionally, the share of elderly citizens and patients with chronic diseases has increased substantially (Oxholm et al., 2022). Consequently, the workload on general practice increases, work structures change, and the provision of person-centred and continuous care is challenged. Greater use of technology, such as video consultations, is often mentioned as a way to free up time to secure good care for patients (Jeffers and Baker, 2016). As of January 2023, video consultations account for 1% of all consultations in Danish general practice, but the number is steadily increasing (Praktiserende Lægers Organisation, 2022a). Little is known, however, about how video consultations influence GPs' and their staff's conceptualisations of good care in practice.

Method

Using interviews and multi-sited fieldwork

Our data corpus consists of 30 semi-structured interviews with 27 GPs from 27 different clinics and 132 hours of multi-sited fieldwork, including informal interviews with GPs and staff, across seven clinics in Denmark. Within that corpus, we have focused on the data segments that yielded high information power (Malterud et al., 2015) regarding perceived added value within the context of video consultation use, and we thus focused on use situations and excluded non-users in our analysis because the latter would not provide information in this regard. The first author conducted all interviews, focusing on how GPs and their staff experienced the introduction of video consultations on a political, organisational (i.e., clinic) and personal level. GP interviews were conducted either face-to-face (n=3), telephone (n=6) or video (n=21). The video interviews provided an opportunity to relate to the setting of the video consultation, and most GPs were engaged in interviews at the exact location where they would also conduct video consultations. This helped to support a mutual, embodied understanding of the interview topic. Interviews lasted between 21 and 74 minutes and followed a semi-

structured interview guide. Adjustments were made to the interview guide during data generation as interview situations and fieldwork inspired new questions. At the same time, external factors such as GPs' new collective agreement commenced in January 2022 gave rise to further questions. Moreover, it should be noted that the data generation period exhibited a degree of instability as many GPs and staff adjusted their work routines after Covid-related lockdowns. They were either transitioning back to pre-Covid routines or striving to establish a "new normal" that included video consultations. Some GPs and staff expressed how certain patients had asked to see them in person after an extended period of remote consultations. This might have influenced GPs' and staff's use of video consultations. Interviews were audio- or video-recorded and transcribed verbatim by ECL (n=6) and a student assistant (n=24) concurrent with the data generation.

Likewise, the first author performed the fieldwork. Whilst the interviews encouraged a discussion and reflection of individual attitudes and experiences, the fieldwork focused on understanding how video consultation was integrated into the clinic's daily routines. Following a multi-sited fieldwork strategy meant that the first author followed a topic, namely the use and non-use of video consultations, across several field sites (n=7) in shorter periods (Marcus, 1995) which is suitable for discovering dynamics "within and across social entities" (Hannerz, 2003). ECL adjusted her focus while doing fieldwork. This meant that on some days, she followed GPs and on other days, she followed a member of staff. When following GPs, nurses or health and social care assistants, the first author observed both physical, telephone and video consultations with patients as well as the preparation and summarising of journal work for each patient. Although patients were included in these observations, the focus always remained on the practices performed by the GPs and staff. Following the secretaries meant sitting next to them either in their back office or by the front desk in the waiting room, overhearing their conversations with patients on the telephone and observing how they perform a wide range of booking and planning tasks using the clinic's management system. Furthermore, on each fieldwork visit, ECL aimed at observing one or more video consultations (in clinics where they used video consultations). Thus, ECL could follow a GP for the first two hours when they had video consultations, and then move into the back office or front desk to observe how the secretaries booked (or chose not to book) video consultations. In this way, ECL tried to gain a holistic understanding of the workflows in the clinics while always keeping video consultation in mind. ECL was flexible in her data generation, mixing interviews and fieldwork to the level of "information power" (Malterud et al., 2015). Moreover, in combining interviews and fieldwork, the fieldwork served as a contextualisation of the interviews, while the interviews likewise informed and inspired new fieldwork strategies and made room for unexpected discoveries and new perspectives. Fieldnotes were written by hand and transferred to Word documents afterwards by ECL.

Selection of GPs and clinics

We applied a purposive sampling method to ensure variation in GP's and staff's sex, age, geographical location, size of the clinic and extent of video consultation use ranging from no use to daily use. The GPs and staff were recruited using our professional network and social media. The informants are aged 35 to 71 years

old and are based in 4 out of 5 Danish regions with varying clinic sizes (see Table 1). Recruitment for interviewees and fieldwork clinics happened concurrently. Some GPs agreed for ECL to visit their clinic, others agreed to an interview, and some agreed to both.

TABLE 1: GP characteristics (also to be found in Lüchau et al. (2023) and Lüchau et al. (2024))

Interview GPs	
Variable	**Participant sample**
Age	39-71 years
Sex	14 female and 13 male
Clinic size	3 single-handed GPs; 10 small partnership clinics (2-3 GPs); 11 large partnership clinics (4-6 GPs); 3 GP locums
Geographical distribution	4 out of 5 Danish regions
Size of city where clinic is located	<9999 inhabitants = 8 10.000-50.000 inhabitants = 8 >50.000 = 8 GP locums with several work locations = 3

TABLE 2: Fieldwork clinic characteristics (also to be found in Lüchau et al. (2024))

Fieldwork clinics		
Clinic	**Clinic characteristics**	**Observation days**
Clinic 1 (pilot)	5 GPs 8 staff 10.000-50.000 inhabitants	2
Clinic 2	5 GPs 16 Staff <9999 inhabitants	5
Clinic 3	Single-handed GP 2 staff <9999 inhabitants	3
Clinic 4	6 GPs 19 staff 10.000-50.000 inhabitants	2
Clinic 5	2 GPs 6 staff >50.000 inhabitants	4
Clinic 6	4 GPs 18 staff 10.000-50.000 inhabitants	2
Clinic 7	Single-handed GP 2 staff	2

	>50.000 inhabitants	
		Total 19 days (=132 hours)

TABLE 3: Data generation timeline (also to be found in Lüchau et al. (2023) and Lüchau et al. (2024))

Month	**Data generated**
June ‘21	Observation Day 1 – clinic 1 Observation Day 2 – clinic 1
August ‘21	Observation Day 1 – clinic 2 Observation Day 2 – clinic 2 6 GP interviews
September ‘21	Observation Day 1 – clinic 3 Observation Day 2 – clinic 3 Observation Day 1 – clinic 4 Observation Day 1 – clinic 5 9 GP interviews
October ‘21	Observation Day 2 – clinic 4 Observation Day 1 – clinic 6 Observation Day 1 – clinic 7 4 GP interviews
November ‘21	Observation Day 2 – clinic 5 3 GP interviews
December ‘21	Observation Day 2 – clinic 7
January ‘22	4 GP interviews
May ‘22	Observation Day 3 – clinic 2 Observation Day 3 – clinic 5 Observation Day 4 – clinic 5 Observation Day 2 – clinic 6 1 GP interview
June ‘22	Observation Day 4 – clinic 2 Observation Day 5 – clinic 2
July ‘22	Observation Day 3 – clinic 3
August ‘22	3 GP follow-up interviews

Ethical approval

The research aim and procedure were introduced to the interviewees before each interview or observation. All participants gave written consent and were informed that participation in the study was voluntary. The study was approved (approval number 11.401) by the institutional board of the University of Southern Denmark, the Research and Innovation Organization.

Data analysis

In our analytical process, we followed Braun and Clarke’s reflexive thematic analysis (2006; 2020). Following this approach, the transcripts were initially read and re-read while notes were taken along the way using the

CASDAQ software NVivo (version 14) and by hand. Afterwards, the first author coded the data inductively and searched for "patterns of shared meaning" (Braun and Clarke, 2020) in an iterative and organic process that included discussions with EAH and FO. In doing this, we were also inspired by abductive analysis, looking for surprising findings and going with "where the data is strongest" (Timmermans and Tavory, 2022). In the data, we noticed a broad interest among our informants concerning how video consultations can be used in a constructive manner without compromising the quality of their work. Reflection on what this might be what Timmermans and Tavory call "a theoretical case of", the relationship between fitting the use of video consultations to the provision of "good" care came up. This made us further reflect on how we can understand care in the context of video consultation use. Consequently, we turned to Mol (2010) and Pols (2012), and used their lines of reasoning about care and fitting to sort our data into four themes: video consultation enabling more convenient care, video consultation enabling more time-efficient care, video consultation enabling more continuous care and video consultation enabling more sustainable care.

Using reflexive thematic analysis means recognizing that the themes developed do not correspond to reality in a transparent sense; instead, they are interpretive constructs of the researchers. The above themes are thus the researchers' interpretations that another person using the same data may have organised otherwise. In this regard, we understand our subjectivity as a resource for knowledge production (Braun and Clarke, 2020). We perceive our diverse backgrounds in media studies, sociology, anthropology, philosophy and medicine as a robust foundation for enriching discussions and reflections in the author group.

Findings

Video consultation enabling more convenient care

Many GPs explained how video consultation could be used to enable more convenient care for people otherwise experiencing inconvenience in accessing general practice, e.g., taking time off work, having long travel distances, inconvenience of transportation, etc. Using video consultation in this way was mainly oriented towards so-called "resourceful" people, i.e., people in the workforce and parents with young children or as one GP puts it: "those who are actually least sick" (GP06).

In increasing convenience in accessing general practice through video consultation, there is a significant aspect of caring for people's time and life circumstances. Although a few GPs expressed how they expected their patients to prioritise coming to the clinic during work hours, most GPs indirectly accepted that general practice must tailor appointments to the labour market structures with people working from 8 am to 4 pm. Many GPs mentioned how a video consultation could save the patient the trouble of allocating a half or whole day to see the GP in the clinic. For instance, one GP explained who, in his opinion, benefits most from the use of video consultations:

> …the busy younger people, let's say those under 65, who are working and who find it difficult to take half a day off to go to the doctor (…) They have to drive from work to the doctor and

> then back again and so on. I mean, it's a major planning task, and costs half a day off or at least half a morning, just to get to the doctor. So, they're happy to have something that will do while they're at work and where they can get their questions answered if it doesn't require a physical examination. (GP15).

In a similar vein, during fieldwork, ECL observed a somewhat unusual video consultation situation involving a patient who lived far from the clinic:

> The name of another patient is now present in the virtual waiting room on the GP's monitor. The GP pushes the "start consultation" button. When the GP and patient, a middle-aged woman, have finished their conversation (concerning different matters such as an irritation with the patient's eye), the patient expresses her gratitude to the GP, telling him how she "appreciates his support". When the GP ends the video call, he explains to me that this patient has moved to another city located more than one hour from the clinic. The patient plans on finding a new GP when she has settled in her new surroundings. However, in this "transitional phase" she prefers to keep her GP, whom she knows well. (Fieldnote excerpt, clinic 4).

The patient's choice to keep the GP was made possible by the video consultation, which made the contact between the patient and GP quicker and easier compared to in-person meetings. Though the video consultation could not change the physical distance between the GP and the patient, it enabled care to be in "close proximity", referring to the facilitation of closer contact through technology (Pols, 2012: 36), which made the patient feel supported.

Not least, a GP highlighted how the video consultation offers a "good service" for parents and thus for society:

> I think that we provide a good service to people who have sick children, where the parents are worried about whether they should stay at home with the child and whether the child has to be looked after... For example, if they think they have chicken pox, then they can just look at it and say, "Well you'll be okay to go to work", sort of "It's not a problem", and... So, I really think that we provide a good service, also for society as such. (GP33).

This theme especially demonstrates how offering the patient a video consultation is an act of caring for the efficiency of people's time and of the labour market and society as such. However, all GPs and staff stress that video consultation should not be used if it leads to a decrease in the quality of care. Thus, to make a good fit, GPs and staff constantly draw on their professional expertise, an aspect of fitting also emphasised by Pols (2012). Valuing convenience and efficiency of people's time as part of a conceptualisation of good care should be understood in conjunction with the value of securing good clinical quality of the consultations.

Video consultation enabling more time-efficient care

Using video consultation to accelerate GPs' and staff's work and thus enable more time-efficient care was mentioned by several GPs and staff, expressing that using video consultation allows them to get more work done in the same amount of time. A GP explained how he had shortened his consultations and offered video consultations as an even quicker consultation, reducing the consultation time from 10 to 5 minutes because: "There is a greater demand to see the GP than the resources we have to meet that demand". (GP15). In this way, this GP tries to distribute his limited time to as many patients as possible, using video consultations as part of his effort to ensure the optimisation of appointment slots and thus solve the incongruence between rising patient demand and scarce healthcare resources. Hence, the video consultation is not perceived or approached as an isolated unit. Instead, it is viewed as part of all the care provided by GPs and staff, what Pols refers to as the overall "caring arrangement" (Pols, 2012: 29). Similarly, another GP explained how video consultations enabled her to save time, not having to fetch each patient in the waiting room, and, consequently, she felt she could mentally engage better in the consultations. When using video consultation in this way, GPs and staff experience how they can optimise their resources and thus quantitatively care for more patients in qualitatively more focused consultations. Similar to the theme above, this demonstrates how the value of efficiency as part of a conceptualisation of good care is also tied to the value of securing the quality of the consultations.

Moreover, some GPs experienced that using video consultations in the abovementioned ways indirectly benefitted patients in vulnerable situations. The rationale here is that acceleration and resource optimisation through the use of video consultation liberate resources for other patients in need of more complex care. For instance, one GP explained:

> …we would like to try to provide a supplementary offer to resourceful people who can use video so that we can create more time for the vulnerable ones. So, we would like to try to turn things around to get more time to do real medical work and help those who need it most. (GP22).

Yet, freeing up time for "vulnerable" patients through the use of video consultation requires the GPs to manage and distribute their time and resources well. As one GP emphasised, this is essential in fighting social inequality. She explained how they must be careful not to "open up too much for those having the resources, making us forget the others" (GP34). However, to secure time for the patients in most need of a GP, the prevalent attitude amongst GPs and staff is to make their work as efficient as possible. As exemplified by the use of the expression "real medical work" in the quote above, many GPs expressed taking care of the most "vulnerable" patients as one of the essential parts of their job; an important part of their conceptualisation of providing good care.

Video consultation enabling more continuous care

Fitting video consultation practices to enable more continuous care relates to how video consultation can be

used to facilitate access to and continuity in health care for those patients who would otherwise be reluctant to seek health care enhancing the connection of 'harder to reach' patients.

GPs referred to these patients as "vulnerable", tying different characteristics and life circumstances to them, but all whom video consultation was thought to improve their possibilities of receiving care.

For example, some GPs referred to some of their male patients who give low priority to attending the clinic, affecting their health negatively. As one GP said: "So, men really like video. It's actually quite funny. Those classic men who otherwise don't want to go to the doctor like that. They want it on video. They're fine with that. There's also a certain distance with video". (GP19). During fieldwork, ECL observed an example of this:

> The next patient has booked a video consultation through the clinic's online booking system, the GP tells me while scrolling through the patient's record. The GP then clicks on the virtual waiting room and presses the "start consultation" button. A middle-aged male patient now appears on the screen. The patient explains how he is generally not feeling mentally well, but does not know what the problem might be. While listening to the patient and nodding his head, the GP opens his browser and searches for "Major Depression Inventory" on www.sundhed.dk [a Danish national health portal]. The GP now starts to weave questions from the depression questionnaire into their conversation while he fills out the questionnaire on the webpage according to the patient's responses. Having been through all the questions, he looks at the patient's scores and concludes that the patient is not suffering from depression. When the GP informs the patient about this, the patient sighs with relief and answers "I am glad to hear that". The GP and patient talk a bit more before the GP ends the video call. He then turns towards me and tells me how he believes this is a good example of how he can stay in contact with male patients who are otherwise often very difficult to reach. (Fieldnote excerpt, clinic 4).

In this way, video consultation affords a way of communicating that fits well with some male patients. Whereas distance is often mentioned as a negative consequence of telecare, with technology being cold as opposed to "warm hands" (Pols, 2012), GPs and staff nuance this understanding: since video consultation is more appealing to some men, enabling the GPs to handle their health care needs in due time, video consultation constitutes "good care".

Another group of vulnerable patients for whom video consultation was thought to be fitting, and thus beneficial, was the group of "marginalised" citizens, struggling socially and/or financially, i.e., due to meagre incomes, homelessness, mental illness or the like. Not having the surplus energy it takes to attend the clinic in person, video consultation could be used to create an "entrance gate" - "warming up" the patient for a future physical meeting:

> But today, when almost everyone has a mobile phone, I actually think that you reach out further to some of those who are actually having a hard time. (…). They would never come to the clinic, but you can create an "entrance gate", and in fact, I've had an experience with someone where we've had some conversations, and then it makes them feel a little more secure and you can sort of help them, to speak to them warmly and create some trust (…), and then, over a period of time, you actually get them to come up to the clinic and get the help they actually needed. (GP43).

Similar to the above example, another GP used video consultations to keep in touch with patients who found it hard to leave their homes due to mental and physical circumstances. The GP described the case of a challenging patient:

> [The patient] has a BMI of 53, chronic pain and he won't set foot outside the door. He has difficulty cooperating and taking his medicine (…) But for someone like him, who's just sitting in his little room at home, and where we're really, really trying to help all the time, he can figure out video consultation. And it's a really great opportunity for him because I can see him every time, and he can show me the things he wants (…) he can see me- yes, we have eye contact and all that. It means a lot when I have to try in a kind but firm way to get him to take his medicine. And do the things that benefit him. (GP17).

The above quote demonstrates how the GP tried to fit her interaction with the patient by being sensitive to his needs and life circumstances. In this case, a digital approach to healthcare provision supports compliance, relationship-building and continuity and thus makes a good fit.

In all of the above examples, there is an inequality aspect to using video consultation because the technology is used to offer remote and flexible access as a first point of contact or as a supplement to other consultation forms. As also argued by Pols (2012), this shows how technology can "strengthen bonds" between people, in this case between GP and patient. As demonstrated in the quote above, making the video consultation fit the patient's situation is contingent on the relationship between the GP and the patient and the GP's knowledge of the patient's circumstances and health condition. Meanwhile, the video consultation also, as demonstrated above, enables further relationship-building and continuity, contributing to the GPs' and staff's conceptualisations of good care.

Video consultation enabling more sustainable care

When reflecting on their use of video consultation, the staff and especially the GPs also considered how their choices impacted the overall running and organising of their clinic. GPs and staff expressed a strong "mirroring

effect" in their work, meaning that the well-being of GPs and staff reciprocates the well-being of patients. Securing one's job satisfaction contributes to a generally healthier and more sustainable running of the clinic, with GPs and staff better able to care for patients now and in the long run. As one GP mentioned, her patients need her to be healthy so she can take care of them: "If we suddenly fall ill with stress, they all have a problem" (GP40).

Several GPs explained how video consultation allowed them to structure their days in less stressful manners. For instance, a GP described how the day's first consultation was always a video. He elaborated: "And it has something to do with job satisfaction. Then you can sit down and get down to business while having a cup of coffee, without it being directly provocative to a [patient] physically. But a gentle start to the day, that's a video consultation for me." (GP22). While he said this was "an egoistic choice" he did, however, mention the patient in the quote, which exemplifies how many GPs constantly consider the interaction and their way of presenting themselves in front of their patients. For this GP, using video consultation made him less "empathy-fatigued", he explained. This resembles the point by Pols (2012) that "a self is never by itself" but is interdependent and tied to other people, in this case, the patient. In this regard, the video consultation is utilised to fit the situation not (only) to the needs of the patient but to the needs of the GP with the aim of making his work life more comfortable and less stressful. In a similar case, a secretary explains how video consultation has led to more silence in the reception and waiting room of the clinic:

> …the fewer patients there are, the quieter it is. So, when the whole place is full of doctors and nurses, there's also an enormous flow of patients. And for one reason or another, at least half have to come and talk to us in the reception without us really knowing why. There's always one thing or another. Is there a prescription for it or how did I last get a blood test or something. So, the more patients who sit at home and have a video con[sultation], the less commotion there is down here." (Secretary3_clinic2).

The secretaries in this clinic have struggled with noise and disturbances due to a combination of the suboptimal design of their workspaces, telephone queues and being surrounded by colleagues and patients all day. Hence, the video consultation helps to ease the pressure, and a GP from the same clinic agreed that when implementing video consultation, the staff "had more time", and it "improved work conditions" (GP4).

This theme especially emphasises how fitting is a relational activity (Pols, 2012), and GPs and staff recognise that providing patient care is contingent on their ability to take care of themselves and each other through fostering and maintaining good work conditions.

Discussion

Inspired by Pols' (2012) and Mol's (2010) concepts of fitting and care this study demonstrates how GPs and staff engage in continuous activities of fitting video consultation, patients and situations to meet their norms

of “good care”. Our findings show how GPs and staff care for a variety of circumstances when deciding with whom and in which situations to use video consultation, and what they perceive to be “good care” is highly context-dependent. As emphasised by Johnsen et al. (2021), the perceived suitability of video consultation cannot be generalised but depends on specific circumstances. In accordance with existing literature (e.g., Thiyagarajan et al., 2020; Johnsen et al., 2021; Wanderås et al., 2023), the use potentials of video consultation vary considerably across situations, patients and health issues. Although advice and recommendations regarding suitability and appropriate target groups (E.g., Sandbæk et al., 2021) can be useful in providing broad, overall guidance for GPs and staff in the initial preparation, implementation and use of video consultation, they are – as the word suggests – only indicative. As the experience base grows, it might become easier to adjust and develop new guidelines. Guidelines can serve as good starting points for implementing video consultations in the clinics, but the guidelines must always leave room for the professional, situational assessment made by GPs and staff.

Furthermore, our findings reflect a widespread health policy discourse pointing towards convenience and efficiency improvement in the healthcare system and oftentimes related to the increasing use of digital technologies (see for example Indenrigs- og Sundhedsmnisteriet, 2023; Regeringen et al., 2022; Danske Regioner, 2018). Empirical studies have investigated how efficiency discourses- and agendas have shaped the logic, language and culture of healthcare professionals’ daily work. For example, Andersen and Vedsted (2015) described how healthcare professionals in Danish general practice must carefully balance increasing demands of efficiency and increasing complexity of biomedical and technological knowledge, which alters the nature of the doctor-patient interaction. Additionally, Eines et al. (2019) described how Norwegian municipal healthcare organisations were asked to use a service design approach to develop more efficient solutions, making healthcare professionals work “smarter and faster”. As mentioned in the introduction, the workload on Danish general practice increases, as also seen in other countries with similar primary care systems (e.g., in the UK, seeZiebland et al., 2021). Consequently, GPs and staff focus on the organisation of their time and on how to economise with their resources - primarily time – to make the most of what they have (Assing Hvidt, 2022). Hence, when GPs decide upon the usability of new digital health technologies, such as video consultation, their assessment must be understood against the backdrop of a pressured healthcare system. By the same token, as described elsewhere (Lüchau et al., 2023), some GPs do not see the added value of using video consultation compared to existing ways of working. Thus, implementing and learning how to use the technology potentially results in a perceived waste of time they cannot afford and, consequently, the GPs choose not to use video consultations. Including non-use in this study could have added further nuances and complexities to the use situations described in this paper, showing how the nexus of care and new technologies in general practice is a highly diverse field. Moreover, further research exploring the relationship between non-use of video consultations and conceptualisations of care would provide a valuable supplement to the current study.

While the perceived relationship between technologies and convenience and efficiency improvement is often emphasised politically and discursively, our results also point to another aspect of video consultation use that deserves more attention and research. Our findings demonstrate how GPs and staff use video consultation to care for those patients whom they believe to be the most vulnerable. Prioritising the most vulnerable patients is described as a so-called "landmark" in the Danish College of General Practitioners guide for how to fulfil the role of general practitioner (Dansk Selskab for Almen Medicin, 2016). Expressing concern for vulnerable patients, and employing strategies to tackle health inequalities, seems to be a widespread social norm among GPs and staff that is reflected in their video consultation use. Additionally, using video consultation to enable more continuous care resembles the discursive and political ideal of "continuity of care" as described in the introduction. However, it should be borne in mind that the care distribution through video consultation that the GPs and staff in this study target some of their vulnerable patients reflects their interpretation and former experiences of how to best fit the interaction to the patients' needs. It would be helpful to further explore the appropriateness of this fitting practice by investigating the perspective of the patients themselves. In this regard, a scoping review demonstrates widespread differences in access and use of virtual care (referring to any interaction between patient and member of their care team occurring remotely) among cultural and ethnic minorities, older people, socioeconomically disadvantaged groups, people with limited digital and/or health literacy and those with limited access to digital devices and good connectivity (Mistry et al., 2022). This review, however, does not include any Danish settings. Additionally, two California studies show how patients with limited English proficiency experience disparities in access to telehealth use (Hernandez and Moreno, 2023), and specifically how patients with limited English proficiency have worse video consultation experiences compared to in-person visits (Rodriguez et al., 2024). Our study does not account for such aspects of access and use of video consultation, and further studies would be needed to gain knowledge about this in a Danish general practice context.

Nonetheless, as earlier described, fitting the use of video consultation to enable more convenient care and more continuous care target different types of patients, the least sick and the ones mostly in need of care, respectively. Taken together, both use practices seem to indicate a potential to use video consultation as a new person-centred way of "meeting the patient where they are" (metaphorically and literally) by fitting the situation to their needs and life circumstances.

Building on this, the findings also show how the fitting activities are interdependent. For instance, fitting the use of video consultation in such a way that it enables an enhanced connection to 'harder to reach' patients is dependent on the use of video consultation for more convenient and more time-efficient care, since the latter free up time and resources to focus more energy on tasks based on more continuous care. Keeping a balance between the fitting activities, though, becomes an ongoing and essential task for GPs and staff. As our findings show, GPs and staff "target" and "dose" their care based on a professional judgment of how to best help their patients.

In continuation hereof, we argue that fitting video consultation to enable more sustainable care is helpful in elucidating another important aspect of video consultation use. As earlier described, this fitting has a reciprocal dynamic and a relational focus because the well-being of healthcare professionals mirrors the well-being of patients and becomes a precondition for good treatment and care. Sustainable care is both a prerequisite for the other fitting activites as well as a consequence of them (see Figure 1). In this way, the fitting activities seen together emphasise how care provision is increasingly complex, involving a highly connected system of resources, people, processes and values. In times of increasing pressure on healthcare professionals, staff shortage, rising burnout rates, compassion fatigue etc., video consultation might also be enacted by healthcare professionals as a tool to care for themselves and the clinic.

Conclusion

Our findings demonstrate how a group of Danish GPs and staff use video consultation in specific situations that align with their conceptualisations of "good care". These situations emerge based on four fittings activities that enable: more convenient care, more time-efficient care, more continuous care and more sustainable care. Following a reflexive thematic analysis approach, it must be emphasised that other empirical studies may identify different fitting activities, and our findings represent our interpretation of the expressions and observations of the specific practices of our informants. Future comparative analyses could highlight different understandings of 'good care' that lead some to reject or minimise their use of video consultations. We conclude that GPs and staff are on an ongoing task of fitting the technology to the specific situation and patient while also considering their own needs and interests. In doing this, they engage in different fitting activities when they "dose" their care based on a professional judgment of how to best help their patients. Our findings point to the complex interrelatedness of technologies, people and societal and organisational structures. Moreover, we demonstrate how the fitting activities are interdependent. Not least, the findings demonstrate the variety in video consultation use potentials that might inspire potential ways forward regarding the use of the technology. This information is useful for people working with the development and implementation of video consultation in general practice and other healthcare settings.

Author contributions

ECL generated all data material and researched literature. ECL and EAH conceived the manuscript design. ECL wrote the first draft of the manuscript with help from EAH. All authors contributed iteratively with adjustments and supplements to the manuscript, discussed the theoretical approach and the findings, and reviewed and approved the final version.

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None declared.

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Data availability

There is no public availability of the interview transcripts or fieldnotes outside of the research team due to confidentiality reasons. Interview guide available upon request.

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