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# How digital documentation in electronic health records forms healthcare professionals' identity: A qualitative case study

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## ABSTRACT

**Background:** Digital documentation systems are increasingly used in healthcare to streamline workflows and improve resource management. However, their influence extends beyond administration, potentially affecting healthcare professionals' identity. **Aim:** The aim is to analyse how digital documentation in Danish municipal healthcare influences Health Care Professionals (HCP)' identity through subtle identity regulation processes, focusing particularly on mechanisms of organisational control. **Methods:** A qualitative single-case study was conducted in a medium-sized Danish municipality. Data were collected through 124 hours of field observations and 15 semi-structured interviews with 23 HCPs. Alvesson and Willmott's (2002) identity regulation framework guided the analysis. **Results:** Three modes of identity regulation were identified: 1) regulating context, 2) regulating actions, and 3) regulating organisational functions. These modes shaped how HCPs perceived and enacted their professional identity. **Discussion:** Digital documentation systems position HCPs as efficient service providers rather than autonomous professionals. However, HCPs engage in identity work to adapt, resist, or reinterpret these regulatory demands, highlighting tensions between care values and managerial logic. **Conclusion:** Digital documentation serves as both a technical tool and a powerful identity-regulating mechanism. To support professional autonomy and care quality, future digitalisation strategies must involve HCPs and recognise the complexity of their work.



## KEYWORDS

Digital documentation, electronic health records, healthcare professionals, identity regulation, municipal healthcare, professional identity, qualitative case study.


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# Introduction

Almost all healthcare organisations in high-income countries have implemented digital systems (Watson, 2016). A key element in healthcare digitalisation is the use of Health Information Systems, which enable healthcare professionals (HCPs) to document their activities and communicate effectively (European Commission, 2020). Denmark has a highly digitalised healthcare system (Department of Economic and Social affairs, 2024) and the digital infrastructure of the public sector extends across sectors and organisations. Since 1998, Danish municipalities have implemented electronic health records (EHRs), resulting in the Common Language Platform (CLP) (KL - Local Government Denmark, 2019).

# Literature review

Historically, healthcare professions have, as other professions, been characterised by strong internal values and competencies, leading to professional autonomy and internal quality assessments (Abbott, 1988). Furthermore, healthcare professions are characterised by performing their tasks with dual loyalty towards the service user and the state (Hjort, 2012). Accordingly, health professional practice has been guided by a profession-specific normative framework including nurses' professional identity, which revolves around interactions with patients and relatives, and their identity is rooted in their assessment expertise, teamwork, advocacy, and relationships with patients and families (Landis et al., 2020). As such, professional identity is formed in a continuous process that influences and is influenced by the surroundings and contextual factors. This is evident in Thompson and McNamara (2022) concluded that circulating discourses construct the professional identity of advanced practice nurses. Furthermore, various organisational factors, such as service organisation, budgets, and clinical focus areas, significantly influence the development of a hybrid management identity, which often exhibits ambivalence (Bresnen et al., 2019).

Over the past 20-30 years, Western world healthcare has witnessed the introduction of numerous managerial and political initiatives to strengthen efficiency and quality, often driven by digital technologies. These changes have moulded a new professional landscape characterised by standardised professional work (Alvehus &Andersen, 2018). EHRs are a part of new digital technologies. Galasiński & Ziółkowska (2022) argue that HCPs shape clinical communication by translating patients' voices into formats that align with institutional logics and documentation templates. In doing so, professionals produce 'institutionally legible' accounts of the patient that may omit relational or emotional nuances. Critical research indicates that Danish municipal EHR initially designed for efficiency have increasingly transformed into tools of managerial control, shaping both digital documentation practices and resource allocation (Duval Jensen et. al 2023a; 2023b). Still, EHRs may support continuity of care, enable structured communication, and facilitate cross-sectoral information sharing (Greenhalgh et al., 2009), particularly in municipal healthcare settings where multiple actors are involved in a patient's care trajectory. However, as managerial rationalities gain dominance, they potentially displace the profession specific normative frameworks that have historically guided healthcare practice. From Akrich's (1992) perspective, EHRs inscribe assumptions about what matters in healthcare practice and

both guide and constrain how HCPs record information and prioritise tasks. As managerial rationalities become encoded into digital documentation systems (Alvehus & Andersen, 2018), EHRs may extend their regulatory influence beyond administrative coordination, subtly shaping professional self-understanding and micro-level interactions. In this way, digital documentation does not merely support care delivery. It also participates in the regulation of professional identity by embedding normative assumptions about what constitutes legitimate work and valued knowledge. In this study we apply Alvesson and Willmott's (2002) concept of organisational control to examine identity regulation.

### Aim

The aim is to analyse and display how digital documentation in Danish municipal healthcare influences HCPs' identity through subtle identity regulation processes, focusing particularly on mechanisms of organisational control.

## Methods

This section describes the theoretical framework of identity regulation, study design, methods, and analytical strategy.

### Theoretical framework

To explore how identity regulation processes unfold in everyday practice, we draw on Alvesson and Willmott's (2002) theory of identity regulation, which allows us to focus on how professional identity is subtly structured and negotiated through encounters with managerial structures such as digital documentation systems in everyday practice. Identity regulation functions as modes of organisational control and serve as a key mechanism that embeds managerial rationalities in everyday practices. Alvesson and Willmott's (2002) theory has previously been applied in healthcare contexts to examine professional identity, showing how "a new professional" is constituted by material and discursive conditions (Jensen & Muhr, 2020). Building on recent critical scholarship on digital health technologies (Greenhalgh et al., 2009; Justesen & Plesner, 2024), this study extends theories on identity regulation by demonstrating how such regulation increasingly unfolds through technical architectures including digital documentation systems. The digital documentation systems embed specific vocabularies, values, and logics of care (e.g., efficiency, risk management) and shape healthcare professionals' identity through both material constraints and discursive framings. Rather than viewing EHRs merely as administrative tools, we conceptualise them as mechanisms of identity regulation. They affect professional self-understanding by structuring what can be documented, what is valued, and what requires justification. Organisational control refers to the subtle ways organisations seek to align employees' orientations with organisational objectives (Alvesson and Willmott, 2002). In contrast to traditional management and control, which rely on direct orders, regulations, and formal procedures, organisational control

operates more indirectly through language and habitual practices that shape employees' identities. Identity regulation operates through modes of control and target how individuals define themselves in relation to their work.

To theorise how digital documentation systems shape professional identity, we draw on Alvesson and Willmott's (2002) framework, which conceptualises identity regulation as a process, which can be described through three elements:

1. **Identity regulation** refers to organisational strategies and discursive mechanisms that shape professional self-understanding.
2. **Identity work** captures how individuals actively respond to these regulatory influences, particularly in moments of ambiguity or tension.
3. **Self-identity** is the emergent, reflexive narrative professionals construct through navigating these tensions.

The three elements are analytically interlinked and provide a layered understanding of how digital documentation systems both constrain and prompt identity processes. Alvesson and Willmott (2002) further describe nine modes through which identity regulation operates as a form of organisational control (See Table 1).

***Table 1.*** *Modes of Regulation (adapted from Alvesson & Willmott, 2002, pp. 629–632).*

| No. | Modes of regulation | Explanation |
|---|---|---|
| 1 | Defining the person directly | Assigning labels or roles how employees are expected to think and behave. |
| 2 | Defining the person by defining others | Constructing identity by contrasting with outsiders. |
| 3 | Providing a vocabulary of motives | Using terms (e.g., "task list") that guide how employees understand and describe their work. |
| 4 | Explicating morals and values | Presenting documentation as valuable or burdensome, thereby expressing moral and normative orientations. |
| 5 | Constructing knowledge and skills | Linking identity to competence and professional affiliation. |
| 6 | Group categorisation and affiliation | Creating belonging through social categories such as teams. |
| 7 | Hierarchical location | Positioning individuals within formal or informal status structures. |
| 8 | Establishing rules of the game | Defining and normalising behavioural norms and expectations. |
| 9 | Defining the context | Framing the broader environment in ways that highlight specific identity traits. |

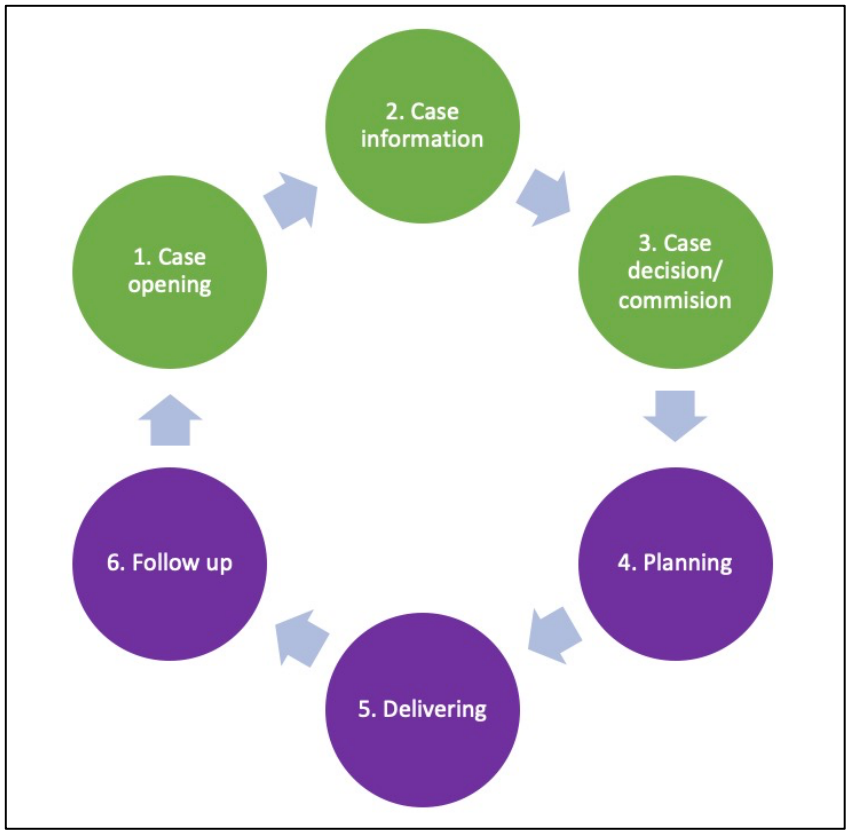
These modes collectively illustrate how identity is shaped through discourse and organisational practices, often subtly and indirectly. To further nuance the framework, we incorporated the concept of invisible work (Allen, 2015; Justesen & Plesner, 2024) to shed light on how undocumented, compensatory practices, such as informal coordination or reframing of tasks, can be understood as a form of identity work. Within Alvesson and Willmott's framework, such invisible work can be seen as a form of identity work, thus as a response to regulatory efforts embedded in systems and structures. In our analysis, the framework is applied to examine how digital documentation practices in Danish municipal healthcare regulate the ways in which HCPs construct and negotiate their professional identities. The operationalisation is further elaborated in the analysis section.

## Study design

This study was designed as a qualitative single-case study (Stake, 1995) on digital documentation practices in Danish municipal healthcare. The design was chosen because it is particularly well suited to exploring HCPs' ongoing real-time, everyday digital documentation practices, which are inherently complex and context dependent.

The study was conducted in a medium-sised Danish municipality that represented an ordinary case comparable to most other Danish municipalities in terms of size, organisation, devices, or staff. The case selection supported the strategy of a representative case and strengthened the case study´s analytical generalisability (Baxter & Jack, 2008). In Denmark, all municipal EHRs are structured by a specific documentation methods coined the Common Language Platform (CLP). The documentation methods are outlined in a handbook (KL - Local Government Denmark, 2019), that instructs users on municipal documentation practices. Figure 1 illustrates the steps in the documentation processes.

***Figure 1.*** *CLP platform/documentation method (Translated by author).*




In the CLP documentation processes, municipal assessors (various HCPs) were responsible for conducting needs assessments and allocating services (steps 1 and 2). These authority processes refer to the practical decision-making procedures defined by legislation. Designated planners then scheduled services (step 3), which were carried out by healthcare providers (steps 4 and 5). In addition, the CLP methods (KL - Local Government Denmark, 2019) outlines three organisational roles involved in

municipal service delivery: care assessors (evaluating needs and allocating services), care planners coordinating and scheduling), and care deliverers (providing services to users). These roles should be understood not as technical functions of the system, but as professional grounded tasks and responsibilities. Importantly, these roles are integrated into the digital documentation system, which structures both the everyday work and documentation responsibilities of healthcare professionals, such as nurses, nursing assistants, social and healthcare helpers, and occupational therapists. Hereby, all involved HCPs are subject to the regulatory effects of digital documentation.

## Data collection

The first author, a former municipal nurse, conducted fieldwork and interviews. Over a period of 17 weeks in spring 2021, 124 hours of field observations were conducted, followed by 15 interviews carried out in autumn/winter 2021. A total of 23 HCPs were selected through purposeful sampling including 10 social and healthcare workers, five nurse assistants, six nurses, and two occupational therapists. All of them were experienced in municipal healthcare. Seven HCPs took part in both observations and interviews, with10 participants quoted under pseudonyms.

Drawing on Wadel's (2014) approach to fieldwork, the first author adopted an apprentice role accompanying HCPs in on 5–8-hour shifts in a variety of social and professional settings where documentation took place. Observations included writing in EHR in HCP offices, service users' homes, reading others documentation between visits in the municipal cars, information exchange about patients at staff meetings, and conferences. Handwritten field notes were later transcribed into text.

Interviews (Kvale & Brinkmann, 2015), conducted post-shift in local offices, explored documentation practices based on prior research and field observations. After an informal introduction, HCPs elaborated on their use of EHR for reading, writing, and searching. During the interviews, participants were asked questions to prompt reflection such as: "I have noticed that the timetable or "my tasks" is the first thing that appears, when you open the system. Please explain how you use the timetable?". The questions encouraged participants to link specific actions and routines to their broader understanding of digital documentation. Interviews lasted 55–95 minutes, were recorded, and transcribed verbatim.

## Ethical considerations

The case study was conducted in agreement with the municipal management. Potential participants were informed about the study at a staff meeting and subsequently invited by their managers. All participants were asked to re-read the information document and give their written consent to participate before being included. Before entering their houses, service users were asked if they accepted that a researcher would be present during the visit and were informed that observations would focus on the HCP's digital documentation practices. It was voluntary for HCP users to participate in the study. Pseudonyms have been employed to guarantee participant anonymity.

### Data analysis

The analysis followed the case study design (Abma & Stake, 2014), combining close engagement with empirical material and theoretical interpretation. We examined how HCPs´ professional identities were shaped through their interactions in specific professional situations involving digital documentation in municipal healthcare. The empirical material was first coded to identify recurring patterns of control, such as time constraints, coordination outside system boundaries, and moral evaluations of digital documentation. These patterns were then categorised according to the relevant regulation modes, allowing us to trace how identity regulation unfolded through both discursive framings and material constraints. For example, we identified mode 3 (see Table 1) when HCPs labelled a incident as a "deviation," they drew on a vocabulary that framed the event as significant and actionable, thereby shaping what was considered meaningful and legitimate digital documentation. Finally, we examined how professionals responded to these regulatory mechanisms through identity work, understood as the interpretive and often subtle practices through which individuals negotiate, resist, or accommodate organisational expectations.

## Results

We identified three identity regulation processes: 1) regulating context, 2) regulating actions, and 3) regulating organisational functions, each of which is presented in the following sections. We then examine HCPs' identity through the lens of identity work.

### Regulating context

The allocation of services, assignment of staff, and scheduling of healthcare visits were all managed directly within the EHR system, which also served as the central platform for providing essential treatment and care information. Furthermore, the planning module supported task scheduling by indicating the staff resources needed for daily tasks. HCPs demonstrated co-responsibility for resource management, often prioritising this higher than their personal time and well-being. The following field note exemplifies this resource awareness:

> A temp arrives having not been cancelled the day before. The planner must manage the situation and find a solution. She makes a few calls to see if any permanent HCPs are interested in taking time off. They reach out to four employees and find two that are willing to take some time off. They are on their way to work but return to their respective homes (Field note, planner, home care, Inge)

Thus, despite union rights guaranteeing payment due to established work schedules and the inability to cancel temp workers on short notice, the permanent staff and planners adapted to ensure that resources were utilised effectively. This adaptability reflects a value of thriftiness, often requiring HCPs to diverge from union guidelines. Tasks were structured around predefined time slots and categories, limiting the space for nuance or individualised assessment, hereby establishing efficiency and flexibility as normative ideals. Through the digital documentation system, HCPs received the constant message that they had to 'manage' care with limited resources. As a result,

HCPs came to see themselves as key agents in managing scarce resources, which reshaped their professional identity around efficiency. They consistently aimed to meet the demands presented in the digital schedule and actively ensure efficient time management, as illustrated by the following dialogue:

> Mette: Do you need the usual help? Shouldn't we correct this visit?
>
> Service user: No... (hesitating). I would like you to come.
>
> Mette: But we can just cut 10 minutes off?
>
> Service user: Yes. Yes, I guess that's ok.
>
> (Observation, Mette, social- and healthcare helper)

HCPs did not question the efficiency-driven digital documentation and how this specific context influenced their perception of digital documentation processes as a tool for optimal resource management. The HCPs accepted the need to actively promote the efficient use of resources. They also accepted using breaks or leisure time to organise tasks in the EHR as a taken for granted routine among them. This unchallenged practice highlights the deep-seated nature of resource constraint and efficiency as fundamental factors of healthcare.

## Regulating actions

We found that all HCPs used the same imposed language when documenting care. For instance, the EHR's main page includes a 'My tasks' list that reduced care activities to specific tasks, each to be completed within a set time slot. This terminology exemplifies an assembly-line approach to care: it communicated to HCPs that their interactions were tasks to tick off, reinforcing a fragmented and standardised view of their work upon completing services:

> Back in the car Mette shows me that she now creates an 'extra visit' on her driving list. She must subsequently approve the 'task', accept the task, and deliver it in the EHR. (Observation, Mette, social and healthcare helper)

Registering tasks as delivered allowed management to retract activity data from the EHR, which meant that a task was legitimised in the organisation when registered as delivered. However, they could only create tasks within predefined categories, limiting their ability to document non-standard tasks. One example would be when a planner needed to arrange for a plumber because a boiler needed repairs in a service user's home. The time and actions of the planner remain invisible because the EHR did not have a category to record such actions. Furthermore, in time-constrained situations, HCPs often prioritised managing incidents, for example a service user's fall, and did not register extended time in the EHR, leaving some work undocumented. During observations and interviews, it became clear that the term "deviation" functioned as a key justification for written entries in the EHR beyond the standard act of marking visits as completed. Writing narrative information was generally considered unnecessary unless something deviated from the predefined and expected care trajectory. This was reflected in HCPs' descriptions of their own practices, where writing in the EHR was seen as warranted only when care did not proceed "as planned":

> It's something that deviates from the norm. I don't write that he ate a sandwich and had a glass of milk. I'll only write something that deviates from the norm for example not eating anything. Then we document. (Interview, Line, nurse)

Implicit in this usage of the term "deviation" is an understanding of healthcare services as unfolding in linear and predictable ways. The design of the digital documentation system reinforced this assumption by centring standard task execution and requiring additional effort to justify non-standard actions. As a result, digital documentation became less about capturing care in its relational or contextual dimensions and more about signalling compliance (or explaining non-compliance) with pre-structured routines. For example, when a service user refused prescribed medication, this refusal was documented explicitly, alongside the consequences communicated to the user. These practices illustrate how the system's regulatory logic guided digital documentation toward accountability and exception management, while everyday relational aspects of care were often left undocumented. Consequently, HCPs prioritised checking off completed tasks within the EHR rather than writing narrative descriptions. Digital documentation was framed as an administrative function requiring justification under time pressure and efficiency demands. Accordingly, writing in the EHR was considered morally justified only when documenting deviations. During observations, it became evident that the design of the EHR system made narrative writing challenging. Healthcare professionals had to navigate multiple tabs and work through predefined checklists before reaching a field where free-text entries could be made. This structure appeared to prioritise checkbox completion over narrative input, making the act of writing feel cumbersome and potentially non-value-adding in everyday practice. HCPs viewed the process ambivalently, recognising its potential for communicating valuable insights, as HCPs valued professional documentation about care. They also read the EHR in advance to ensure they were prepared for their visits. This included reviewing the visit plan, which described the service user's daily routine, such as the services to be provided and instructions for medication. Important information was documented whenever it seemed relevant to share with others. Even small signs or subtle changes in behaviour were noted, as it could make it easier to anticipate potential challenges and to reflect on past situations.

While the EHR system was designed to streamline workflows, many informants reported that its structure often made digital documentation feel cumbersome and time-consuming. This perception emerged particularly when digital forms failed to accommodate the relational or contextual aspects of care. The CLP is built on the presumption that basic information is available in the EHR, based on professional assessments of the service user's health and functional conditions. However, often, these were not updated. Instead, HCPs marked visits as delivered or entered very short observations. In this field note, a nursing assistant was unable to build an overview of a service user's trajectory, as the basic information had not been updated:

> Sanne opens the EHR on her tablet. She clicks on the service user´s name on the "Extra task" to open the record. She finds contact information for the doctor and calls using her mobile phone. There is music on hold. She is number 7 in the queue. While she waits, she opens 'health conditions'. They were last updated 1 year ago. She also opens the functional states and overall assessment, which were last updated 2 years ago. The journal is incomplete. (Observation, Sanne, nursing assistant)

This example illustrates that HCPs often relied on basic clinical information stored in different parts of the EHR and required time-consuming navigation. However, such documentation was rarely updated in routine practice. Although HCPs recognised the value of detailed records for care quality and coordination, the system's emphasis on documenting only deviations discouraged comprehensive updates. This prioritisation

of efficiency over completeness reflects an organisational logic that devalues thorough documentation in favour of streamlined task execution.

## Regulating organisational functions

The CLP requires that every HCP be assigned to one of three fixed roles: care assessor, care planner, or care deliverer - regardless of their professional education or specialty. This rigid role classification created a uniform framework for task distribution that overrides individual professional autonomy. By reducing HCPs to organisational functions, the system constructed them as interchangeable parts of a process, effectively stripping away their professional autonomy and making them anonymous within the organisation. The role of a 'care assessor,' for instance, involves evaluating service users' care needs by entering information into standardised fields, ensuring that these assessments align with the service users' legal rights, as stipulated by the Method Handbook (KL - Local Government Denmark, 2019). The care assessor's tasks are facilitated by the EHR system, which restricts writing access in the assessment module to assessors exclusively, although other HCPs can view the information entered. Similarly, the 'planner' role is reserved for those with access to the EHR planning module. These individuals are responsible for creating schedules and allocating services to HCPs throughout the week. This exclusive access ensures that planning tasks are managed systematically and efficiently. The third role, 'deliverer,' is defined within the CLP but is not a term commonly used by HCPs in their daily routines. According to the CLP, the deliverer's responsibilities include providing care, documenting and communicating any deviations or changes in a service user's condition to the authorities. The digital documentation process is rigorous: any variation from the planned service must be recorded, and in the absence of deviations, the documentation confirms that the planned service has been provided (KL-Local Government Denmark, 2019). This digital documentation process portrays HCPs in a neutral, almost industrial manner, emphasising precision and adherence to plans above and beyond any individual caregiving nuances (KL - Local Government Denmark, 2019). The timetables further reinforced the deliverer's identity by providing a clear outline of tasks and organising the timeline of visits. After each visit, deliverers should mark the visit as "delivered" in the system. This technological feature facilitated the material manifestation of service delivery and focused exclusively on individual tasks, reinforcing the notion of HCPs as components of a larger operational system.

Communication among HCPs was structured by the organisational roles in the digital documentation system. To send an observation, HCPs entered a note in the EHR, specifying the receiver's function rather than their name. This method underscored the impersonal nature of the system, as illustrated in this observation.

> She opens her timetable and selects the visit of service user no. 9. She marks it as delivered. She presses the small plus on the service user's page and creates an observation. She writes that the service user is incontinent and would like to be given adult nappies. She sends the task to a 'user role' and selects 'Incontinence nurse'. (Observation, Rikke, social and healthcare helper)

This practice highlights that digital documentation was task-oriented and depersonalised, reducing HCPs to anonymous actors within the broader organisational mechanism. Ultimately, the digital documentation system categorised HCPs into specific organisational groups and hierarchically divides tasks within the EHR. This structured approach, perceived as an organisational tool, emphasised task-based

categorisation and diminished individual professional autonomy, rendering HCPs nameless, anonymous, and without autonomy within the system.

## Identity work

Building on the previous analysis of modes of regulation, this section describes the analysis of how the digital documentation practice is enacted in everyday municipal healthcare practices. We draw on empirical examples to illustrate how HCPs engaged in identity work: they interpreted, adapted to, and sometimes resisted these regulatory modes. This process was not merely reactive but constituted an ongoing negotiation of professional self-understanding. Often, these were marked by tensions between traditional care values and the managerial expectations inscribed in the digital system.

The EHR system supported detailed task planning and allocation. For example, planners often quickly adapted schedules and managed staff resources, demonstrating flexibility and commitment to efficiency, even at the expense of HCPs' time and well-being. This adaptability reflected a deeply ingrained value of resource awareness, positioning HCPs as pivotal in managing limited resources. The HCPs collaborated and communicated within their teams, but the focus on service users' trajectory was often initiated by time allocation issues:

> If it´s a progression in dementia or in Parkinson's, or whatever it is. Well, then, of course, you must apply for some time. Or is it because she has been sick with the flu. There is a difference. (Interview, Birthe, social and healthcare helper)

The prioritisation of task completion and resource management over comprehensive patient care influenced how HCPs perceived their roles and responsibilities. The emphasis on efficiency and resourcefulness, even in the face of personal or professional sacrifices, had become a core aspect of their daily actions. The organisational roles embedded in the CLP and EHR systems reshaped HCPs' professional identities. They were often seen as 'deliverers' of care who managed tasks efficiently, with digital documentation primarily focusing on deviations from the norm. However, a "deliverer" is not expected to maintain an overview of the service users' trajectory or collaborate with other HCPs. There was a clear sense of restriction in the workflow. Decisions about whether a service could be provided at all were initially made by 'assessors' located elsewhere, without direct involvement in the care trajectory. The amount of time allocated for carrying out the service was also determined in advance. Overall, this redefined HCPs' identities as essential agents of resource management, for which they took responsibility. This impacted their daily practices and professional interactions, emphasising the importance of optimising resources and maintaining efficiency in their roles.

However, the regulation modes seemed to elicit some resistance. HCPs reported feeling unprepared if they had not read the visit plans and perceived digital documentation as a collective memory of their service users' needs, personal information, treatment, and previous healthcare contacts. By documenting and subsequently reading this information, they ensured continuity of care and training of new employees:

> I don't have any experience with wounds, because my previous employment was in the emergency department. Much of what I know about wound care comes from reading notes written by others

> like their thoughts on the wound, what should be done, how it's being treated, how often, and things like that. It really helps me build my professional knowledge. (Interview, Annika, nurse)

Traditionally, HCPs relied upon communication to coordinate care trajectories. However, as Annika also explained, the digital documentation challenged coordination activities and service user experiences:

> I'll come next week and find that nothing has been done. What has happened here? It clearly wasn't sent to the right place in the EHR system and then the service user didn't get a visit at all despite the fact that I had promised one. It's unprofessional and embarrassing! I end up being that stupid nurse who promised a visit and didn't follow through and once again, it looks like we nurses don't have control over anything, we don't communicate with each other. That is exactly what the service user says. (Interview, Annika, nurse)

Annika's statement illustrates how digital documentation systems can disrupt established coordination routines, leading to breakdowns in service delivery and professional accountability. This caused frustration, expressed through the phrase "stupid nurse" and reveals emotional impact of being perceived as unreliable or unprofessional. This highlights tensions in HCPs' identity work. They perceived themselves as responsible for providing safe, quality healthcare, using the EHR as a knowledge resource to provide customised care. However, they often conformed to the expected role of simply delivering visits. This influenced their daily tasks and interactions and challenged their professional ethos, compelling them to prioritise resource management, often at the expense of their own needs and traditional care practices.

While the EHR prescribed specific user behaviours such as ticking off predefined tasks and documenting only deviations, observations and interviews revealed that healthcare professionals did not always comply passively with these expectations. Several HCPs subtly reinterpreted the system's constraints. For example, some used comment fields, even when not strictly required such as in the description of wounds, to convey contextually important information or relational nuances. In some cases, a HCPs noted that while they were "supposed to" document only deviations, they occasionally added information "for the next colleague," framing this practice as a professional responsibility rather than adherence to a formal rule. These practices show how professionals mediated system logic through values and care ethics.

# Discussion

The findings indicates that digital documentation systems significantly shape how healthcare professionals understand and perform their roles. Through predefined structures, standardised language, and role division, professionals are positioned as efficient service providers rather than autonomous caregivers. While these systems support coordination and oversight, they also limit flexibility and reduce attention to relational aspects of care. The following sections discuss how these dynamics affect professional autonomy, everyday practices, and communication in municipal healthcare.

## Health professional autonomy

Professions are anchored in internalised values, expert competencies, and a commitment to independent clinical judgment (Abbott, 1988). However, contemporary governance structures require HCPs to continuously negotiate professional compromises (Solbrekke and Heggen, (2009) A key challenge in this negotiation process is the role of the EHR in reshaping professional autonomy. Petrakaki et al. (2016) argue that EHRs not only interact with but actively transform professional work, redefining the boundaries of autonomy and decision-making. Research further highlights the broader implications of EHR implementation. These systems introduce new responsibilities for HCPs, including ethical dilemmas in health information management (Salminen-Karlsson & Golay, 2022), tensions between macro-level policy goals and professional micro-level practices (Findikoglu & Watson-Manheim, 2016), and the role of technology in shaping attitudes toward administrative initiatives (Yoo et al., 2022). Together, these studies underscore how digital documentation systems are not merely administrative tools but active agents in restructuring professional identity and work dynamics. Our findings contribute to this body of knowledge by demonstrating that digital documentation functions not just work as a passive record-keeping tool but as an active mechanism of organisational regulation and control. Technological design of EHR embeds specific managerial priorities, a controlled vocabulary, and a rigid temporal structure, transforming documentation into a mechanism of professional identity regulation. As a result, HCPs experience a progressive erosion of professional autonomy, as decision-making regarding care trajectories becomes increasingly constrained by pre-defined templates and efficiency imperatives. Öresland (2011) conceptualises home healthcare as an "endless journey," emphasising the fluid and unpredictable nature of patient care. Similarly, our findings illustrate how HCPs must navigate unpredictable patient needs while operating within the restrictive framework of digital documentation. Despite their professional expertise, HCPs are compelled to adapt to structural limitations that sets managerial oversight over clinical expertise. The tension between professional judgment and bureaucratic constraints underscores the dual role of digital documentation: as both an enabler of administrative control and a barrier to flexible, patient-centred care.

Moreover, our findings underscore how EHR systems structure professional identity by shaping what aspects of care are rendered visible. HCPs engage in significant “invisible work” (Allen, 2015), including undocumented problem-solving, relational engagement, and adaptive decision-making, to maintain care quality within digital constraints. While some professionals strategically resist rigid digital documentation by using deviation categories to capture narratives that fall outside the norm, others respond with passive compliance, marking visits as delivered without further elaboration. This duality reflects a broader negotiation of professional identity in an era increasingly dominated by digital regulation. Invisible work helped HCPs preserve professional values and navigate EHR-imposed compromises. Thus, digital documentation emerges as a site of tension between technological efficiency and the humanistic dimensions of healthcare, pointing to the need for systems that better accommodate professional ethics and expertise, communicative nuance, and clinical complexity. As Alvesson and Willmott (2002) argue, identity regulation is always met with identity work, through which HCPs interpret, negotiate, and sometimes subvert

regulatory efforts. In our study, HCPs exercised agency within constrained conditions, seeking to maintain care values and collegial obligations even when these fell outside the system's narrow logic.

## Data registration or care communication?

A central tension in digital documentation is the shift from care-centred communication to data-driven registration, as demonstrated in previous studies on digital documentation in Danish municipal EHRs (Duval Jensen et al, 2023a; 2023b). HCPs often prioritised marking services as completed over documenting nuanced clinical and care narratives. This aligns with broader trends of datafication in healthcare, where administrative demands shape documentation priorities (Wallenburg & Bal, 2019). HCPs perceive non-clinical data entry as "meaningless work," frequently adjusting recorded data to align with organisational requirements (Hoyer and Wadmann, 2020). Our study supports these findings by demonstrating that digital documentation often prioritises data capture over substantive care communication. HCPs exhibited pragmatic adaptation strategies, such as selectively documenting information when time permitted and occasionally omitting entries under pressure. Despite this, they relied heavily on EHRs for care coordination, recognising their value in tracking patient trajectories and ensuring continuity of care. Laukvik and colleagues (2023) emphasise that information-sharing strengthens teamwork in healthcare, particularly in elderly care settings where complex needs require seamless communication. Similar, Gao and colleagues (2023) underscore the role of effective documentation in facilitating interdisciplinary collaboration, reinforcing the critical function of communication in digital healthcare systems. Taken together, these studies support our findings by highlighting that EHRs, despite their constraints, play a critical role in supporting interdisciplinary collaboration and care coordination. Our findings indicate that, despite operating within a system largely designed around task efficiency and standardisation, HCPs make active use of the EHR to uphold their professional responsibilities and sustain collaboration across disciplines. Thus, digital documentation emerges not only as a mechanism of organisational control, but also as a crucial communicative infrastructure that supports care coordination and interdisciplinary teamwork.

## Strengths and limitations

A strength of this study lies in its broad empirical base, which combines interviews and field observations. This methodological mix allowed us to capture both articulated experiences and more implicit processes of identity regulation within the case (Stake, 1995). The integration of identity regulation theory (Alvesson & Willmott, 2002) with digital health perspectives (Paring et al., 2017) enabled a nuanced analysis of how professional identity is shaped through both discourse and digital infrastructures. However, the case-specific nature of the data limits generalisability. Even though the findings are based on a single case study conducted in a specific context, they offer conceptual insights that may be transferable to similar healthcare settings undergoing digital transformation.

# Conclusion

This study demonstrates that digital documentation in Danish municipal healthcare operates as a subtle yet powerful mechanism of identity regulation. Through standardised language, predefined roles, and efficiency-oriented structures, EHR systems shape how HCPs perceives and perform their work, often positioning them as resource managers rather than autonomous decision-makers. At the same time, professionals engage in identity work to navigate and occasionally resist these constraints, preserving care values, performing invisible work, and using the system strategically to support continuity and quality. Digital documentation thus emerges as both a tool of organisational control and a site of professional negotiation. To strengthen future digital documentation systems, we suggest co-designing new documentation initiatives or revising existing ones with healthcare professionals, providing support for narrative documentation, and increasing system flexibility to ensure that digital infrastructures enable rather than constrain relational and context-sensitive care.

# Declarations

## Funding

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## Ethical approval

Under Danish law, formal ethical approval of this study was not required, and ethical considerations followed the fundamental principles for research given in the Helsinki Declaration (World Medical Association, 2013). The participants received verbal and written information about the purpose of the study, their right to withdraw, and the confidentiality of the data provided. Furthermore, the study has been registered with the Danish Data Protection Agency [ID no: 2016-051-000001].

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# References


Abbott, A. (1988). *The system of professions: an essay on the division of expert labour*. University of Chicago Press.

Abma, T. A., & Stake, R. E. (2014). Science of the Particular: An Advocacy of Naturalistic Case Study in Health Research. *Qualitative health research*, *24*(8), 1150-1161. https://doi.org/10.1177/1049732314543196

Allen, D. (2015). *The invisible work of nurses: hospitals, organisation and healthcare*. Routledge. https://doi.org/10.4324/9781315857794

Alvesson, M., & Willmott, H. (2002). Identity Regulation as Organizational Control: Producing the Appropriate Individual. *Journal of management studies*, *39*(5), 619-644. https://doi.org/10.1111/1467-6486.00305

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: study design and implementation for novice researchers. *Qualitative report*, *13*(4), 544-559.

Bresnen, M., Hodgson, D., Bailey, S., Hassard, J., & Hyde, P. (2019). Hybrid managers, career narratives and identity work: A contextual analysis of UK healthcare organizations. *Human relations (New York)*, *72*(8), 1341-1368. https://doi.org/10.1177/0018726718807280

Croft, C., Currie, G., & Lockett, A. (2015). The Impact of Emotionally Important Social Identities on the Construction of a Managerial Leader Identity: A Challenge for Nurses in the English National Health Service. *Organization studies*, *36*(1), 113-131. https://doi.org/10.1177/0170840614556915

Department of Economic and Social affairs. (2024). *United Nations E-Government Survey 2024-Accelerating digital transformation for sustainable development*. https://desapublications.un.org/sites/default/files/publications/2024-09/%28Web%20version%29%20E-Government%20Survey%202024%201392024.pdf

Duval Jensen, J., Ledderer, L., & Beedholm, K. (2023a). How digital health documentation transforms professional practices in primary healthcare in Denmark: A WPR document analysis. *Nursing inquiry*, *30*(1), e12499-n/a. https://doi.org/10.1111/nin.12499

Duval Jensen, J., Ledderer, L., Kolbæk, R., & Beedholm, K. (2023b). Fragmented care trajectories in municipal healthcare: Local sensemaking of digital documentation. *Digital Health*, *9*, 20552076231180521. https://doi.org/10.1177/20552076231180521

European Commission. (2020). *Digital Economy and Society Index 2020: European Analysis*. E. Commission. https://digital-strategy.ec.europa.eu/en/policies/desi

Findikoglu, M., & Watson-Manheim, M. B. (2016). Linking macro-level goals to micro-level routines: EHR-enabled transformation of primary care services. *Journal of Information Technology*, *31*(4), 382-400. https://doi.org/10.1057/s41265-016-0023-5

Galasiński, D., & Ziółkowska, J. (2022). Managing the communication channel. Discursive representations of clinical communication in forensic psychiatric reports. *Qualitative Health Communication*, *1*(1), 134-150. https://doi.org/10.7146/qhc.v1i1.130374

Gao, H., Yous, M.-L., Connelly, D., Hung, L., Garnett, A., Hay, M., & Snobelen, N. (2023). Implementation and impacts of virtual team-based care planning for older persons in formal care settings: A scoping review. *Digital Health*, *9*, 20552076231151567. https://doi.org/10.1177/20552076231151567

Gilster, S. D., Boltz, M., & Dalessandro, J. L. (2018). Long-Term Care Workforce Issues: Practice Principles for Quality Dementia Care. *The Gerontologist*, *58*(suppl_1), S103-S113. https://doi.org/10.1093/geront/gnx174

Greenhalgh, T., Potts, H. W. W., Wong, G., Bark, P., & Swinglehurst, D. (2009). Tensions and Paradoxes in Electronic Patient Record Research: A Systematic Literature Review Using the Meta-narrative Method. *The Milbank quarterly, 87*(4), 729-788. https://doi.org/10.1111/j.1468-0009.2009.00578.x

Hjort, K. (2012). *Det affektive arbejde* [The affective work] (1st ed.). Samfundslitteratur.

Hoeyer, K., & Wadmann, S. (2020). 'Meaningless work': How the datafication of health reconfigures knowledge about work and erodes professional judgement. *Economy and society*, *49*(3), 433-454. https://doi.org/10.1080/03085147.2020.1733842

Jensen, M. C. F., & Muhr, S. L. (2020). Performative identity regulation in rehabilitative home care work: an analysis of how experts' embodied mediation of the managerial ideology "activates" new frontline identities. *Culture and Organization*, *26*(3), 211–230. https://doi.org/10.1080/14759551.2019.1566234

Justesen, L., & Plesner, U. (2024). Invisible Digi-Work: Compensating, connecting, and cleaning in digitalized organizations. *Organization Theory, 5*(1). https://doi.org/10.1177/26317877241235938

KL - Local Government Denmark. (2019). *Common Language Platform - the method handbook vs. 1.61*. KL. https://fs3.nu/filer/Dokumenter/Metode/FSIII-Metodeh%C3%A5ndbog.pdf?t=1681887592

Kvale, S., & Brinkmann, S. (2015). *Interview : det kvalitative forskningsinterview som håndværk* [Interviews: Learning the Craft of Qualitative Research Interviewing] (3rd ed., 1st printing). Hans Reitzel.

Landis, T. T., Severtsen, B. M., Shaw, M. R., & Holliday, C. E. (2020). Professional identity and hospital-based registered nurses: A phenomenological study. *Nursing forum (Hillsdale)*, *55*(3), 389-394. https://doi.org/10.1111/nuf.12440

Laukvik, L. B., Rotegård, A. K., Lyngstad, M., Slettebø, Å., & Fossum, M. (2023). Registered nurses' reasoning process during care planning and documentation in the electronic health records: A concurrent think-aloud study. *Journal of clinical nursing*, *32*(1-2), 221-233. https://doi.org/10.1111/jocn.16210

Paring, G., Pezé, S., & Huault, I. (2017). 'Welcome to the whiteboard, the new member of the team': Identity regulation as a sociomaterial process. *Organization (London, England)*, *24*(6), 844-865. https://doi.org/10.1177/1350508416686407

Petrakaki, D., Klecun, E., & Cornford, T. (2016). Changes in healthcare professional work afforded by technology: The introduction of a national electronic patient record in an English hospital. *Organization*, *23*(2), 206-226. https://doi.org/10.1177/1350508414545907

Salminen-Karlsson, M., & Golay, D. (2022). Information systems in nurses' work: Technical rationality versus an ethic of care. *New technology, work, and employment*, *37*(2), 270-287. https://doi.org/10.1111/ntwe.12231

Solbrekke, T. D., & Heggen, K. (2009). Responsibility of Nursing -- From Professional Moral Responsibility to Technical Accountability?. *Tidsskrift for Arbejdsliv*, *11*(3), 49-61.

Stake, R. E. (1995). *The art of case study research*. Sage.

Thompson, W., & McNamara, M. (2022). Revealing how language builds the identity of the advanced nurse practitioner. *Journal of clinical nursing*, *31*(15-16), 2344-2353. https://doi.org/10.1111/jocn.16054

Wadel, C. (2014). *Feltarbeid i egen kultur* [Fieldwork in own culture] (Rev. ed., 1st printing). Cappelen Damm Akademisk.

Wallenburg, I., & Bal, R. (2019). The gaming healthcare practitioner: How practices of datafication and gamification reconfigure care. *Health Informatics Journal*, *25*(3), 549-557. https://doi.org/10.1177/1460458218796608

Watson, A. R. (2016). Impact of the digital age on transforming healthcare. In C. A. Waever, M. J. Ball, G. R. Kim, & J. M. Kiel (Eds.), *Healthcare information management systems* (4. ed., pp. 219-233). Springer International Publishing. https://doi.org/10.1007/978-3-319-20765-0_13

Yoo, S., Lim, K., Jung, S. Y., Lee, K., Lee, D., Kim, S., Lee, H.-Y., & Hwang, H. (2022). Examining the adoption and implementation of behavioral electronic health records by healthcare professionals based on the clinical adoption framework. *BMC medical informatics and decision making*, *22*(1), 1-210. https://doi.org/10.1186/s12911-022-01959-7

Öresland, S., Määttä, S., Norberg, A., & Lützén, K. (2011). Home-based nursing: An endless journey. *Nursing ethics*, *18*(3), 408-417. https://doi.org/10.1177/0969733011398098

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