QUALITATIVE HEALTH COMMUNICATION
VOLUME 5, ISSUE 1, 2026
ISSN: 2597-1417

Stabilizing the use of video consultations through legitimacy tactics: A qualitative study in general practice in Denmark

Johannes van den Heuvel[1,2]
Elisabeth Assing Hvidt[3]
Janus Laust Thomsen[1]
Camilla Hoffmann Merrild[1]

NAME OF DEPARTMENTS AND INSTITUTIONS:

[1] Department of Clinical Medicine, Center for General Practice, Aalborg University, Denmark

[2] Copenhagen Academy for Medical Education and Simulation (CAMES), Denmark

[3] Department of Public Health, Research Unit of General Practice, University of Southern Denmark, Denmark

CORRESPONDING AUTHOR:

Johannes van den Heuvel. E-mail: jvdheu@dcm.aau.dk.

QHC Qualitative Health Communication

ABSTRACT

Background: Video consultation in general practice in Denmark is part of a political ambition to increase efficiency and stretch resources by using technology in healthcare. Adoption remains slow, indicating a gap between policy expectations and clinical practices. **Aim:** As video consultations have become a permanent consultation modality, this article investigates how video consultations are stabilized and legitimized in clinical practices. **Methods:** This article draws on 15 semi-structured interviews with Danish general practitioners. The data were analysed abductively, focusing on how general practitioners adopted video consultations. In the process, we identified general practitioners' need to justify video consultations. The concept of legitimacy tactics was applied, understood through Actor-network Theory. **Results:** We identified five legitimacy tactics that general practitioners enacted to stabilize video consultations: self-care, patient autonomy, selective triage, hybrid consultation, and communicative techniques. **Discussion:** Video consultation requires legitimacy to align political expectations and clinical realities, and the legitimacy tactics that general practitioners use often work in combination. **Conclusion:** The legitimacy tactics enacted by general practitioners is an ongoing process, but by establishing meaningful use of video consultation through legitimacy tactics, its role as a care and medical technology may move towards stabilization.

KEYWORDS

Actor-network theory, general practice, legitimacy tactics, telehealth, video consultations.

BIOGRAPHIES

Johannes van den Heuvel is Postdoc at the Copenhagen Academy of Medical Education and Simulation. He has a background in Techno-anthropology and general practice research. His work focuses on medical anthropology and healthcare technologies researching the negotiation and mediation of technologies and digital tools in healthcare settings.

E-mail: jvdheu@dcm.aau.dk. ORCiD: 0000-0002-3840-8963.

Elisabeth Assing Hvidt is associate professor at the University of Southern Denmark, Research Unit of General Practice. She has a background in sociology of religion and works at the intersection of the health sciences,

the humanities and the social sciences, predominantly using qualitative methods to study relational dynamics in healthcare and the ways digital technologies and AI shape care practices, and the experiences of patients and healthcare professionals.

E-mail: ehvidt@health.sdu.dk. ORCiD: 0000-0003-3762-8478.

Janus Laust Thomsen is a general practitioner, Professor, and Director of the Center for General Practice at Aalborg University. His research spans primary care, quality improvement, and health services research, with particular focus on patient-centered care, digital health technologies, clinical decision-making, and the organization of general practice. He combines extensive clinical experience with leadership in national and international research initiatives.

E-mail: jlt@dcm.aau.dk. ORCiD: 0000-0002-0745-6815.

Camilla Hoffmann Merrild is an anthropologist and Associate Professor at the Center for General Practice, Aalborg University. She works at the intersection of medical anthropology, primary care, and critical public health. Her research focuses on how families living in socially disadvantaged situations interact with health care systems, with particular attention to the ways symptom experiences and diagnostic practices are shaped and negotiated.

E-mail: chm@dcm.aau.dk. ORCiD: 0000-0002-2444-3311.

Introduction

In Denmark, there is a general political ambition to increase efficiency and stretch existing resources by using more technology in healthcare environments (Bruun Jensen & Ross Winthereik, 2003). This longstanding ambition is also reflected more recently in the process of implementing video consultations into Danish general practice (Dansk Selskab for Patientsikkerhed, 2021; Indenrigs- og Sundhedsministeriet, 2024). Video consultations were first introduced in Denmark in 2020 as a temporary measure to curb COVID-19 (RTLN & PLO, 2020). Reflecting Danish health authorities' push for digitalization, video consultations initially carried a higher reimbursement fee than physical consultations. This disparity, designed to incentivize adoption, was eliminated in 2025. In 2022, video consultations were integrated into the collective agreement between Danish general practice organizations (PLO & RTLN, 2021) and by 2025, they became a mandatory consultation modality, requiring all general practitioners (GPs) to offer video consultations (PLO, 2022).

The wider implementation of video consultations in general practice speaks to a larger discourse of a challenged primary sector, characterized by time pressure, extended responsibilities and more patients with comorbidities (Simonsen et al., 2024). Although rarely explicitly mentioned in political discourses on implementation of video consultations in general practice, time efficiency is often highlighted as a key advantage (van den Heuvel et al., 2024). Video consultations are believed to free up time for prioritizing patients with greater needs (Vælg Klogt, 2024), and to improve accessibility in areas with a shortage of GPs (Jessen, 2025). This political communication is often directed at patients and disseminated through the broader national discourse, e.g., by actors involved in "Choosing Wisely", an international campaign with the Danish iteration consisting of Danish Patients and Danish Medical Societies (Vælg Klogt, 2024). Video consultations have thereby gained political momentum in Denmark as a proposed solution to systemic healthcare challenges. This promissory discourse underpins the forthcoming healthcare reform, which introduces a "digital-first" initiative, granting patients the right to be digital patients with enhanced access to digital healthcare provision (Indenrigs- og Sundhedsministeriet, 2024; Marent & Henwood, 2021).

Despite political support and initial financial incentives, adoption of video consultation in Danish general practice remains low. Video consultation use after the COVID-19 pandemic has dropped to 1.4% of all patient contacts (Jessen, 2025), revealing a gap between policy ambitions and local clinical practices. Furthermore, throughout political statements (Jungersen, 2020) and in the academic literature, video consultations are continuously compared to other consultation forms (Greenhalgh et al., 2022; Wanderås et al., 2023), which suggests that video consultation is still a new actor within general practice without a stabilized role.

In this paper, we aim to explore how video consultations, once incentivized through higher fees and now politically mandated, are adopted and stabilized in local clinical practice. To do this, we focus on how legitimacy tactics have emerged as part of an overall legitimacy work.

We draw on Treviño et al. (2014) who, using grounded theory, developed the concept legitimacy tactics to describe and explain how the new role of Ethics and Compliance Officers in organizations gained legitimacy through work and maneuvers. We see

similarities between the implementation of a new professional role in established organizations and video consultations, in the sense that both face external pressure for implementation, without preestablished internal support, which creates a need for internal legitimization through tactical work within the local network (Treviño et al., 2014). By borrowing the terminology of legitimacy tactics, we focus on the actions that go into building and enacting legitimacy, i.e. tactics that allow for more or specific video use. Legitimacy work, on the other hand, is broader and encompasses the ongoing, continuous process of building, negotiating, sustaining, and repairing legitimacy over time.

To account for the socio-material complexity of the process, we integrate legitimacy tactics with Actor-network Theory (ANT), framing legitimacy as a dynamic translation where human (GPs, staff, patients) and non-human actors (the video technology) negotiate roles and stabilize relations (Law, 2008). Our ANT anchoring inspires our approach to understanding how video consultations are adopted and stabilized as a new consultation modality within general practice, looking at GPs' legitimacy tactics for video consultations.

We specifically tether legitimacy tactics to the ANT concept of translation developed by Michel Callon (Callon, 1984). A translation is compounded of several moments and, in its complete form, is a collective agreement and mobilization of actors to act and achieve a collective goal (Callon, 1984). The need to legitimize shows similarities with the translation moments of interessement and enrolment. Callon defines the moment of interessement as the series of actions that stabilize and lock the relations between actors toward a shared path, while enrolment is these same actors acting aligned with the newly established network (Callon, 1984). In our analysis, this path would be establishing video consultations as a stable and viable consultation form in general practice, through legitimacy tactics, i.e. actions that lock relations, set aims for using video consultations, and use them in a way that promotes their future use. Moments of interessement and enrolment are only subsections of a translation process, which in this instance would be the stabilization of video consultations' role in general practice.

By integrating legitimacy tactics with ANT, these tactics can be aimed at all relevant actors. We purposefully look for tactics that engage all involved actors, in the aim of creating interessement and enrolment of the clinic staff, other GPs, patients, and the technology, as all are involved in establishing video consultations as legitimate locally. Since we present video consultations as still finding their footing as actors within a network, our analysis does not present the complete translation process, i.e., the situation when video consultation has found a stable role in the ecology of care.

In the following, we examine the literature on the perceived limitations of video consultations, which may explain, to a large degree, the gap between policy expectations and contextual realities of clinical practice, and that simultaneously motivates the need for legitimacy tactics among GPs and clinic staff.

Perceived limitations of video consultations among users

Video consultations are used to transfer visual and audio data, a data transfer of only two senses that has its obvious limitations (Osman et al., 2018). However, the use of video consultations in general practice is challenged by several other factors which

might inhibit their uptake. According to Kofod et al. (2024), patients feel more relaxed in their homes during video consultations than in the clinic. However, they also find the interactions mediated through video consultations more superficial. Similarly, other studies show how patients perceive encounters with their GP during video consultations as more impersonal, experiencing a diminished sense of presence from their GP (Assing Hvidt et al., 2025; van den Heuvel et al., 2024). This resonates with a widespread perception of telecare as cold and distant , a perception that Jeanette Pols (2012) has nuanced, arguing that telehealth can also intensify caring relations depending on use cases.

From a GP perspective, video consultations have been perceived as inhibiting the development of personal connections and are therefore found challenging when meeting new patients (Gomez et al., 2021). According to Gomez et al. (2021), the lack of personal connection when using video consultations is explained by the lack of visual clues and the absence of physical examination. Nordtug et al. (2022) found that GPs felt uncertainty during the early implementation of video consultations due to difficulties in reading the patients' emotions in the video feed and fear of missing out on important clinical details.

Research on users and non-users of video consultations among GPs showed that non-users shared an understanding of video consultations as "compromising occupational values" (Lüchau et al., 2023: 04). By this, GPs meant that video consultations were too efficient and "cold" a technology to uphold the social interpersonal standard that they expected themselves to deliver (Lüchau et al., 2023). Video consultations were also perceived by GPs to impact the social presence between themselves and their patients in a way that influenced the act of caring (Lüchau et al., 2024). It has also been pointed out that using video consultation to consult with patients was perceived as limiting GPs' range of actions, and without physicality, more extensive examinations were difficult to perform (Wanderås et al., 2023). Moreover, and supporting the above studies, video consultations have been found to be shorter with fewer subjects per consultation compared to physical consultations (Gold et al., 2021; Koch & Guhres, 2020).

Methods

This article is based on semi-structured interviews with 15 GPs across 10 clinics. In the recruitment process, we made use of purposive sampling (Campbell et al., 2020). Our interlocutors should work as physicians in general practice and use video consultations with their patients. We avoided interlocutors with preexisting connections to the authors to avoid biases, e.g., social desirability (Bispo, 2022). GPs were recruited through the authors' professional networks of GPs, who reached out to their social/professional network by distributing a link to a questionnaire developed in RedCap. This approach was chosen to find interlocutors twice removed from the research group. The questionnaire served to sign up for study participation and to comply with GDPR.

The first author conducted all interviews, following a semi-structured interview guide (DiCicco-Bloom & Crabtree, 2006; Jamshed, 2014). The interviews focused on the GPs' accounts of their experiences with and rationales for using video consultation in

general practice, and the questions would revolve around "why use video consultations?" or "what do video consultations offer in regards to general practice?", usually asking for concrete examples. The interviewer would follow these stories and examples, in a repetitive cycle of questions/answers, and examples. All interviews were conducted in Danish, and the first author later translated the quotes used.

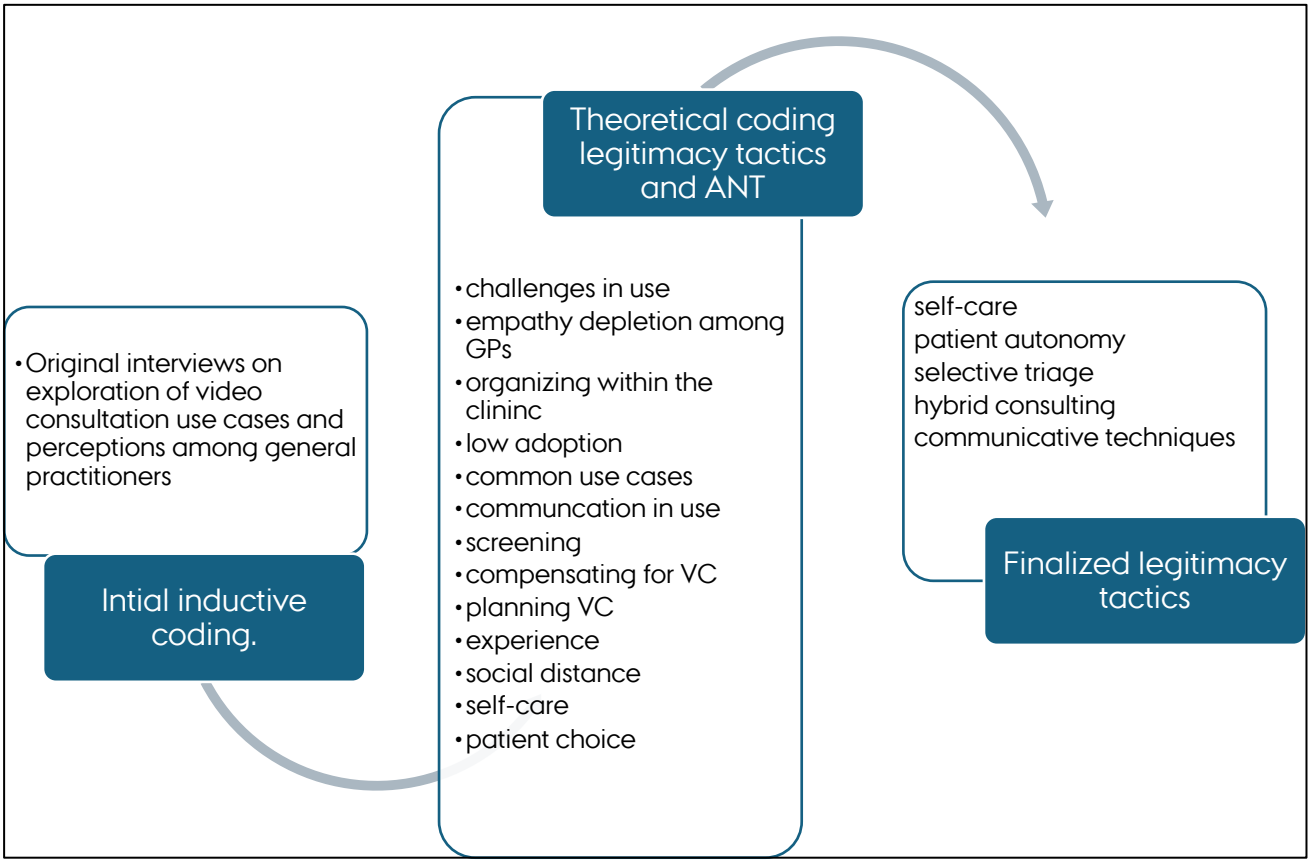
Table 1. *Table of interviewed GP.*

nr.	Educational status	Type of interview	Clinic nr.	Region	Length of interview (in minutes)
GP1	GP in training	Face-to-face	1	Central Denmark Region	47
GP2	GP specialist	Face-to-face	2	Region of Southern Denmark	65
GP3	GP specialist	Face-to-face	3	Region of Southern Denmark	68
GP4	GP specialist	Face-to-face	1	Central Denmark Region	62
GP5	GP specialist	Face-to-face	4	Central Denmark Region	42
GP6	GP specialist	Face-to-face	5	Region of Southern Denmark	63
GP7	GP specialist	Face-to-face	6	Region Zealand	74
GP8	GP in training	Face-to-face	7	Central Denmark Region	68
GP9	GP specialist	Face-to-face	4	Central Denmark Region	53
GP10	GP in training	Video	8	Central Denmark Region	63
GP11	GP in training	Video	3	Region of Southern Denmark	54
GP12	GP specialist	Video	9	Central Denmark Region	70
GP13	GP specialist	Video	10	Central Denmark Region	75
GP14	GP specialist	Video	11	North Denmark Region	30
GP15	GP specialist	Video	5	Region of Southern Denmark	35

The initial interviews were conducted between May 2022 and February 2023. Nine interviews were conducted face-to-face, and one via video. To secure the necessary information power (Malterud et al., 2016), a second round was therefore initiated, inviting additional GPs who could only commit to a video interview. The video interviews were conducted between March and May 2023, and five additional GPs were interviewed. The video element was used as an example and a way to bring the actual experience of a video consultation into the interviews.

All interviews were transcribed and coded by the first author. The data were coded in a QDAS program (NVivo 14). The empirical data were analyzed abductively (Vila-Henninger et al., 2024; Ryan & Bernard, 2003), focusing on how general practitioners adopted video consultations and reacted to their limitations. This was done through initial inductive coding, followed by additional deductive coding. In the initial inductive coding, we identified GPs' and staff's need to justify the ongoing use of video consultation despite perceived limitations. To explain this, we applied Treviño et al.'s (2014) concept of legitimacy tactics, strategies to align practices to institutional norms, to the initial codes and analyzed these through ANT, which allowed us to establish the theme of legitimacy and examine how actors collaboratively sustain video consultation legitimacy. The coding process can be seen here:

Figure 1. *Coding structure for the abductive analysis.*



We identified five distinct manifestations of legitimacy tactics that are presented in the coming section.

Results

Legitimizing video consultations with self-care as a tactic

The first identified legitimacy tactic, tied to video consultation use among the participating GPs, was self-care, emphasizing how use of video consultations might positively impact the GPs' own well-being. This tactic becomes particularly relevant in a profession characterized by a narrative of increased workload, administrative pressures, and concerns about empathy fatigue and burnout. Thus, by using a consultation type characterized by the above-mentioned interactional limitations (e.g., being more superficial, impersonal, and of a shorter duration than physical consultations), GPs adopted video consultations to manage a demanding work environment.

Some of the GPs mentioned that using video consultations in their daily work as a supplement to physical consultations reduced the perceived challenges of managing a daily emotional overload, including interactions with patients. For example, GP8 explained:

> 'I don't feel the same empathy fatigue when I've had two or three video conversations in a day compared to when I've had no videos, and it [working a full day of physical consultations] takes a

> lot of my energy and empathy. When I have them over the screen as opposed to in the clinic, I'm a bit more protected' – GP8

GP8 in the above excerpt describes the use of video consultation as energy- and empathy-saving, at least in the short term. GP8 furthermore linked video consultation use to being more present at home after a long workday. Thus, adopting video consultations adds meaning on a personal level by enabling her to prioritize her own well-being. As other GPs noted, using video consultations helped prevent burnout and sustain a work-life balance, allowing them to provide care-work longer. Based on this logic, self-care via video consultation can be seen as a proactive tactic that grants legitimacy and relevance to the consultation modality for GPs. While the self-care legitimacy tactic primarily resonates with GPs, as they experience video consultations to ease their workday, it serves to entice other GPs as well. Using this tactic, alignment between users and non-users within the GP profession is strived for.

However, other GPs felt more ambivalent about self-care through video use. They were considering the possible interactional and ethical implications of being distant, both physically and socially. One GP reflected on her own video practice, acknowledging room for improvement:

> 'I can be a little relieved when I'm swamped, and there are some video consultations, which might be to our advantage. And it may not always be the case, but patients find it a little easier to stay on track in a video consultation. And then I have to look inwards... I also have to leave room for it to be about other things than just what they bring up. But I find it easier to cut out the peripheral stuff on a video. It's not that I do it, but the patient is more disciplined on video.' - GP3

While taking emotional breaks is standard in many professions, GP3 frames the break that video consultations provide as a dilemma: preferences in how to meet patients cannot be governed solely by the clinician's need for respite. GP3 advocated for a reflective practice, "looking inwards", redirecting video consultations toward addressing more than just the reason described for contact. This might add professional legitimacy to a tactic perceived as too self-oriented.

Summing up, while self-care provided legitimacy and meaning for some GPs using video consultations, the above quote also revealed a need for additional legitimacy tactics to address relational dynamics with patients and clinic staff. The self-care tactic does not directly establish legitimacy with patients but serves more to influence professional peers.

Legitimizing video consultations with patient autonomy as a tactic

The second identified legitimacy tactic employed by GPs in adopting and stabilizing video consultations was patient autonomy, manifested through patient demand for video consultation. This was not due to overwhelming demand but because the idea of patient demand - and specifically, patient autonomy - served as a justification. While video consultation might be a secondary choice from the GPs' perspective, patient demand legitimized its use. By adopting this ethical value, GPs were able to legitimize their use and offer of video consultations. Including patient autonomy and patients' choice of consultation modality as influential ethical values in general practice afforded the social responsibility to be shared between patient and GP. The rationale for offering video consultations was straightforward: GPs recognized the benefits for patients:

> 'In this clinic, we also believe that we help the patients tremendously because sometimes you feel a little guilty when you must ask a patient to come up to us. They have taken half an hour or an hour off work before they come up to us. Then they sit and wait for half an hour because we are running late. Then we look at that mole, which takes 34 seconds, and say: "it looks fine. Goodbye!"' – GP6

In the above quote, GP6 gives an example of how visiting general practice can entail an unbalanced time use between the patient and the GP, which calls for efficiency and flexibility in access. Efficiency was framed as a patient benefit by GP6, and it was considered positive to enable this benefit, with GPs trusting patients to make appropriate choices for themselves. Patient autonomy as a legitimacy tactic relied on a continuing process because patients must also show they can handle this autonomy in consultation choices. On a general note, the GPs expressed a high level of trust in their patients, and patients were considered to understand their own needs and desires best:

> 'I think they [the patients] are very good at assessing what is relevant and what can be done on video... some of the biases that... many doctors had in the beginning: 'Patients can't figure it out.' It's pretty rare that I have to say, "We'll have to figure that out." So, they are good at assessing for themselves what is best in relation to the medium.' – GP2

GP2 explained that he had been pleasantly surprised by the variety of patients and issues he had seen using video consultations, including patients in their late nineties and alcohol-dependent patients, and most of them had shown an ability to assess video consultation capabilities well. Sometimes, however, there were situations where a video consultation turned out to be unsuitable. Still, in these cases, it was often stressed how GPs and their patients adapted and moved forward as part of their longitudinal relationship. "They might also say that: 'next time I would actually like to come in because I think it's a bit difficult over video'" – GP8. This showed that video consultations required fitting, and rejection of video consultations in specific situations did not invalidate video use in general.

We frame patient autonomy as a clinic-oriented legitimacy tactic as it is enacted between patient and clinic but serves the interessement of actors within the clinic and the profession of general practice. This is exemplified by GP2's account of initial reservations towards use of video disproven by actual video consultation use. His intention was not to convince more patients but rather to influence other GPs and legitimize his own position towards video consultations.

Legitimizing video consultations with selective triage as a tactic

The third legitimacy tactic employed by the GPs was selective triage, which involved a clinic-wide dialogue on when to recommend or discourage video use among patients. This triage process considered both the patient and the reason for contact, legitimizing video consultations by elevating their success rate and limiting their use to situations where they were expected to work well. It also established legitimacy within clinics by encouraging ongoing dialogue about the appropriate role of video consultations. In the interviews, the GPs expressed how they often used video consultations to assess or quickly treat simple health issues:

> 'If they're too complex, I run into the limitations of not having the patient in the room... we are selective in some way, right? We look at what we think can be solved [in a video consultation], and my secretaries do that too, and they're really good at it' – GP5

By GPs agreeing with their medical secretaries on when to offer video consultations, video consultations became a conscious choice not only for the patient but also for the clinics providing the service. Video consultations offered a more straightforward presentation of the reason for contact, often with only one subject at a time. As the quote showed, selective triage could help decide when to suggest a video for patients with less medical and social complexity. However, it was a prerequisite in adapting to and triaging video consultations that all staff knew which types of patients and cases could fit well into video consultations. This knowledge was a sign that the clinic had a stable understanding of when to use video consultations, and by having an ongoing dialogue on how, with whom, and when to use video consultations, each clinic built up a shared understanding of the legitimacy of video consultation use. This tactic was thereby supported by the continuing process of discussing and evaluating video consultations within the clinic, merging actors, such as the GP and medical secretary, into a singular actor of the clinic, thereby acting as one unit in selective triage situations. The same triage tactic worked when screening bookings of video consultations made online, which also originated from the shared dialogue within the clinic. By having an in-clinic agreement and prioritizing discussion of video consultation use, the rest of the clinic experienced the interessement, i.e., being in alignment on the practice of video consultations. The medical secretaries, nurses, or other staff were enrolled and acted according to the clinic-wide alignment when they helped provide and triage video consultations. There was security and legitimacy in having multiple actors involved and being in agreement when offering video consultations.

Legitimizing video consultations with hybrid consulting as a tactic

The fourth legitimacy tactic identified was hybrid consulting, emerging within the treatment plan where GPs strategically alternated between video and physical consultations. This tactic was favored by most interviewed GPs who regularly used video consultations, as it allowed them to balance efficiency with relational continuity:

> 'Still, there is also an insecurity in whether you manage to get around it all or whether there is something you are missing, which I think seems challenging to balance...that is perhaps also why it's often within slightly longer treatment trajectories that video ends up being used. Where you know that we can always see each other again... physically next time if it goes a little wrong.' - GP8

In the above quote, GP8 highlights how using video consultations can be an ambivalent practice if not applied to the proper consultation subjects and patients. Concerns about missing important details were mitigated when patients were also seen in the clinic, which provided a form of safety netting. Over time, this tactic legitimized video consultations by reducing these concerns. This tactic, however, depended on the GP continuing to offer a hybrid treatment plan, thereby stabilizing video consultation as a quick and flexible option - although not a universal consultation modality.

In a similar vein, some GPs also legitimized video consultations through the time they saved. As GP5 said, "So if you have some quick video consultations, it's obviously a time-saver for me so that I can do something else." This “something else” was often just returning to the scheduled program of the day and caring for other patients. Video consultations were usually quick and used less time than allocated, allowing other patients to reap the benefit from the unused time. Here, video consultations were

legitimized through a zero-sum logic of time: the idea that what is lost in one interaction is balanced in another. Thus, patients who missed out (on empathy, social presence, or time) during video consultations would receive their fair share in future consultations, thereby downplaying the potential negative aspects of video consultations over time.

This practice of exceeding or underutilizing the allocated time was not unique to video consultations, as time balancing between patients also occurred in physical consultations. However, it was much more evident in video consultations due to their shorter duration. This zero-sum logic fitted into the legitimacy tactic by providing a safety net for patients and GPs and ensuring that GP-patient relations and continuity of care were not traded for efficiency. Here, the legitimacy tactic focused not on the individual patient but on the clinic's entire patient population, framing video consultation as an efficient way to be a GP for all patients under the clinic's responsibility.

Legitimizing video consultations with communicative techniques as a tactic

A fifth legitimacy tactic emerged whereby the reduced communicative quality of video consultation was enhanced through good communication techniques. It is necessary to differentiate in terminology, as the communicative tactic consists of several smaller practical techniques. Legitimizing video consultations within the consultation demanded techniques that displayed the GPs' attentiveness, within their care, despite potential communicative deficits. These techniques were employed to limit uncertainty and frame video consultations as a safe tool.

The first practical technique identified was to mimic eye contact. By resizing the video feed from the patient and placing it as close as possible to the webcam, the direction of the GP's eyeline was as near to the camera as possible: "You do not have eye contact. Although I put the video up here to roughly make it like there is eye contact" – GP8. These were attempts to normalize the dynamic in the consultation and make video consultation less distant by compensating for the lack of eye contact, thereby allowing more non-verbal communicative elements and information into the consultations.

Another practical technique was to force small talk, thereby asking relational and social questions to the patient.

> 'On the video, I might comment on something, like 'that's a beautiful painting you have in the background.' I have realized that small talk also builds relationships. But it is just not as intense as if they [the patients] are here physically… Small talk is also something you actively choose to do on video…' - GP6

This technique aimed to build or maintain GP-patient relations and counteract video technologies' mediation towards efficiency and diminished presence, thereby advancing legitimacy by negating the deterioration of relations. Small talk was uncommon in video consultations, unlike physical consultations, and GPs, therefore, needed to force small talk to keep this part of their relationship going. Part of this was to ask more questions in video consultations, as stated by GP5; "I cannot see it, but I can ask about it". While this technique was simple, it demanded a change in communication modality, which aimed to counter uncertainties by promoting

thorough verbal communication. The GP over-verbalized to compensate for the senses that could not relay the patient's information:

> 'So, there is some information that is lost because you are not sitting with the patient… I can't smell if they smoke. I can when I'm sitting with them. It sometimes matters how likely an issue is… If they [the patient] don't say anything about something and sit and smile at me, I might not catch it. That's the limitation of it. But otherwise, there's nothing else to do than to try and articulate [the unsaid].' - GP5

The use of communicative techniques demanded the GPs' attention. Trying to compensate for these senses was challenging and GPs often had to react to minor signs from the patient, which on video were very limited. Doing over-verbalization knowingly and actively helped compensate for the deficits of the video consultation form, thereby limiting uncertainty and legitimizing it as a safer tool within the network of GP-patient-video technology.

This tactic of communicative compensation combines GPs' active efforts to enhance presence and information exchange in video consultations with the need to reduce professional uncertainties. Video consultation gained legitimacy within the clinics and with patients when limitations were explicitly acknowledged and collaboratively addressed through communicative techniques. These techniques were part of the GP's enrolment of patients in the use of video, and, depending on the actual use of video, their purpose as a legitimacy tactic was to fit the video as the right choice to meet the patients' needs.

Discussion

In this article, we have initially presented how the political momentum for video consultations has failed to translate into widespread clinical use, and how there have been no pre-established actors with alliances to speak on behalf of other actors as spokespersons, as classically understood by Michel Callon (1984). This has left local GPs to adopt, adapt, and enact legitimacy tactics to stabilize and find a space for video consultations within the network of general practice, making them responsible for interacting and negotiating interessement and enrolment with the medical secretaries, other GPs, patients, and the technology.

In the above analysis, Treviño et al.'s (2014) concept of legitimacy tactics has guided us in identifying and presenting five legitimacy tactics GPs enact in adopting and stabilizing video consultations in their daily work. These tactics are aimed at involving GP, clinic staff, patients, and the technology in video use and thus to capture the interessement of actors in the video consultation network and lock them into alliances on how and when to use video consultations.

Importantly, however, the tactics presented cannot stand alone. They overlap and need to align all of the actors to legitimize video consultations broadly within each clinic. GPs used self-care as a tactic to motivate themselves and the profession's use of video consultations. Patient autonomy was leveraged as an ethical value to justify clinic-wide adoption of video consultations, fostering interessement among actors. While the selective triage tactic established enrolment with all clinic staff, it also aimed to ensure the best conditions for patients to have a successful experience with video consultations. Planning adoption of video consultation through the hybrid consulting tactic, GPs integrated video consultations as a part of a stable GP-patient relationship

and continuity of care. Lastly, GPs compensated for the communicative limitations of video consultations using communicative techniques as a legitimacy tactic to secure the best possible communication with the patients.

Accepting video consultations as self-care has been identified as a practice among GPs in the work of Lüchau et al. (2024), where participants also describe their actions as egoistic (Lüchau et al., 2024). While it might be self-oriented, we would argue that the relief video consultations afford in terms of avoiding empathy fatigue, at least in the short term, creates personal relevance and, thereby legitimacy for GPs. Self-care entangles with other legitimacy tactics as a reason to stabilize video consultations and relies heavily on the logic that everything that goes around comes around (in regard to care and time), as relief is allowed in restrained quantities and under the right conditions. The self-care tactic also has threads to patient autonomy and selective triage, while it becomes easier to accept self-care when the decision to use video is a shared decision between the GP, the patient and the staff. There is also a clear relation between the legitimacy tactics of hybrid consulting and patient autonomy, as patient autonomy and selective triage become practical ways that video consultations, care, and time are distributed among patients. If patients indicate a willingness to use video, they also take part in choosing less care and less time, a choice the experienced video-patient have been shown to be aware of (van den Heuvel et al., 2024). Legitimizing video consultations through patient autonomy reflects a small step toward ethical values that Dutch philosopher Annemarie Mol (2008) has dubbed the logic of choice and away from ethical values that she has dubbed the logics of care, as the idea of choice is positively valued (Mol, 2008). This is perhaps indicative of a more general shift in Danish healthcare toward providing service rather than care. In our analysis, however, this shift is continually balanced with tactics like hybrid consulting and communicative techniques, to allow for choice but minimize its consequences.

As a newly introduced actor, the video consultation undergoes a process to stabilize connections within networks and become legitimized and known. In this process of fitting and legitimizing video consultations, patients and GPs test the technology's fluidity (De Laet & Mol, 2000), in terms of functions, flexibility, and malleability, to figure out when video consultations are suitable. This fluidity is tested when employing legitimacy tactics, e.g., trusting patients' demands, relying on patient autonomy, or employing adaptive communicative techniques such as small talk and over-verbalization. The limits of what video can do are still unknown until the network tests them.

On a macro level, video consultations may gain institutional legitimacy from their political mandate through the communal agreement that establishes clear funding guidelines for video consultations. This form of legitimacy is further advanced through the digital-first initiative and the proposed right to be a digital patient (Indenrigs- og Sundhedsministeriet, 2024). However, as our analysis shows, on a more practical level, these forms of legitimacy have not entirely transferred into the clinical setting. The digital-first initiatives are politically motivated aims that create political legitimacy but appear as top-down decisions within general practices. To become relevant in practice and sustain meaningful implementation, video consultations must be legitimized, meaning that they become medically and professionally relevant for healthcare professionals and patients. This legitimacy can only be established in networks where the technology, patients, GPs, and staff are engaged. In some cases, GPs might engage in political networks, be moved by political agreement, or perhaps

use video consultations to be prepared for the future (Lüchau et al., 2023). However, any political initiative needs local spokespersons to create legitimacy in local networks.

As also shown in the literature, GPs are very attentive to the benefits that patients experience when using video, such as short and efficient consultations (Wanderås et al., 2023). In general, there are different motivations for the patient, the technology, and the GP, for using video consultations, and all these become entangled in an alliance, by the actions of interessement (Callon, 1984). The moment of enrolment - defined as the actors acting in and as an alliance - is reinforced and manifested when video consultations are used. With the alliances made through legitimacy tactics, all the actors move to obtain differentiating aims through a shared path, or an obligatory passage point (Callon, 1984) – here from using video consultations. Every use, especially by new actors, helps stabilize video consultations as a legitimate tool in its own right.

Conclusion

Although video consultations are politically mandated, they must still undergo a process of legitimation to be accepted and utilized as a consultation modality within general practice. As demonstrated, this process is multifaceted and enacted by GPs who legitimize video consultation in their local clinical practices through different legitimacy tactics. Personal legitimacy is practiced through self-care as a tactic, whereas professional legitimacy is enacted through patient autonomy, selective triage, hybrid consulting, and communicative techniques used within video consultation. These legitimacy tactics are aimed at legitimizing video consultations among GPs, and other actors such as medical secretaries, the technology, and patients. The integration of video consultations into the broader consultation ecology requires such sustained legitimacy work to secure a stable position within clinical networks and to mediate the disjunction between policy expectations and everyday clinical practice. Through these processes, the challenges inherent to video consultations are not eliminated but are instead mitigated, and by establishing meaningful practices around their use, the role of video consultations as a viable care and/or medical technology may ultimately be stabilized.

Declarations

Ethical approval

The North Denmark Region Committee on Health Research Ethics has deemed that this research (2022-000764) does not need approval, based on Danish standards for qualitative data in healthcare.

Funding

This research is funded by Sygeforsikringen Danmark (2020–0117) and the Research Fund for General Practice (1398791).

Disclosure of AI use

Artificial intelligence (AI)

During the preparation of this article, the author(s) used Grammarly in order to improve readability. After using this tool, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the article.

References

Assing Hvidt, E., Kofod, F. G., van den Heuvel, J., & Scheffmann-Petersen, M. (2025). The obscured face in video consultations. A Levinasian analysis. *Medicine, Health Care and Philosophy, 28*, 461-472, https://doi.org/10.1007/s11019-025-10271-w

Bispo, J. P. (2022). Social desirability bias in qualitative health research. *Revista De Saúde Pública, 56*, 101. https://doi.org/10.11606/s1518-8787.2022056004164

Bruun Jensen, C., & Ross Winthereik, B. (2003). Political and moralising moments: on visions of IT in Danish health care. *Information Technology & People, 15*(3), 227–241. https://doi.org/10.1108/09593840210444764

Callon, M. (1984). Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen of St Brieuc Bay. *The Sociological Review, 32*(1_suppl), 196–233. https://doi.org/10.1111/j.1467-954X.1984.tb00113.x

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. *Journal of Research in Nursing, 25*(8), 652–661. https://doi.org/10.1177/1744987120927206

Dansk Selskab for Patientsikkerhed. (2021). *REMOTE – guide til videokonsultationer i almen praksis* [REMOTE – guide to video consultations in general practice]. patientsikkerhed.dk. Retrieved on 18 February 2025 from https://patientsikkerhed.dk/viden/patientsikkerhedsvaerktoejskasse/remote/

De Laet, M., & Mol, A. (2000). The Zimbabwe Bush Pump: Mechanics of a Fluid Technology. *Social Studies of Science, 30*(2), 225–263. https://doi.org/10.1177/030631200030002002

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Gold, K. J., Laurie, A. R., Kinney, D. R., Harmes, K. M., & Serlin, D. C. (2021). Video Visits: Family Physician Experiences With Uptake During the COVID-19 Pandemic. *Family Medicine, 53*(3), 207–210. https://doi.org/10.22454/FamMed.2021.613099

Gomez, T., Anaya, Y. B., Shih, K. J., & Tarn, D. M. (2021). A Qualitative Study of Primary Care Physicians' Experiences With Telemedicine During COVID-19. *Journal of the American Board of Family Medicine, 34*(Suppl), S61–S70. https://doi.org/10.3122/jabfm.2021.S1.200517

Greenhalgh, T., Ladds, E., Hughes, G., Moore, L., Wherton, J., Shaw, S. E., Papoutsi, C., Wieringa, S., Rosen, R., Rushforth, A., & Rybczynska-Bunt, S. (2022). Why do GPs rarely do video consultations? qualitative study in UK general practice. *The British Journal of General Practice, 72*(718), e351–e360. https://doi.org/10.3399/BJGP.2021.0658

Indenrigs- og Sundhedsministeriet. (2024). *Aftale om sundhedsreform 2024* [Agreement on healthcare reform 2024]. Copenhagen, Denmark: Indenrigs- og Sundhedsministeriet. https://www.ism.dk/Media/638682281997250085/01-Aftale-om-sundhedsreform-2024_TILG.pdf

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy, 5*(4), 87-88. https://doi.org/10.4103/0976-0105.141942

Jungersen, D. R. (2020, 6 May). *Videokonsultationer i almen praksis under lup* [Video consultations in general pratice under a magnifying glass]. Ugeskrift for læger. Retrieved on 13 March 2025 from https://ugeskriftet.dk/nyhed/videokonsultationer-i-almen-praksis-under-lup

Koch, S., & Guhres, M. (2020). Physicians' Experiences of Patient-Initiated Online Consultations in Primary Care Using Direct-To-Consumer Technology. *Studies in Health Technology and Informatics, 270*, 643–647. https://doi.org/10.3233/SHTI200239

Kofod, F. G., Christensen, A. S., Hvidt, E. A., Arreskov, A. B., & Guassora, A. D. (2024). Space, time, and presence in video consultations: an interview study in Danish general practice. *BMC Primary Care, 25*(1), 425. https://doi.org/10.1186/s12875-024-02660-6

Law, J. (2008). Actor Network Theory and Material Semiotics. In B. S. Turner (Ed.), *The New Blackwell Companion to Social Theory* (pp. 141–158). Wiley-Blackwell. https://doi.org/10.1002/9781444304992.ch7

Lüchau, E. C., Atherton, H., Olesen, F., Søndergaard, J., & Assing Hvidt, E. (2023). Interpreting technology: Use and non-use of doctor-patient video consultations in Danish general practice. *Social Science & Medicine, 334*, 116215. https://doi.org/10.1016/j.socscimed.2023.116215

Lüchau, E. C., Olesen, F., Atherton, H., Jens Søndergaard, & Elisabeth, A. H. (2024). Caring remotely through 'fitting': Video consultation use in Danish general practice. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 29*(5), 693-711. https://doi.org/10.1177/13634593241306577

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research, 26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Marent, B., & Henwood, F. (2021). *Digital health. Routledge International Handbook of Critical Issues in Health and Illness*. Routledge.

Mol, A. (2008). *The logic of care* (1st ed.). Routledge.

Nordtug, M., Assing Hvidt, E., Lüchau, E. C., & Grønning, A. (2022). General Practitioners' Experiences of Professional Uncertainties Emerging from the Introduction of Video Consultations in General Practice: Qualitative Study. *JMIR Form Res, 6*(6), e36289. https://doi.org/10.2196/36289

Osman, M. A., Schick-Makaroff, K., Thompson, S., Featherstone, R., Bialy, L., Kurzawa, J., Okpechi, I. G., Habib, S., Shojai, S., Jindal, K., Klarenbach, S., & Bello, A. K. (2018). Barriers and facilitators for implementation of electronic consultations (eConsult) to enhance specialist access to care: a scoping review protocol. *BMJ Open, 8*(9), e022733. https://doi.org/10.1136/bmjopen-2018-022733

PLO. (2022). *Overenskomst om almen praksis 2022* [Collective agreement on general practice 2022]. Praktiserende Lægers Organisation (PLO). https://laeger.dk/media/bmhpndle/plo_overenskomst_2022_web-1.pdf

PLO, & RTLN. (2021). *Overenskomst for Almen Praksis 2022* [Communal agreement in general practice 2022]. Copenhagen, Denmark: Regionernes Lønnings- og Takstnævn. https://laeger.dk/media/evmpqffo/forhandlingsaftale_ok22_0.pdf

Pols, J. (2012). *Care at a Distance; On the Closeness of Technology*. Amsterdam University Press. https://doi.org/10.26530/OAPEN_413032

RTLN, & PLO. (2020). *Midlertidig aftale mellem Praktiserende Laegers Organisation (PLO) og Regionernes Lønnings-og Takstnaevn (RLTN) om honorering af videokonsultation i almen praksis og laegevagt* [Temporary agreement between the Danish Practitioners' Organisation (PLO) and the Regional Wage and Tariff Board (RLTN) on remuneration for video consultations in general practice and on-call doctors]. RTLN. https://okportal.dk/media/19995/5508.pdf

Ryan, G. W., & Bernard, H. R. (2003). *Techniques to Identify Themes*. SAGE Publications. https://doi.org/10.1177/1525822x02239569

Simonsen, L. M., Eilerskov, N., Rikke, S. A., Soendergaard, J., Nielsen, J. B., Dorte Ejg Jarbøl, Thilsing, T., Balasubramaniam, K., & Elisabeth, A. H. (2024). Introducing Point-of-Care PCR technology in general practice: Ambiguities, experiences, and perceptions among health care professionals. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 29*(3), 427-446. https://doi.org/10.1177/13634593241254988

Treviño, L. K., den Nieuwenboer, N. A., Kreiner, G. E., & Bishop, D. G. (2014). Legitimating the legitimate: A grounded theory study of legitimacy work among Ethics and Compliance Officers. *Organizational Behavior and Human Decision Processes, 123*(2), 186–205. https://doi.org/10.1016/j.obhdp.2013.10.009

Jessen, B. (2025, 17 January). *Når lægen er på video – ikke kun for de »stærke« patienter* [When the doctor is on video – not just for the "strong" patients]. Ugeskrift for læger. Retrieved on 4 February 2025 from https://ugeskriftet.dk/nyhed/naar-laegen-er-paa-video-ikke-kun-de-staerke-patienter

van den Heuvel, J., Assing Hvidt, E., Dahl-Larsen, R., Thomsen, J. L.., & Hoffmann Merrild, C. (2024). Patient-initiated video consultations: A qualitative study on reasons for patient-booking in Danish general practice. *Digital Health, 10*. https://doi.org/10.1177/20552076241288637

Vila-Henninger, L., Dupuy, C., Virginie, V. I., Caprioli, M., Teuber, F., Pennetreau, D., Bussi, M., & Gall, C. L. (2024). Abductive Coding: Theory Building and Qualitative (Re)Analysis. *Sociological Methods & Research, 53*(2), 968–1001. https://doi.org/10.1177/00491241211067508

Vælg Klogt. (2024, 18 December). *Patienter skal have mulighed for at vælge digitale konsultationer* [Patients must have the option to choose digital consultations]. Danske Patienter. Retrieved on 13 March 2025 from https://danskepatienter.dk/politik-presse/nyheder/patienter-skal-have-mulighed-for-at-vaelge-digitale-konsultationer

Wanderås, M. R., Abildsnes, E., Thygesen, E., & Martinez, S. G. (2023). Video consultation in general practice: a scoping review on use, experiences, and clinical decisions. *BMC Health Services Research, 23*(1), 316. https://doi.org/10.1186/s12913-023-09309-7

QUALITATIVE HEALTH COMMUNICATION

VOLUME 5, ISSUE 1, 2026