Struggling with and mastering e-mail consultations

A study of access, interaction, and participation in a digital health care system

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Abstract

In Denmark, medical consultations and the institutional practice of going to the doctor have been expanded upon over the past decade, with e-mail consultations (e-consultations) now supplementing conventional consultations. As a form of communication with different constraints than face-to-face and telephonic communication, e-consultations are likely to both afford some benefits and present struggles. In this article, I examine the use and perception of primary care e-consultations from the perspective of the patient. The study is based on qualitative interviews with 20 patients and guided by the following research question: How do patients struggle with and master digital participation during e-consultations? The study demonstrates that e-consultations are more than a digital access point to the healthcare system: patients often struggle to maintain contact with their general practitioner, and e-consultations can help them navigate the healthcare system. Indeed, those who master this form of communication are appreciative of it and perceive it as screen care.

Keywords: digital consultation, participation, primary care, patients, screen care

Introduction

The most frequent communicative purpose of Internet activity in Denmark is e-mailing, with 94 per cent of Internet users between 16 and 89 years old having sent or received e-mails (Statistics Denmark, 2019). In addition, Denmark has the highest number of doctor–patient e-mails in all of Europe, placing it at the forefront of e-consultation adoption in the Nordic countries. Compared with Denmark, Sweden is ranked as number four and Finland number five after Italy and Estonia when it comes to the percentage of the population who has sent or received an e-mail to or from their doctor, nurse, or health care organisation (Newhouse et al., 2015).

Medical consultations have expanded over the past decade, with asynchronous e-consultations supplementing consultations that are conducted face-to-face in a clinic, by telephone, or during a home visit (Fage-Butler & Jensen, 2015; Hansen et al., 2014).

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A governmental strategy includes a plan to transform one-third of all consultations into digital consultations (Ministry of Health, 2018a). However, because of the different constraints they present, e-consultations will likely lead to new benefits and present new challenges. Struggling with and mastering digital medical consultations are the central concepts of this article, as I investigate the use and perception of e-consultations with general practitioners (GPs) from the perspective of the patient.

In 2009, an update to the Danish collective agreement made it mandatory for all GPs to offer e-consultations in order to “support efficiency and quality through the digitalisation of health care [translated]” (General Practitioners Organisation, 2010). Patients can e-mail a doctor via a secure web messaging system (Assing Hvidt et al., 2020) or a mobile phone app. Thus, for patients in Denmark, e-consultations are a digital access point to their family doctor. From the perspective of the patient, e-consultations provide a greater degree of convenience when contacting a GP (Grønning et al., 2020). In 2019, the number of e-consultations amounted to approximately seven million, which corresponds to 21 per cent of all GP consultations (General Practitioners Organisation, 2020). This development raises a number of questions about struggling with and mastering technology and digital participation (Carpentier, 2011): first, with regard to new technology for which six different software systems (and one app) were approved by the Danish health authorities for use by patients and GPs that limits each e-consultation to a maximum of 500 characters; and second, with regard to the participation and understanding of this new kind of digital service encounter (Félix-Brasdefer, 2015) between patients and doctors.

Therefore, I pose the following question: How do patients struggle with and master digital participation during e-consultations? The empirical data stems from patients born in 1954 or earlier (65+ years old), as the latest developments show that, in Denmark, senior patients are the most frequent users of e-consultations (General Practitioners Organisation, 2020).

In media studies, the term “struggle” has been explicitly applied in a variety of contexts. I thus begin with a review of three recent media studies where the term was emphasised (in headlines and abstracts), published in *Journalism Studies* and *Feminist Media Studies*.

Mette Mortensen (2019) used the term in a study about terrorists who take part in struggles for mediated visibility in news media; she refers to John B. Thompson’s “struggles for visibility” (2005) without defining or discussing the term any further. Thompson’s study reveals that, in this context, struggles are social and political: “Mediated visibility is not just a vehicle through which aspects of social and political life are brought to the attention of others: it has become a principal means by which *social and political struggles* are articulated and carried out [emphasis added]” (2005: 49). In addition, Joyce Stroobant, Sarah Van den Bogaert, and Karin Raeymaeckers (2019) discussed “the fierce struggle for attention in the new hybrid media environment” that happens when health news are coproduced by health and media professionals. They state that the “fierce struggle” is “a struggle to find profitable digital business models and the fierce online competition due to an overcrowded and hybrid media environment”, though they do not explain what it means to struggle fiercely. Moreover, Linda Steiner and Carolyn Bronstein (2017) published a study about “mommyblogs” and the everyday struggles of mothers, in which they use the term “struggle” in the headline of the study but do not define nor discuss it in their article. In the conclusion, they state that “such

blogs help parents negotiate the everyday politics of raising children” and that these blogs are “thus allowing audience members to face head on their anxieties about modern parenthood, especially the risk–reward calculations that otherwise can be so agonizing” (Steiner & Bronstein, 2017: 73). They do not clarify if or how the negotiation, anxiety, and risk–reward calculations can be linked to this everyday struggle.

Therefore, the question of what it means to struggle within the context of media and communication still remains. The purpose of this study is to bring the term “struggle” into the context of healthcare and digital participation from the perspective of the patient. In this context, struggling has a potential as an ambivalence within the process of mastering. Mastering new technology may not be the same as not struggling with it, and both mastering and struggling hold detailed nuances that can provide information about the process of struggling with new technology. In this sense, struggling is an inherent aspect of mastering that has both positive and negative implications, hence the ambivalence.

The context: “Going to the doctor” in Denmark

In Denmark, GPs serve as the primary point of access to the healthcare system, which provides almost all services, including e-consultations, free of charge to citizens. GPs play a key role in healthcare by “defining patients’ complaints” according to Davis (1988: 14; see also Eeckman, 2019). GPs act as gatekeepers to specialised treatment.

Compared with conventional consultations (in a clinic, on the telephone, and home visits), e-consultations challenge both GPs and patients with regard to health communication (Fage-Butler & Jensen, 2015). Successful communication between a patient and their own GP is essential for both the relationship and accurate medical decision-making. As David Biro (2011: 14), a physician with a PhD in literature, stated: “Physicians rely on a patient’s story – how well he or she is able to describe symptoms – as much as they do on stethoscopes and blood tests”. In this respect, patients’ use and perception of e-consultations are important not only for the patients themselves, but also for the GPs who rely on the patients’ stories.

This article is structured as follows: This short introduction is followed by a presentation of the empirical material, as well as a presentation of the theoretical framework. The analytical themes are then defined, followed by a discussion of these from the perspective of digital inclusion and exclusion, struggling, and mastering. The conclusion summarises the analytical points that are most relative to the patients’ use and perceptions of digital service encounters and primary care.

Methods: Empirical data and approach

The data collection for this study was part of a larger qualitative research project exploring the potential of e-consultations from the perspective of patients and GPs. The study for this article is based on 20 semistructured interviews with twelve female and eight male patients between 66 and 83 years old (see Table 1). The majority of the interviews were conducted individually, but one interview was with a married couple together (their choice). All patients were recruited via their GPs through an open call disseminated orally in our professional network within the Region of Southern Denmark, one of Denmark’s five geographically defined regions. All patients who were interviewed

had attempted to have e-consultations with their GPs. I conducted the interviews face-to-face in a setting of the respective patient's own choosing, such as their home (16), a senior centre (2), and a public library (2). A semistructured interview guide included open-ended questions, such as "In your opinion, what are the advantages of an e-consultation?", "What are the challenges?", and "In what ways, if any, do e-consultations have an impact on your relationship with your GP?" All participants gave written consent.

In addition, this subproject included interviews with eight GPs and two nurses, as well as two focus-group interviews with 17 GPs. This material is not explicitly included in this article but it provides useful background information about the subject.

The interviews were conducted in Danish, transcribed verbatim, pseudonymised, then coded using the software programme NVivo 12 before translation. The transcripts were coded in two phases: an initial open coding and a subsequent closed thematic coding using a node structure that reflected identified themes and subthemes and allowed for expansion and reduction along the way. This process led to the identification of the following subthemes: access, interaction, participation, sharing, helping, and power. The analytical process was inspired by Kozinet's (2015) netnographic approach and included analytical rounds of coding, note-taking, abstracting and comparing, checking, and refining in an abductive process. A potential limitation of the study is that the participants were all born in 1954 or earlier (65+ years) which might influence the results. Furthermore, as the interviewees were those who *chose* to e-consult, these patients may struggle less with and not be as critical about e-consultations as those who rarely or never use the form.

Table 1 Interviews

Gender	Age	Location	Duration (min)
Male	70	At home	46
Female	66	At home	64
Female	69	Activity house	34
Male	74	At home	64
Male	77	Activity house	35
Male	80	At home	49
Male	74	At home	42
Male	67	At home	42
Female	70	At home	46
Female	71	At home	33
Female	72	At home	41
Female ^a	77	At home	47
Male ^a	71	At home	47
Female	72	At home	30
Female	70	Public library	54
Female	71	At home	30
Female	68	At home	48
Female	67	At home	44
Female	83	At home	49
Male	81	Public library	56

^a couple interviewed together

Theoretical framework: Access, interaction, and participation

Media and communication scholars use the concept of participation to describe engagement in different social practices, including those related to healthcare (Stage et al., 2015). The basis for this study is an understanding of participation as a collective process through which participants become empowered in various ways (Klausen & Grønning, 2021). In this context, participation not only describes situations of direct citizen influence and power redistribution (e.g., by collecting sufficient petitions to introduce a bill), it also reveals the so-called maximalist approach (Carpentier, 2011), which includes studying the various agencies and elements involved in the participatory process. Through this approach, the e-consultation “produces what we call unruly data vitality in how the data circulate and recombine in the larger digital ecosystem of the Danish primary care sector” (Klausen & Grønning, 2021: 13). However, the various agencies and elements involved can be found in everyday practices of patienthood, as “the logics of power and participation work in every societal sphere” (Carpentier & Dahlgren, 2011: 8). In addition, the e-consultation has “a potential for self-reflection through the processes of putting sensations and emotions into words” (Klausen & Grønning, 2021: 12–13). The e-consultation represents a concrete digital access point to the abstract healthcare system. E-consultations are thus a mediating tool for power struggles both in their own right and also together with other digital tools and processes, such as searching for health information on websites or Facebook groups and participating in online health communities. We know from other studies that the media are one of the most important sources of health information (Christensen, 2017). Furthermore, when it comes to lifestyle and forms of identity, health is one of the most dominant discourses in later life (Christensen 2017; Higgs et al., 2009). Being responsible for one’s own health is therefore also an obvious discussion in a welfare society, and being able to do something by themselves, such as e-consulting, may be perceived by some patients as an active way in which they can participate in their own healthcare. For other patients, however, this responsibility may be perceived as a burden.

Struggling with technology and digital participation

Carpentier (2011) bases the concept of participation in democratic theory as a political process, stressing the importance of power in defining the concept of participation, which captures the distinction between minimalist and maximalist forms of participation along with other power logics of decision-making, such as explicit or implicit participation, formal or informal participation, and egalitarian or nonegalitarian participation. Furthermore, to enhance the conceptualisation of participation, Carpentier (2011) divides the concept into three subconcepts: access, interaction, and participation. Access is a condition for interaction, and access and interaction are both conditions for the possibility of participation, not equal to participation. In line with this thinking, access is articulated in a variety of ways as a presence related to technology, content, people, and organisations. Interaction is articulated as socio-communicative relationships within media technology, which, again, can be acted out in a number of ways related to technology, content, people, and organisations. Furthermore, Carpentier (2011) argues that these relationships do not necessarily lead to a decision-making process, even though they contain a dimension of power. In this sense, participation is broadly defined in

a political (processual) way, pointing to “power relationships that are (to an extent) egalitarian” (Carpentier, 2011: 31).

Potentially, the conceptual broadness of participation causes problems, as in academia, where “the stringent requirement to define core concepts is surprisingly rarely followed when it concerns participation” (Carpentier & Dahlgren, 2011: 7). At the same time, the term “participation” has a positive connotation and thus the subtle assumption of being beneficial to itself: if participation is possible, it will also be beneficial for all participants. In this regard, Carpentier and Dahlgren (2011: 9) highlighted the following: “This assumption is problematic because it decontextualises participatory practices, and, as Cooke and Kothari (2001) implicitly argue, disconnects them from a very necessary articulation with democracy, empowerment, equality and a number of other crucial concepts”. Without digging deeper into this complex theoretical discussion, I would argue that Carpentier’s participatory approach is beneficial for understanding mastering and struggling. The separation into three subconcepts is helpful for enhancing the conceptualising of participation in general, and in particular, it enhances the conceptualisation of mastering and struggling as a suitable way to approach and discuss the empirical material.

As stated previously, e-consultations were implemented in the Danish primary care system in 2009. Since then, all patients have been offered access to the technology, which in turn allows patients to access the media content (e-mail from their GP) either through a medical practice’s website or via the *Min Læge* [My Doctor] app. The implementation of e-consultations is part of a governmental digitalisation strategy that also includes the Danish Public Digital Post Act from June 2012, which was a significant driver of the Danish legislation on access to digital services.

To summarise the theoretical framework, with regard to access, patients can choose to be present in the system, and with regard to interaction, patients are part of the socio-communicative relationship with their GP. Interaction implies socio-communicative relationships within the media technology, which, again, can be acted out in a number of ways. Access is necessary for interaction, and interaction-plus-access is necessary for participation. Understanding participation is the epitome of power when making decisions. Similarly, participation in and through e-consultations has the potential for power with regard to decision making. A patient’s e-consultations may involve several different desires or expectations, intentions, or end goals; for example, the patient may want something specific from the doctor, but the patient may also have doubts as to whether the doctor will act on the content of the interaction. Moreover, a patient may also desire confirmation that no action needs to be taken, and the patient may also want a faster approach to the physical consultation via e-consultation (Assing Hvidt et al., 2020; Grønning et al., 2020).

In the following, I focus on three analytical themes related to the above theoretical framework: mastering and struggling with access (system and people); mastering and struggling with interaction (content and people); and mastering and struggling with participation (power and decision-making).

Mastering and struggling with access (system and people)

Access to the system

The use of the e-mail system is often related to a user's technical ability: the easier a user perceives the e-mailing system to be, the more likely they are to use it (Karhula et al., 2011). For instance, one patient commented, "I think that it is a little cumbersome [laughs]" (male, 70 years old), while another said, "Well, as long as you know what to do, it goes quickly" (female, 69 years old). These two contrasting statements by patients are characteristic of how e-consultations are experienced by patients. A number of the patients interviewed felt that accessing the technology through the doctor's website was rendered more difficult by security restrictions. In other words, they struggled, but they talked about their struggles with a smile. One restriction, for example, is that passwords are only active for ten minutes and are re-sent to the patients each time they need to access the system. Another restriction is the potential of a doctor's website to be difficult to find, especially if a patient does not bookmark the page but searches for it on Google every time they need digital access to the doctor. However, the patients also showed a certain amount of understanding of the fact that it was difficult to gain access to a doctor. In reference to the sensitive data of the consultations that necessitates the struggle with passwords, one patient said the following:

I've said before that it can go haywire because it's so easy. What makes it a little cumbersome, therefore, is that a little code is needed before you can come into contact with the doctor in an e-consultation. This should also be necessary, in my opinion. (male, 74 years old)

A commonality of the patients who were interviewed was that they had all participated in e-consultations with their GPs and therefore been successful in gaining access. In addition, as the aforementioned female patient emphasised, gaining access is fast and easy if one knows what to do. When asked directly how she became aware of the access option for e-consulting, she replied:

I was an IT supervisor in my job as a teacher and was therefore a little interested in it, so I started working with it as soon as it was set up here. It's important to keep up with the times [bangs on the table]. It doesn't help when you get older that you can't do one thing or the other, because that's how it is. (female, 69 years old)

This woman became accustomed to using computers through working as a teacher and IT supervisor. Indeed, studies have found that age and education level are powerful factors for understanding the Internet among older adults (Bergström, 2017). This woman also became accustomed to helping others access new technology through her work. Several of the patients interviewed received help from or helped a cohabitant gain access to an e-consultation. An 81-year-old man mentioned that he helped his wife, who struggled with the digital environment. He explained, "My wife is no good with anything digital. No good at all. No! It doesn't interest her".

In these cases, there may be differences in how the access options were experienced, as was the case for a 70-year-old female patient who helped her husband with his e-consultations: "My husband has experienced a few problems with the access code, which is necessary when he needs to order medicine. I have never experienced this.

I don't know, he must have been unlucky from the start." As can be seen, the woman explained her husband's struggles by saying that he was "unlucky from the start" and thus does not blame the doctor (i.e., access to people) or the system (i.e., access to technology). Referring to her own digital access, she said: "Yes. I think that it has worked well for a long time. It has. I have been in and changed the code to my own and have used it ever since".

With respect to helping a cohabitant gain access to the system, thereby sharing experiences and knowledge about e-consultations, I also asked whether the patients shared their knowledge of e-consultations with their own network, for instance, among friends and family members. The answers revealed that some patients did not talk to others about it at all, while others enjoyed discussing it with their friends and recommended that they use e-consulting. Some patients also said that talking with their friends showed them that the doctors' system facilitates a certain amount of variation, for instance, in terms of scope, content, and response time.

Several of the patients also used other access points to the healthcare system, sources of information concerning health, and platforms for discussing health-related issues. They mentioned, for example, the website *sundhed.dk* [*health.dk*], *Netdoktor* [*Net Doctor*], discussion groups on Facebook, and "Dr. Google", as one patient explained:

I asked Dr. Google [laughs]. As I call it. I did so simply because I wanted to know a little more about it. And especially to begin with, when I had no idea what was actually wrong and what it really involved, because I had never speculated about it until I found it by accident. (female, 70 years old)

The patient here had been diagnosed with a metabolic disorder and was struggling to relate to her new health situation. Other patients performed Google searches for diabetes, dyssomnia, and hearing impairment. It is therefore not uncommon for patients to search for formal and informal digital health information in several places in order to relate to considerations about their own illness and health.

Access to people

In addition to having access to a system, access is also articulated as presence related to people and organisations. With regard to their relationship with their GP, some patients attached importance to having known the doctor beforehand. When asked whether it is important for a doctor to know a patient, a 70-year-old male patient replied: "Yes! It is very important. It is. There must be a form of trust". When asked why, he elaborated:

Well, I think that you are more open if there is a greater form of trust – concerning one's small issues, if there are any [laughs]. It is very important. It is. And this was also the case with regard to the nurse. It was also important for it to work.

When asked the same question, a 72-year-old female patient replied:

Well, yes. I always find that there is an extra dimension when you have a sense of each other, know each other a little. It's not just a name floating out in thin air, right? I believe that. We cannot ignore the fact that it has an extra dimension of easiness, right? In communication. But that's not the most important thing for me, I could easily correspond with someone that I didn't know, it doesn't matter.

For some patients, therefore, it was important that they e-consult with their own doctor, while for others, e-consulting with a doctor known to them was not crucial, and they would not be against corresponding with someone they do not know.

Access to people does not necessarily mean having access only to a GP but also potentially to other healthcare professionals, such as a nurse or a medical secretary. When asked about this, one patient (male, 70 years old) mentioned that he was not nervous about it, as nurses work closely with GPs: “Because I firmly believe that she [the nurse] – she clears it with him [the doctor] each time”. It became clear in the conversation with this patient that the nurse’s assumed collaboration with the physician determined the patient’s perception of access to the nurse. Other patients expressed a need for more direct contact with the doctor, for instance, an 83-year-old female patient who received an e-consultation from her doctor stating that the doctor had ordered the patient’s desired prescription medication:

In such cases, it is nice, as it is not something the secretaries have the authority to prescribe. Of course, if you are under a lot of stress they will talk to the doctor, right? But it is good to be able to go directly to her [the doctor], right?

The patient emphasised that it is nice to have direct access to and interaction with the doctor. She preferred this over how it was done in the past with either a nurse, which meant longer waiting times, or secretaries, who do not have the authority to prescribe medication.

Mastering and struggling with interaction (content and people)

Patients value the opportunity to choose the interaction modality they want with a doctor. When asked “How do you experience the e-consultation?”, one patient replied:

Yes... Well, I feel it’s quite okay for what I use it for. It’s as it’s supposed to be... Well, I guess I can choose for myself if I feel that it should be a physical consultation versus an e-consultation. I think that I kind of sort it out for myself. (female, 72 years old)

Several patients commented on the limited space for content, which was perceived as a struggle, as one patient explained:

The space for how much you can write and ask about is limited. [...] So, I have to go back and delete something and try to formulate it differently. I don’t think that I have an enormous vocabulary and such, but it could still be nice with a little more space. (male, 81 years old)

This patient struggled with having to adjust his content to the constraints of the system, but he found a way to master it by reformulating the content. Other patients chose to submit multiple e-consultations on the same topic, and some of these patients marked them numerically (1/3, 2/3, 3/3), which is a so-called workaround to bypass a rigid system (Timmermans & Berg, 2010). Once the content had been adapted to the system, the actual interaction with the doctor could begin. When patients were asked how they experienced the doctor during the actual e-consultation, several patients replied that they could still recognise the doctor as someone they knew via the digital consultation:

Patient: Well, he would also say what he writes here during a [physical] consultation.

Interviewer: Okay, so you can recognise him from that?

Patient: Yes, I most certainly can. I most certainly can. He is thorough and prudent. But that suits me fine. It does [brief pause]. Yes, it is typical of him.

(male, 70 years old)

Another patient talked about a doctor's informal language in the e-consultation and described why she chose to interact informally with the doctor:

I guess it's because of my nature. That I'm not so overly formal. Because we're not when we sit there, are we? So why should it be so artificial, right? [laughs]. The content is the same, right? And it's not that as though it's intimate, you know? Not in any way. (female, 72 years old)

In her e-consultation, she expressed a concern about cancer, and she elaborated on this concern in the interview: "Yes, it is this that I would like to tie up the loose ends on, you know? And she [the doctor] does so" (female, 72 years old). In this example, the patient contacted the doctor with the expectation that her concern would be alleviated, and the patient felt that the doctor fulfilled that expectation. A doctor's capacity to act and the speed of an interaction are essential for many patients, and the doctor should preferably respond quickly if the interaction is to be experienced as meaningful in relation to treatment. For example, one patient said the following about her desire for prompt treatment:

Well, it is, if you have cystitis it is very important that you receive an immediate response, right? Because otherwise you have to drive down there. But even that [an immediate response] is possible [in an e-consultation], because I've experienced it. If the doctor acts fast. (female, 70 years old)

Therefore, it is not only the content of the interaction that influences the patient's perception of the physician, it is also the capacity of the physician to act promptly and efficiently – in other words, quick decision-making. Speed therefore, becomes an affordance (Hutchby, 2001; Gibson, 1977, 1979; Norman, 1990) related to both technology and interaction; it is possible to respond asynchronously at any time, and it is related to the experiences of both the doctor and the interaction, as the physician can be perceived as having the capacity to act, for example, by responding quickly. However, despite having access to technology and the doctor, as well as the possibility of interaction, several patients expressed that they preferred not to make use of any of the available options, regardless of whether they were physical or digital:

Well, you could say that I avoid going to the doctor as much as I possibly can [laughs]. It's not exactly a place I really want to be, you know? So it's not like I go to get weighed regularly, or this, that, or the other. But, well, I'm on an anticoagulant, um, Marevan, because of a heart operation I had... (female, 72 years old)

Mastering and struggling with participation (power and decision-making)

As mentioned, patients take responsibility for both the choice of mode for the consultation and tone of voice. For example, one patient found e-consultations more appropriate for diabetes than for back pain, reflecting Biro's (2011) point that, to a large extent, a doctor is dependent on how good a patient is at describing their symptoms. One patient elaborated on this as follows:

Yes, it's true... I use it, yes, apart from diabetes, it is extremely rare that we have contact with the clinic, or I have contact with the clinic... But there is no doubt that one could, but then if you have a back disorder for example, then you have to be good at describing what it is and where it is. I therefore believe that a [physical] consultation is much more important in this context. But an e-consultation is just fine for this thing with the blood sugar level for example. (male, 70 years old)

Thus, a patient's ability to describe an illness or symptoms is essential to a successful digital interaction. Another patient emphasised that not everything can be solved via e-consultation:

Yes, I think it's so great! Instead of having to make an appointment, and then three weeks go by. That takes far too long, but with this you get a reply the same day. So, it's, well, for minor things or something definite, you can definitely ask about that. But of course, you can't use it for everything. (female, 69 years old)

It is particularly interesting here that access to the technological system and the doctor are linked together as a form of an e-consultation struggle about decision-making, which is equivalent to "not using it for everything". The patient is aware that she cannot use an e-consultation for everything, but when asked to clarify, she did not have a clear perception of exactly what not to use it for.

Several patients expressed frustration about the long waiting times for direct physical communication with the doctor, a communication that, by contrast, they were able to participate in more quickly via access to e-consultations.

The institutional practice of going to the doctor includes an "asymmetric power balance between patient and medical doctor" (Eeckman, 2019: 185), as a patient typically chooses to contact a doctor because they desire some kind of expert evaluation. While an e-consultation greatly increases patients' access to the system and the doctor, whether there is an actual participation could be questioned. The responsibility for making contact lies with the patient, even though they may be in a vulnerable or difficult situation. The patient is familiar with this from telephone calls, booking appointments, and arriving in the physical waiting room. However, unlike the synchronous forms of consultation (physical attendance, telephone, video consultation), in an e-consultation, it is not a doctor who frames the interaction with an initial greeting and then listens and asks follow-up questions; rather, it is the patient who initiates and formulates the content, thereby mastering the interaction and ensuring the desired outcome.

Discussion

In general, communication is important for giving patients a sense of control and autonomy in their interpersonal relationship with a GP (Eeckman, 2019); communication is a part of caring. The e-consultation is an important digital access point to the abstract healthcare system, and struggling with and mastering this digital access point is a new kind of struggle that includes access, interaction, and participation. Struggling with digital participation indicates a need to overcome the struggle of achieving access and attempt to master the interaction. With regard to decision-making, not only should one try to reach an understanding with their GP through interaction, they should also successfully receive the GP's advice, decision-making, and actions. As a patient, one needs a GP who can provide care in and through an e-consultation, and for most patients, an established positive relationship is important.

E-consultations foster different kinds of struggles. The majority of the patients interviewed appreciated the digital access and the brief replies from their GP. These can be seen as a kind of screen care (Kristensen et al., 2021), which is when care as communication is conveyed through technology. The concept of screen care is based on the assumption that communication is care and that caring is possible through a screen (Chayko, 2017). Arrangements of care and technology also "consist of the imaginaries that shape our thinking about what we can expect from them, and what patients and professionals make of them in concrete interactions" (Schwennesen, 2019: 189). Meaningful digital connections between patients and GPs lead to overcoming struggles with technology and a perception of mastery.

Awareness of the physician's presence and the possibility of around-the-clock digital access to a doctor is important for patients, even if they do not make use of this option. At the same time, the e-consultations are seen as an extension of general access to the healthcare system, which itself carries significance for the patient. None of the patients reported negative experiences or negative perceptions of their digital participation, and they did not question the behaviour of their GP or the health authorities in general. As a doctor in an e-consultation is dependent on what patients write and how patients present themselves via health technology, struggling with this process can affect, and in some cases even determine, the impression the patient makes on the doctor, which can have consequences for the patient's subsequent course of treatment and is ultimately crucial to the patient's health. In this sense, e-consultations are potentially shifting some obligations from the doctor to the patient and adding other new obligations to the patients in terms of digital health literacy. The patient interviewees felt empowered by this tool, but it could also disempower other patient groups who have not mastered e-consultations. Indeed, research has shown that while digital solutions might reduce inequalities for some groups, for example, those with mental health issues (Taiminen et al., 2019), for other groups, digital solutions may exacerbate health inequalities (Rich et al., 2019).

A relevant question is whether digital access is a form of pseudo-security for the patient; it may lead to a form of participation, but it does not necessarily lead to decision-making or taking action. This could be problematic, as it would support the assumption that access and interaction result in increased influence, which is not the case.

From a democratic perspective, it is positive that patients have this digital option for accessing important health decision-making with their own doctor. There is an implicit perspective of power in potential decision-making with regard to being able to act and

ask the doctor to take action. However, socioeconomic struggles must be considered. For example, in Denmark, it has been estimated that 12 per cent of adults struggle with literacy (OECD, 2013), which could make e-consultations difficult for them. Indeed, for non-Western immigrants, the proportion of so-called functional illiterates has been estimated to be more than 50 per cent (OECD, 2013). On the other hand, many people with mental health disorders (e.g., anxiety, depression) are happy about the digital possibilities (Rasmussen et al., 2017). Likewise, homeless people in Denmark are typically in possession of a mobile phone and might easily access a doctor via an app. At the same time, older people in Denmark (65+ years old) are the most active on social media among all of the older people in Europe (Statistics Denmark, 2019), which might be counterintuitive knowledge for the authorities. To proceed with this major democratic issue in relation to digital access to healthcare falls outside the primary focus of this article. However, when it comes to the issue of possible digital exclusion, it is important to note that there will be more space for patients in the physical waiting rooms and on the telephone queues when one-fifth of all consultations can be managed via e-mail. Indeed, it has been estimated that 30 per cent of e-consultations are resolved directly and do not lead to physical or telephonic consultations (Farr et al., 2018). Furthermore, the number of telephone consultations dropped significantly, from 4.3 million in 2007 to 3.8 million in 2018 (Statistics Denmark, 2018; Ministry of Health, 2018b).

Conclusion

In this article, I have examined the use and perception of e-consultations from the perspective of the patient. The study is based on qualitative interviews with 20 patients between the ages of 66 and 83 and contains key questions about how these patients participate in e-consultations. The study has demonstrated that e-consultations are more than a digital access point to the abstract healthcare system, they are also a mediating tool for power struggle or technology in itself. The interviewees appreciated having digital access and enjoyed their GP's brief replies, which they perceived as a kind of screen care. These socio-communicative relationships are played out through interaction based on access to the system and technology, as well as access to people. Patients often struggle to communicate with their doctor, both digitally and physically, and e-consultations help them navigate the healthcare system. The act of going to the doctor is considered a service; thus an e-consultation is a digital service encounter from the perspective of the patient. Moreover, due to the nature of an e-consultation, what a patient writes and how they present their situation digitally is ultimately crucial to their health.

Carpentier's (2011) conceptual framework consisting of access, interaction, and participation was used to analyse the e-consultation process. The patients interviewed all managed to gain access to e-consultations and are therefore not in the group of people who have been digitally excluded by the imposed digitalisation of a society, as is the case in Denmark. Ideally, digital patients will make room for non-digital patients in the telephone queues and physical waiting rooms, where they will also come themselves when a consultation cannot be done digitally. However, while the empirical data in this study represents patients who struggled with access, interaction, and digital participation, they had also mastered digital contact with their GP and overcome their struggles.

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