

Research Article

“It Gives Me less Time as Being Ill and More Time for being me and Living My Life”: A Qualitative Study of Patients’ Experiences of Piloting Video Consultations in a Gynaecological Outpatient Setting

Christina Louise Lindhardt^{1,2,4**†}, Maria Monberg Feenstra^{2,3†}, Heidi Faurholt² and Marianne Kirstine Thygesen^{2,5}

¹Centre for Research in Patient Communication, Odense University Hospital, Odense, Denmark

²Department of Clinical Research, Faculty of Health Sciences, University of Southern Denmark, Odense, Denmark

³Department of Gynaecology and Obstetrics, Odense University Hospital, Denmark

⁴Centre for Organisational Change in Person-Centred Healthcare, Deakin University, Australia

⁵Research Unit of General Practice, Department of Public Health, University of Southern Denmark, Odense, Denmark

†Shared first authorship

***Corresponding author:** Christina Louise Lindhardt, Centre for Research in Patient Communication, Odense University Hospital, Odense, Denmark, E-mail: clindhardt@health.sdu.dk

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Abstract

Purpose: This study explores how patients referred to a gynaecological outpatient clinic experience piloting video consultations with healthcare professionals (doctors and nurses).

Methods: A qualitative study design was applied. Semi-structured interviews of patients were conducted after piloting video consultation in situ training of healthcare professionals in a gynaecological outpatient clinic at a university hospital. Thematic analysis was applied.

Results: Fifteen patients with diverse gynaecological disorders were included. Five themes emerged from the analysis: (1) It gives me less time as being ill and more time for my life and living, (2) Video is more like a conversation with an actual human being next to me, (3) Video consultation provides better possibilities for receiving healthcare, (4) The time waiting online feels slightly long and (5) Agenda and agreement matters, and grouped under one overarching theme: “Video consultations are well suited for patients who do not need a physical examination”.

Conclusion: Video consultations were feasible and satisfactory across a broad sample of patients in gynaecological outpatient follow-up, where a physical examination was not required. Patients valued video consultations as they felt less burdened by their disease when time was saved when meeting online. Yet, particular attention should be paid to delays in online consultations, where patients must be informed in line with traditional face-to-face meetings.

Keywords: Gynaecology; Outpatient; Qualitative; Technology; Video consultation

Introduction

Digitalisation allows new technologies to foster patient communication with healthcare professionals (HCPs) from home, workplace, or anywhere [1-3]. People now readily access the Internet and digital devices (smartphones, tablets), as in recent years, information technology equipment has improved its quality and is now usable by most people. These changes have allowed the development of video consultation (VC) as an alternative to in-clinic consultation. For instance, there was an increase in digital consultations in Denmark after the COVID-19 pandemic [4]. Despite increased online consultations, VCs may only be offered to some patient categories. Patients in vulnerable situations may not benefit from VC [3 5-7]. VCs enable patients to access their healthcare provider visually while remaining in their home- or work environment and allow relatives to join the VC from, e.g., their workplace [3,6-9]. Nevertheless, it is still to be fully implemented in all hospital settings. VC is convenient and time-saving for many patients [1,10,11]. However, literature and systematic reviews on the patient’s experience of VC in a gynaecological outpatient clinic are limited [12,13]. While virtual consultations have been evaluated in gynecologic oncology and postoperative follow-up of robotic gynaecological surgery [14], studies are sparse concerning general gynaecology. In gynaecology, patients suffering, e.g., from endometriosis, cancer, or urogynaecological diseases, have frequent outpatient appointments without a physical examination and,

therefore, potentially spent unnecessary time travelling to and from the hospital if VC is offered [15]. Further benefits or challenges could apply, which is why this study aimed to describe patients' experiences of piloting VCs in a gynaecological outpatient setting across a broad sample of gynaecological diseases.

Methods and Design

This study used a qualitative approach to respond to the research aim and followed COREQ guidelines [16].

Setting

This study was conducted at a gynaecological outpatient clinic at a Danish university hospital. The clinic treats patients with various gynaecological disorders, such as endometriosis, cancer, urological problems, or other benign conditions. Patients from one region in Denmark attend consultations in the outpatient clinic, travelling up to 2-4 hours each time. During the study, there was a local focus on implementing VCs across hospital specialities. Acknowledging that conducting VCs requires both communicative- and technical skills, an educational training program for HCPs was developed at the study site. Therefore, before piloting VCs in the gynaecological outpatient clinic, eight HCPs completed the academic training program. The program consisted of a four-module e-learning program of 45 minutes, blended with 4 hours of theoretical instruction about patient-centred communication in VCs based on the Calgary Cambridge Guide [17,18] and combined with in situ communicative and technical skills training with simulated patients by role players. The following day, the eight HCPs piloted VCs in the outpatient clinic with invited patients. The training was facilitated by instructors from the Center of Research in Patient Communication (CFPK), The Simulation Center (SimC) [19] and the technical support team from Mit Sygehus.

When patients are referred to and receive outpatient treatment, they are supported by Mit Sygehus [My Hospital], a secure app and web browser (<https://mit.rsyd.dk>) for patient information and communication [20]. The VCs were conducted using Mit Sygehus with patients using their device (computer, smartphone or tablet), and HCPs used a Cisco Desk screen connected to the Mit Sygehus back-end system for HCPs' use. Patients were automatically notified by the app 15 minutes before their appointment and were asked to press 'Ready for consultation'. If they did not, a technical support team called the patients. On the day of piloting the VCs, the support team was on-site to help patients and healthcare providers, and all involved had the support team's phone number.

Study population

Specialist doctors screened patients for inclusion and invited eligible patients to participate in the piloting of VCs and potentially participate in the study. Patients were informed by secure e-mail (e-Boks) [21]. If patients agreed to participate in a VC, they accepted the invitation by signing a written consent in Mit Sygehus [22]. The inclusion criteria for patients were those who were ≥ 18 years old and needed a consultation with an HCP (nurse or doctor) but did not need a physical examination. They had to be Danish speakers, obtain an electronic personal identifier (MitID) to access Mit Sygehus and have a smartphone, tablet, or computer [24]. Patients were purposefully sampled among patients accepting pilot VCs in the gynaecology outpatient clinic. We strived for diversity in patients' age and disease challenges to gain broad and nuanced knowledge to answer this study's research question and aim.

Data collection

Semi-structured interviews were guided by an interview guide based on the research question and existing literature [23]. The main question was 'Please tell me what it's been like to meet your doctor or nurse through a VC at the gynaecological outpatient clinic', and open-ended and clarifying questions were used to invite the participants to deepen their experiences, such as 'Please tell me more' and 'Could you give me an example of how you experienced?' Summaries of what the participant had been talking about were also used to verify an understanding and to move the conversation forward. Interviews were carried out within ten days after the VCs to minimise recall bias, and all were conducted via phone by H.F. C.L.L and H.F used the first interview as a pilot test to evaluate and discuss interview techniques. This interview was included in the study as no substantial changes in the interview technique were made. C.L.L and H.F transcribed the interviews, and to correct any misunderstandings, they listened to all the transcriptions together, resulting in minor corrections.

Data analysis

All interviews in the study were transcribed verbatim and analysed. An inductive thematic analysis was utilised, applying the approach proposed by Braun and Clarke [24]. This provides a theoretically flexible approach to analysing qualitative data and exploring the participants' experiences concerning the aim of the study. The inductive analysis allows the researchers to develop the coding frame as they familiarise themselves with the data, revising this iteratively over the data collection period. To ensure the placement of a code in a theme, data consistency was searched for, and codes that did not fit were contemplated and placed elsewhere. All quotations behind each code were carefully read, and patterns were sought. Braun and Clarke state that in the last step, the themes and sub-themes should be related to the research question and the literature. This is done to safeguard the qualitative description's validity and the thematic analysis's credibility [24]. The interviewer had a background as an HCP. The consistency and validity of the data were raised by confirming the findings through discussions with the co-authors of this article. The backgrounds of the co-authors should minimise systematic errors and contribute to protecting the correct coding of the themes. Critical coding reviews ensured consistency, paying attention to the context and writing a logbook with considerations during the process [24]. In the first step, two researchers read and re-read the text to ensure correctness and to exclude typing errors. In addition, the researchers debated the transcribed content. The first impressions and the perceived similarities and differences were recorded in the second step. In the third step, the data were systematically divided into meaningful codes. In the fourth step, these initial codes were noted and re-read thus, codes became visible. In the fifth step, the coded data were advanced into a thematic map-making where the researchers considered the adjustment of themes and sub-themes. In the sixth and final step, each theme was analytically refined and related to the literature and evident definitions were made for each theme and sub-theme. Braun and Clarke note that a direct quote from the data can often capture both the content and the analyst's take on a theme. This provides an immediate and clear sense of a theme while staying close to participants' language and concepts. We named the themes in this study from the participants' words [25] (Table 1).

Theme	Category	Sub-theme
The time waiting feels slightly long	Sitting in front of the screen, Challenges logging in, Time spend	Information Aid in peers Transparency

Table 1: Example of the analysis process.

Ethics

The Danish Data Protection Agency approved the study: 22/41990, registered at The Regional Committees on Health Research Ethics for Southern Denmark as number S-20222000 - 103. Approval Date 08.08.2022. All participants filled out a digital written consent form through Mit Sygehus after receiving written and oral information about the study, and consent could be withdrawn on the interview day, leaving patients with time to consider their participation.

Results

Of the 66 patients participating in the in situ training, most accepted a possible follow-up interview, and we purposefully chose 16 patients for an interview. One patient declined, and we reached data saturation after 15 patients. Interviews lasted, on average, 19 minutes (ranging from 12 to 25 minutes), and the patients were between 18 and 75 years of age, including two 60+ years of age (Table 2).

Number of patients	Age range (mean)	Outpatient clinic	Number with a participating relative
4	25 - 49 (38)	Endometriosis	4 = No, 0 = Yes
3	32 - 58 (48)	Oncology	2 = No, 1 = Yes
4	39 - 56 (46)	Bleeding disorder	4 = No, 0 = Yes
4	34 - 75 (56)	Uro-gynecology	3 = No, 1 = Yes

Table 2: Patient data.

From analysis, five themes emerged: (1) It gives me less time as being ill and more time for my life and living, (2) Video is more like a conversation with an actual human being next to me, (3) Video consultation provides better possibilities to receive healthcare, (4) The time waiting online feels slightly long and (5) Agenda and agreement matters, and organised under the overall theme: Video consultations are well suited for patients who do not need a physical examination (Table 3).

Overall theme
Video consultations are well suited for patients who do not need a physical examination
Themes
1. It gives me less time as being ill and more time for my life and living
2. Video is more like a conversation with an actual human being next to me
3. Video consultation provides better possibilities for receiving healthcare
4. The time waiting online feels slightly long
5. Agenda and agreement matters

Table 3: Presentation of themes.

Overall theme: Video consultations are well-suited for patients who do not need a physical examination

Generally, patients conveyed that VC was an excellent way to communicate with HCPs in a gynaecological outpatient clinic, and many patients were already familiar with VCs by, e.g., FaceTime and through work or private situations. This was, for instance, expressed like this:

"I am used to using video through my job and have experienced video a few times at the emergency doctor." (Patient, age 42)

"I am used to using FaceTime with my grandchildren and great-grandchildren; however, I have not tried it with the hospital

before. It was not difficult and will most likely be easier every time." (Patient, age 69)

In summary, VC was favoured. Patients found VCs relevant when not needing a physical examination. One patient expressed it like this:

"Video is ok if I do not have to have a physical examination." (Patient, age 38)

Theme 1: It gives me less time as being ill and more time for my life and living

Generally, most patients mentioned VCs as less time-consuming, which allowed them quickly to continue with their jobs and personal lives. Having appointments at the hospital was more disruptive in their daily lives than a VC. It was argued:

"It (video consultation) gives me less time as (being) ill and more time for my life and living (than to be present at the hospital)." (Patient, age 53)

And further

"My life in everyday life. At 12 (o'clock) a patient and 12.30 I am me again." (Patient, age 53)

Theme 2: The video consultation is more like a conversation with an actual human being next to me

The interaction in consultations was addressed as well. The patients generally experienced HCPs being focused and paying attention during the conversation. They expressed that a consultation via video felt like a real conversation, as expressed by patients:

"The healthcare professionals pick up if I have understood, and they respond to my facial expressions and body language." (Patient, age 65)

And further:

"It feels good that the healthcare professional saw and sensed me – meeting someone instead of a voice on the telephone." (Patient, age 47)

Compared to a telephone consultation, being heard, seen and respectfully reacted to was an advantage of the interaction in VCs. Further, it was appreciated that the HCPs explained the framework of the VC and ensured that the patient could hear and see sufficiently. Another critical factor was that the HCPs looked directly into the screen for eye contact or explained why they were gazing elsewhere. These factors were, for instance, expressed like this:

"At the start of our conversation, the doctor asked if I could see and hear her; this resulted in the speaker being turned slightly up." (Patient, age 75).

"It was my impression that the healthcare professionals were appreciative and listening. She (the healthcare professional) further told (me) that she was looking away from the screen as she wrote notes. That was nice as one (the patient) does not get uncertain whether there is someone else in the room or what is going on." (Patient, age 67)

It was nice for the patients to meet a patient-focused HCP who took responsibility for the VC by paying attention to both the patient's end of the interaction and explaining what was happening at the hospital's end. This could help patients feel they have the complete attention of the HCPs.

Theme 3: Video consultation provides better possibilities for receiving healthcare

Video consultations was experienced as beneficial by patients when in need of healthcare and was envisaged in more situations. Generally, the patients argued that VC worked if they were not newly diagnosed or needed a physical examination. They also suggested that it could work for a follow-up or closure consultation. Further, VC may be used as a pre-consultation before surgery or treatment, as expressed like this:

"If I have been physically examined and know what is wrong with me or what it is all about, video (consultation) is excellent - and I save the transport and time." (Patient, age 37)

And further expressed:

"If a physical examination is unnecessary, I prefer video (consultation). Then I do not have to take time off work and spend half a day at the hospital." (Patient, age 37)

A remote consultation can be okay or even appreciated in situations without a physical examination on the agenda, as it is less time-consuming and requires less transport and waiting at the hospital.

The time allocated for the VC was addressed as well, as it, among others, made it easier for the patients to plan their day and enabled them to invite a partner or relative to participate in the meeting, as expressed like this:

"When I know the time for the scheduled video consultation, I can ask my sister or husband to participate." (Patient, age 31)

The patients argued that a scheduled VC was better than a random phone call. Further, the patients noticed that it did not matter to them or the conversation that they had met the HCPs previously, although it was stated that it was nice to know the HCPs had read their medical notes and knew their story.

Some patients elaborated upon possible future benefits of VC. They hoped implementing VC would reduce hospital waiting lists and cancellations, expressed like this:

"I have experienced several times that my appointment has been cancelled or moved. Maybe video (consultation) can improve the possibility of receiving a conversation, and then there is more time for those (patients) who need to be at the hospital in person." (Patient, age 25)

For some patients, VC was assumed to be less time-consuming for HCPs than in-person consultations at the hospital, which would also benefit the system.

"If I must take time off work, I must involve my colleagues. Using video, I can go into a room for myself and return to work much faster." (Patient, age 45)

Not letting down on colleagues was important for patients. Moreover, sitting in privacy was mentioned as part of the argument for VC. It was, for instance, expressed like this:

"It is easier for me to answer questions (from the HCPs) when I feel safe at home." (Patient, age 31)

Safeguarding the patient's identity at home could be easier than at the hospital, with the added benefit of a higher sense of safety.

Theme 4: The time waiting online feels slightly long

Patients also had challenges in VC. Patients with little knowledge of technology had help from the hospital's IT support or their children, as expressed here:

"My daughter helped me log in, and it went well. (Patient, age 75)

Further, some patients mentioned that the virtual waiting room made them uneasy, unsure if they were still waiting or kicked off the meeting, as discussed here:

"The time waiting online feels slightly long when you (patient) are sitting in front of the screen. I got a bit uncertain if it worked and if I could leave the screen during the waiting period." (Patient, age 53)

Or further elaborated:

"It could be nice to have a text on the screen explaining what to expect. Then I could walk around a bit. After all, one must get ready 15 minutes before starting. I would never think about it if I were sitting in the waiting room at the hospital. However, here I sit and look at an empty screen." (Patient, age 36)

It was a disadvantage in VC that patients in a waiting position felt they had to keep their screens activated to stay in the queue with the physician. They could not spend the waiting time on anything but waiting.

Theme 5. Agenda and agreement matters

It became evident that the patients appreciated being prepared for the VC with the HCPs, as expressed here:

"When using the telephone, they (HCPs) call at a time we have not agreed on, and I am unprepared. Using video, I can rely on the time and prepare myself." (Patient, age 41)

An issue among patients was to feel safe in the consultation. Before the consultation, preparation by HCPs and patients seemed to be the cornerstone in making patients feel safe in VCs. It was, for instance, expressed like this:

"For me, it is not whether the conversation is on video or physical at the hospital but because they (HCPs) have read my medical journal and are prepared. It is so exhausting to have to retell my story every time." (Patient, age 47)

"It would be nice to have an agenda for our conversation. I have had several encounters (at other wards) at the hospital, and I did not know the focus of the video consultation. I feel safe about using video consultation, but I wish the agenda for the conversation were mentioned in the appointment letter." (Patient, age 53)

A scheduled time and an agenda for the conversation, which would have enabled patients to be prepared and HCPs to be well-informed about the patient's hospital trajectory, were asked for, as it would have added to patients' feeling safe during consultation. It should be mentioned that patients might have something for the agenda and that not all themes are suitable for a VC. However, making the consultation form accessible to the patients would solve that challenge, as expressed like this:

"I felt safe using video consultation. However, it is voluntary. Video works well – but it depends on what we are about to talk about." (Patient, age 31)

It was evident that the patients felt that using VC was their choice and were conscious about which topics of their health situation could be discussed during a VC.

As expressed by another patient.

"Telephone conversation is suitable for short, clear and concise messages whereas video gives better possibilities for a two-way communication". (Patient, age 52)

It appeared that the purpose and agenda of the consultation determined patients' preferences regarding the method of consultation, e.g., video or phone.

Discussion

In summary, the results of our study found that patients interviewed agreed that VC was a way forward in meeting HCPs for outpatient hospital appointments. Receiving a VC was valued by patients as it felt like "a real conversation", and they felt less burdened by their disease when time was saved when meeting online. Yet, when delays occurred, waiting online induced insecurity in patients. In addition, the agenda for consultation was essential in determining if VC was suitable, and thus, it was important to include patients' perspectives when planning VCs.

In our study, patients were used to FaceTime situations and appreciated the usability of the technology, as others have also found [26,27]. In addition, we found VCs to facilitate a quick transition into and out of the patient role and again back to the role as a colleague or another private role, which the study participants appreciated. Hospital visits can be disruptive in daily life [28], and a need to take time off work or rearrange family responsibilities can add to a stressful and inconvenient experience [28,29]. Further, the patient role can induce stress when meeting with HCPs, leading to anxiety and a sense of loss of control [30]. It can be important for patients to sustain an everyday life where stable and meaningful daily routines can continue [31] and where VCs can provide the flexibility to do so.

Our patients had an overall positive experience with VCs. For them, important parts were the whole visual and auditive attention from the HCP and an attitude of awareness regarding the technique on the patients' side. To be met with recognition and respect (i.e., to be seen, heard, and taken seriously) and compassion (i.e., I see your suffering and altruistically want to help you) has earlier been found to be necessary for patients [32,33], and why communicative-, technical- and in situ training of HCPs are relevant when introducing VCs in clinical practice. Further, the ability to include the visual part in the VCs has, by others, been noted as a significant advantage over telephone consultations, enhancing the overall patient experience [34,35].

Study participants said they felt safe and secure at home during the VC. Ensuring patient privacy and security during VC is crucial, especially when discussing sensitive topics [36]. For example, raising concerns about patients' lower abdomen can be taboo and make them feel stigmatised and shamed [37]. HCPs report VCs to provide visual information about patients, their home environment and non-verbal cues, which can foster a more trustful and open dialogue [38]. Yet, in general practice, patients and HCPs report that very personal or

serious issues are unsuitable for VCs [5]. As explained by a participant in our study, VCs should be an offer highlighting awareness of setting and patient preferences when introducing VC, as confirmed by others [39].

We found VCs to offer numerous patient benefits, such as increased accessibility, convenience, less time for transport, and potentially reduced waiting times, as seen by others [27,40,41]. Patients can quickly reach a specialist and receive healthcare through expert advice and treatment, enhancing their confidence in their treatment plans and care [42]. In addition, consultation time during VC can be shorter than face-to-face consultations [43], potentially reducing waiting time for an appointment with an HCP. However, it's important to note that patients in our study were triaged for VC eligibility by specialist doctors to ensure no physical examination was required. Otherwise, an extra follow-up visit in-hospital would be necessary, increasing the burden on the patient, using HCPs' resources, and stressing the importance of patient triage in providing VCs in a hospital setting.

Challenges in VCs were also identified, as study participants would experience insecurity while waiting for the VC to start. Their screen was blank, so they were unsure whether they were disconnected or still online. This is an important finding, as attention must be paid to the virtual waiting room, as it is part of the patient experience, informing further development of the technology used for VCs, e.g., a notice on the screen telling the patient that the HCP will connect shortly. It underlines the importance of involving patients and their perspectives when developing digital technologies in healthcare and how delays in VCs could be addressed in the virtual waiting room.

Our study revealed that some participants lacked the agenda for the VC, as they received a standard appointment letter from the hospital with no consultation topic. This added to the participants' insecurity, as they wished to be prepared for the VC. Assurance about the agenda in an upcoming VC allows the patients to prepare themselves. It enables them to ask relevant questions, which is essential to ensure their autonomy and self-efficacy [44,45]. It may also encourage conversation and increase patients' competencies in following the conversation while preserving their independence and communicating on equal terms. Further, an agenda may improve compliance so patients feel they are in control and the dialogue is meaningful and vice versa. A lack of an agenda may increase uncertainty and a lack of power within the patient [36,46]. Following the Calgary Cambridge Guide during patient communication will contribute to more patient-centred communication and pave the way for shared decision-making [47]. In this way, an overall agenda in the appointment letter and a patient agreed-upon agenda at the start of the consultation serve the patients. Moreover, it will further benefit the HCP by providing structure in the conversation and a more focused approach [47].

Strengths and Limitations

Our study holds limitations that should be taken into consideration. This study serves as a pilot study, why results should be interpreted with caution before deciding upon up-scaling the intervention into other settings and patient populations. Further, the smaller study sample must be considered as more and various perspectives may apply in different settings and cultures. Reflexivity was maintained throughout data collection and analysis to reduce bias and ensure transparency [23] by discussion within the author group. A strength of this study was the novel approach to piloting VCs in a university hospital setting that can be further developed and adjusted for

further implementation of VCs in other countries and settings. In the future, this will provide patients with easier and more flexible access to healthcare.

Conclusion

Video consultation is relevant and can be a valuable tool in a gynaecological outpatient setting, as it enhances the patient experience and expands access to healthcare services. However, it's important to note that VCs can be highly effective for discussing patients' symptoms, follow-up care, gynaecological health aspects, and how patients cope with the disease. It is to be noted that some conditions still require in-person visits for physical examinations, diagnostic tests, and specific treatments, which is why it's essential to recognise that VC may not be suitable for all medical evaluations and treatments. Therefore, triaging patients for eligibility for VCs is vital, ensuring relevant patients, e.g., no need for a physical examination, and ensuring patients' preferences regarding the consultation topic align with the patient's preferences in regard to method of consultation, e.g., VC, phone or in-clinic visit. However, for many patients, especially those with anxiety or mobility challenges [5,29], VCs can be a less stressful and intervening alternative to in-person visits. Special attention should be placed on the virtual waiting room and patients receiving adequate support for online consultations.

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Competing Interests

None declared.

Contributors

C.L.L. served as the project's principal investigator (PI) and guarantor, drafting the protocol in collaboration with M.M.F., with further contributions from M.K.T. M.K.T. was responsible for the data. All contributors played an active role in the planning process. H.F. conducted all interviews. C.L.L. and H.F. analysed the data and discussed their interpretations with M.M.F. and M.K.T. C.L.L. wrote the first draft alongside M.M.F., which was refined by M.K.T. and H.F. All authors have approved the final manuscript.

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