

Video consultations in general practice – a multi-method study investigating opportunities and challenges

Introduction

Video consultations provide new opportunities but also challenges for healthcare delivery. It provides rapid, convenient access to healthcare with several studies documenting an increase in patient satisfaction (1-4). In remote areas video consultations have been shown to offer an opportunity to educate patients and improve access for rural areas (5, 6). In a recent research project conducted in the Region of Southern Denmark, “The Partnership Project”, multidisciplinary video-based consultations between cancer patients, oncologists and GPs have been tested and evaluated leading to promising results regarding the degree of patient-centred communication (7-9).

However, video consultation might also lead to safety issues and risk of misdiagnosis due to lack of physical examination (10), it might increase prescription rate and general use of healthcare and it might impact the doctor-patient relationship negatively due to lack of physical contact, mechanical intonation, delayed response and motionless body language. Furthermore, video consultation might increase pressure through supply induced demand and defensive practices and negatively affect equity and access to healthcare, because not everybody has access to or are capable of using this new technology (3). Accordingly, technologies are not passive devices that only facilitate medical actions, but they deeply influence social interaction and meaning-making processes.

Until the Covid-19 pandemic crisis, video consultations were only to a limited extent implemented in general practice in Denmark, mainly by pioneering innovators. Now video consultations have been implemented across many general practices in Denmark at an unprecedented pace (11) and the future of video consultations in general practice, their scope and fee calculation, are at present being negotiated taking account of opportunities and challenges.

A solid and thorough evidence base regarding video consultations is, however, lacking. Therefore, research-based insight is crucial for politicians, clinicians as well as patients for safe and high-quality use of video consultations in future general practice.

The present multi-method study will increase the evidence base regarding video consultations in general practice and assist Danish GPs and politicians in future implementation processes. In the following we will outline the research areas that the present project will investigate and to which individual work packages (WPs) have been planned (described in detail below).

Background

Clinical issues

One central issue to investigate is how video consultations affect the diagnostic process – and thus quality of care. Lack of physical contact has implications for examination of the patient. In the meeting with a patient, a constitutive role of being a doctor is diagnostic certainty. Yet, doctors are not trained to diagnose through video consultation. The diagnostic assessment includes a clinical physical impression that involves notice of, e.g. the patient’s colour, breathing, eye contact, awareness, which may be lost when patient and doctor are looking at a screen (12). Furthermore, normally, the clinical impression already starts when the patient enters the waiting room; the way

they greet the staff, walk to the consultation room, small talk before and after, reacts to the doctor's action (13). This is taught in medical school, by colleagues and through own experiences. Consequently, a central question can be raised as to how doctors interpret and handle the diagnostic uncertainty that follows a new diagnostic setting?

Ethical issues

Moreover, it is important to consider the process leading to the actual video consultation. Who are invited to or able to utilise these online consultations (14)? Health inequalities is an area of great importance in the context of eHealth since it appears that eHealth has both the potential to reduce and increase social health inequalities (15). Is the introduction of video consultation in general practice yet another quality improvement for those patients who are used to and comfortable with navigating the digital health care system, overlooking the digitally illiterate and vulnerable patients who do not fit the criteria for a successful video consultation? This could be because they are deemed unsuitable for video consultation due to health reasons (hard of hearing, sight impaired, cognitive impairment, etc.), language difficulties, inexperience with using technology or due to their 'vulnerability' which is most often categorized by the GP (16). Thus, it is crucial to consider how and by whom patients are evaluated as being suitable for video consultation, and equally to address the reasons informing the decision as to which patients are not considered suitable for video consultation.

Furthermore, knowledge about who the new users of video consultations are is paramount in order to mitigate that vulnerable patients, who are in need of help, are overlooked for inclusion in the use of video consultations (17).

Relational issues

Another central question to scrutinize, pertaining to doctor-patient interactions, is how video consultation impacts on the doctor-patient relationship and how it shapes communicative modes in the doctor-patient relationship. Research shows unequivocally that good communication within a trusting doctor-patient relationship is central to the delivery of quality health care and patient satisfaction (18, 19). This points to the importance of good relationship-building and communication in video consultations if patient satisfaction and good medical care are to be achieved. In face-to-face consultations, the interaction is co-constructed in a variety of communicative modes - for instance, verbal choices, posture, facial expression, clothing, environment, and so on - that combine to create meaning in interactions. However, the basis for this interaction is changed when doctor-patient consultations are mediated by technology. Consequently, the digital consultation shapes social interactions in medical care as it takes out face-to-face encounters and instead mediates the interaction via features in a digital environment. Current studies (20, 21) have described advantages and disadvantages with digital email consultations related to the medium's technological features and mediated relational aspects in the patient-doctor relationship.

Furthermore, patients who are invited to video consultations must handle the challenge to get their agenda across this new media. As a part of the Patient Centered Method, the GP is expected to clarify the patient's concerns and preferences, and to choose those to be addressed together with the patient (22). 'Upfront agenda setting' covers the process by which the GP and the patient prioritize their agendas and negotiate them from the start (23, 24). A study of consultations in a general practice in the UK shows that on average, 2.5 problems are discussed in each consultation (25). In a study from Denmark, 35% of consultations in general practice addressed more than one problem (26). The need for agenda setting is accordingly present in many consultations but may be working differently in video consultations. This might be at the expense of

the patient's agenda and may require new skills from the GP. Shared decision making is an important part of patient involvement and includes elicitation of preferences and exchange of information and experiences eventually reaching a treatment decision through communication between patient and GP on an equal level (27). On a practical level that may also include looking at the same sheet of paper or looking at the same computer screen during a consultation. An important aspect of studying video consultations will therefore be to evaluate technical challenges in information exchange and if agenda setting and treatment decisions are still made in a spirit of shared decision making.

Organizational issues

Lastly, the introduction of video consultations in general practice means that the working methods and routines are adapted to new practices created by new technologies. It is therefore important to investigate, in an initial phase of the introduction, how adaptations to new working methods and technologies are made and how they impact on the working life of practice personnel (6). From existing international guidelines, it is known how the successful implementation of video consultation into general practices requires a planned and coordinated approach, involving staff training, and coordination of responsible staff members (28, 29).

It might be that the introduction of video consultation has created new opportunities for work variation, and selection of new practices and patterns of action for health personnel and that the introduction of new technology in the practice environment has been experienced as an important source of flexibility and change. It might also be, however, that negativity and resistance against this new technology has emerged influencing team interactions- and collaborations. It is therefore important to investigate the views and experiences of the practice personnel regarding this, and knowledge hereof will further a successful implementation of video consultation.

Another organizational aspect to investigate is the inter-relationship between the different consultation forms (f-t-f, telephone, email and video). For instance, how are video consultations used in relation to the other consultation forms – as a supplement, a replacement? And in which situations? What are generally the GPs' motivations behind their choices of consultation forms?

Overall aim

In this project, we aim to explore the opportunities and challenges of video consultations in general practice, focusing on key clinical, ethical, relational and organizational issues.

To target the aim, this protocol includes four work packages (WPs) based on different study designs and empiric materials.

Systematic literature review

As the initial preparation for the project, a systematic literature review will be conducted, reviewing the current evidence on the subject and identifying knowledge gaps (30). The general objective of the review is to identify and determine clinical, ethical, relational and organizational issues (opportunities and challenges) pertaining to video consultation in general practice. A minimum of three databases will be searched and quantitative, qualitative and mixed articles will be included, evaluated and synthesised.

WP1: Clinical issues

WP1 comprises two studies employing quantitative and qualitative methodologies respectively.

Study 1.A is a register-based study combined with a questionnaire focusing on investigating the characteristics of the new users, diagnostic processes, patient safety, quality improvement, and continuing professional and organizational development.

Study 1.A also focuses on contact and prescribing patterns in video consultations (in relation to e.g. antibiotics, painkillers and psychotropic drugs) and also specific patient groups at risk of delay to e.g referral to investigation of symptoms. The clinical encounter consists of a complex interplay of contextual influences and relations. A change in prescription patterns in video consultation may therefore result not just from the video consultation itself but from the change or lack of contextual relations usually present in the clinic.

Research questions:

1. What are the patient characteristics associated with participating in video consultations (socio-economy, health literacy, comorbidity, actions performed, prior use of the health care system and contact pattern with the GP) and how do patients experience and benefit from these consultations (patient satisfaction, patients feeling of being insecure, consultation outcomes)?
2. What are the GP characteristics associated with adopting video consultations in general practice (Gender, practice types, provider profile, prescribing patterns)?
3. To what extent does video consultations substitute other consultation forms (f-t-f, telephone, and email consultations) and to what extent are video consultations just adding to the present patterns of services provided in General Practice?
4. What are the practice patterns (medicine prescribing, hospital admission and other services provided) following video consultations in comparison with other consultation types?
5. What is the number of contacts with primary care (daytime and out-of-hours), stratified for type of contacts (incl. video)?

Design, methods and analysis

Study 1.A is based on the unique National Danish registers. Among the registers is the Danish National Health Register (31), which holds individual information on all in- and outpatient hospital contacts, including discharge diagnosis and operations; the Danish National Prescription Registry, which contains information on all prescription drugs dispensed at Danish Pharmacies (32); the Danish National Health Service Register, which comprises information on activities in the Primary Health Care System including type of consultation and services provided. Data from these registers will be linked with registers on Statistics Denmark on socioeconomic position (e.g. housing, educational level, cohabitation status and occupation) (33) and the Danish Psychiatric Patient register, which comprises information on diagnosis, onset and end of treatment provided by psychiatric hospitals in Denmark including all in- and outpatient contacts. Information on vital status and migration will be obtained through linkage to the Central Person Registry (34).

Furthermore, questionnaires will be developed based on results from interviews conducted in WP 2 (described below) and on a literature review identifying international validated questions concerning health literacy, health status and patient satisfaction with video consultations. A draft questionnaire will be circulated for feedback to the project user panel consisting of patients and health care professionals together with individuals with both content and methodological expertise. Comprehensibility and cognitive equivalence of the preliminary questionnaire will be field tested

through face-to-face interviews with 10 persons with and without experience with video-consultations and diverse gender and education levels.

Population: For the register analysis, all Danish residents are included in order to describe healthcare use in daytime and outside office hours. For daytime, we include contacts with patients from all five regions, whereas for out-of-hours we focus on the four regions with a GP cooperative. Data from the registers are supplemented with data from patient questionnaires. Questionnaires will be sent for a selection of patients, who have been using video consultations and a selection of patients, who in the same period have had telephone contacts, but no video contact with general practise.

Analyses: Healthcare use in General Practice will be operationalized according to patterns of consultations, diagnostic patterns (e.g. blood samples, spirometries, blood glucose measurement, etc), referral to procedures at hospitals. Medication according to type and dispensing pattern, i.e. pain killers, antibiotics etc. Patients' comorbidity will be based on Charlson index as well as on each patient's morbidity as indicated by drug consumption patterns as we do not have direct information on the diagnosis of each patient's diseases treated entirely in General Practice. Descriptive analyses will be stratified per type of contact and time of day (office hours versus out-of-hours). The safety of video consultation will be investigated by a description of hospital admissions and deaths after video consultations compared to other types of contacts. In our multivariable hierarchical analyses, we will focus on associations between whether patients are receiving video consultations versus other sorts of consultations. As explanatory variable we will include: Comorbidity and socio-economy and prior knowledge with the doctor, operationalized by using consultation pattern in the preceding year. Further, by retrieving Geographical Information System (GIS) information, we will analyze associations between distance from home to the GP's clinic and probability of the consultation being a video consultation.

Employing a qualitative methodology, **study 1.B** focuses on whether overall aspects of the diagnostic process are changing during a video consultation compared to a regular consultation. A video consultation and regular consultation could be alike but neither GPs nor patients are trained or experienced in interpreting the small differences. How does this influence the diagnostic process? Furthermore, we will have a special focus on patients with severe mental illness as an example of a vulnerable group of patients.

Research questions:

- What are the GPs' immediate experiences, thoughts, and feelings when they do video consultations in the initial phase of the implementation?
- Which information is getting more attention and value and why?
- Which information and diagnoses are considered more uncertain compared to regular consultations?
- Which information and diagnoses are considered with same certainty or even more certainty than usual?
- What initiatives or actions follow changes in diagnostic uncertainty?

Design, methods and analysis

15 GPs who have limited experience with video consultation prior to the Covid-19 pandemic crisis will be interviewed. The interviews will follow a semi-structured interview guide, which explores perspectives on, and experiences with the GPs' first video consultations in relation to diagnosing. Questions will focus on themes such as the clinical reasoning and diagnosing compared to the

experience from regular consultations and other contact forms; the change in focus and importance of the information they can get through video consultation including their knowledge of the patient prior to the video consultation; the degree of new (kinds of) diagnostic uncertainty compared to regular consultations; and the way the GPs choose to act on the new uncertainty (if any). If the GPs continue using video consultations afterwards, new interviews will be performed to follow up. The sample of GPs is aimed to be heterogenic (but not necessarily with maximum variation) by recruiting doctors of different age, gender, etc. Due to the new conditions for the GPs, the study is furthermore an intensity sampling: the informants will be extra aware of the new setting, thereby amplifying important aspects through more reflections by the GPs. Furthermore, we will use recordings of video consultations to support the data collection and the analysis.

We will use the analytical hexagon as strategy to link empirical data with methodology and theory. Further, based on The Clinic Action Cycle, we will analyse clinical reasoning in the individual consultations in relation to evidence-based medicine (35).

WP2: Ethical issues

WP2 focuses on the process leading to the actual video consultation and addresses how GPs decide which patients should be presented with the opportunity to participate in video consultations. Throughout the WP2 we particularly focus on how different categories of vulnerable patients (e.g. health illiterate, elderly people, people with disabilities and/or mental illnesses, migrants and ethnic minorities, geographically excluded, individuals affected by poverty and unemployment, etc.) may or may not benefit from this option, and how decisions on eligibility are made. Furthermore, WP2 focuses on identifying whom the new users are, both patients and clinicians, describing their characteristics.

Research questions:

- How are decisions to offer video consultations to patients made?
- What factors influence or determine which patients are considered eligible for video consultation?
- Which kinds of consultations (in terms of disease, diagnosis or prognosis) are considered suitable for video consultations?
- How are video consultations presented to patients and how are decisions to use video consultations negotiated?
- How is 'vulnerability' addressed in the process leading to deciding to use video consultations?
- If the patient refuses video consultations offered what is the reason and what is the alternative offer?

Design, methods and analysis

In order to understand how GPs evaluate and arrive at decisions on which patients and consultations are eligible for video consultations, the project is designed in two steps.

The first step of the project consists of individual semi-structured interviews with 12 GPs, who are familiar with using video consultations (17). The interviews will follow a semi-structured interview guide, which explores perspectives on, and experiences with, which diseases, what forms of consultations, and which patients may benefit from video consultations. Questions will focus on themes such as: on what knowledge about the patients do the GPs base decisions to invite them to video consultations, how is this knowledge used, and how is the concept of video consultations presented to and received by the patients? Furthermore, we will ask the GPs to provide descriptions of the different forms of vulnerabilities among patients that they foresee will be of relevance in terms of benefitting from video consultations.

We aim to ensure maximum variation among interview persons in relation to gender, age, geographic location and practice type among our interview persons, by using a purposeful sampling (25) when recruiting participants.

The second step of the project consists of focus group interviews with GPs, who are familiar with using video consultations. The central aim of the focus group interviews is to explore perspectives on how video consultations may be applied in ways that either do not exclude certain patients groups, and perhaps even improve access for some of these groups, or how video consultations may pave the way for more clinic consultation time for the patients most in need. The focus group method is a particularly useful method when it comes to exploring interaction and dynamics among interviewees (36) and thereby presents a unique room for exploring diversities in perspectives on vulnerability and decisions on the appropriateness of video consultations. The descriptions of different forms of vulnerabilities derived from the individual interviews will be used as concrete cases to begin the discussion. Subsequently, the interview persons will discuss how decisions of when to use video consultations are made, both in relation to particular patient groups as well as particular forms of consultations.

We will carry out three focus group interviews and, aim to include 5-6 GPs in each group. In terms of gender, age, geographic location and practice type we will ensure variation, by using purposeful sampling (25). The interviews are expected to last between one and two hours and will be recorded and transcribed verbatim. Subsequently, all interview data will be coded thematically (37) and analysed from a social constructivist perspective, where focus will be on categorization and social identity (38, 39).

WP3: Relational issues

WP3 focuses on how we ensure that patients and health professionals feel seen, heard and included in video consultations and how room is made for those social modes of interaction that relations of care and support are built upon.

Research questions:

1. What perspectives do GPs, nurses and patients have on how video consultations affect communicative processes and the patient-general practice relationship (e.g. trust, confidence)?
2. What communicative and relational processes can be observed in the actual content and context of VC (e.g. sound and image, verbal choices, posture, facial expressions, environment)?
3. What conditions are needed to establish a person-centred approach, including agenda setting, shared-decision making and which elements in the consultations are more satisfactorily covered in other consultations forms in order to maintain good alliances and trust in the doctor-patient relationship?
4. Which measures for individualization are taken in the use of video consultations to accommodate different patients' needs, abilities and contexts?

Design, methods and analysis

WP3 consists of two interrelated studies, each referring to the above-mentioned research questions:

Study 3.A is designed as a qualitative hermeneutic-phenomenological interview study (40). The study population consists of GPs, nurses and patients who have used VC as consultation form. Approximately 30 GPs and 15 nurses will be invited to participate in the study with the aim of including a minimum of 20 GPs, 10 nurses and 20 patients. The GPs will be contacted by email and asked if they want to participate in an interview (of a duration of 30-60 minutes) that focuses on gaining insight into their perspectives on communication and relationship-building through VC.

They will furthermore be asked to invite 1-2 patients, with whom they have conducted VC, to participate in an interview focusing on experiences with VC. Maximum variation is strived for through a purposeful sampling technique (41). The interviews will be guided by a semi-structured interview guide and will be conducted either online or face to face, depending on the measures taken during the corona period. The collected data will be analysed following a hermeneutic-phenomenological framework (40) focusing on technology-mediated perception, transformation and constitution (42, 43).

The empiric material of **Study 3.B** consists of: 1) video recordings of the VC themselves, that is the on-screen interactions between GPs and patients emitted by the devices (e.g. computer, tablet, mobile phone) captured using screen-recording software and 2) video recordings that provide a broader context of the environment beyond what can be seen on the consultation device's screen consisting of footage taken from cameras (e.g. handheld digital cameras or tablets) set up in both the GP's and the patient's room.

GPs and patients of the sample of study A will be invited to participate in study B as well, asking them to record two of their VCs using screen-recording software and to set up a camera in their room during the VC. Using a multimodal interactional perspective informed by a social semiotic theoretical framework (44, 45) a description and analysis of what can be observed in the VC will be undertaken. A discourse analysis based on pragmatic linguistics will address issues of negotiation of agenda (46). The empirical material of Study 1.A and 1.B will be combined in an analysis of individualization based on the theoretical concept of 'tinkering'(47). For both study A and B participants will be asked to provide written informed consent before participation.

WP4: Organizational issues

WP4 focuses on capturing the practice personnel's views regarding how the implementation of video consultation has created and required changes in the organization of work tasks, workflows, workload, responsibilities and duties within the clinic.

Research questions:

- How are the integration- and implementation processes of video consultations being organized within general practice clinics (e.g. appointed coordinators, staff training)?
- What changes and/or alterations into clinic workflows, roles and routines do video consultations imply and how are they being managed by the practice staff?
- How are video consultations, including the virtual waiting room, ideally integrated into and aligned with practice workflow?
- What are the practice personnel's perspectives on whether or not video consultations have created new work opportunities and variation and/or altered workload?
- How are video consultations integrated with other consultation forms?

Design, methods and analysis

WP4 involves a focus group study with practice personnel in which general practice clinics that are familiar with using video consultations are invited to participate. The focus group method has been chosen as method for data generation because its interactional features are fit for exploring subjective experiences and viewpoints in relation to changes in workflow, working routines, new roles and responsibilities that the introduction of video consultations may have created (48, 49). In selecting the clinics, variation is sought in terms of geographic location and practice type and when selecting participants for the focus group interviews, we seek to achieve variation as well in

terms of gender and age through a purposeful sampling strategy.

Data will be generated through six focus group interviews with GPs and practice personnel, approximately 5-8 participants per group. Data will be analysed using a thematic content analysis inspired by a hermeneutic-phenomenological focus on understanding and meaning.

The focus group interviews are expected to last approximately one hour and will be audio-recorded and transcribed verbatim. Data will be analysed according to the core principles of a thematic analysis approach (50).

Research ethics

The collection and handling of data in this project will be carried out in accordance with GDPR regulations. Participants will be issued with an information letter describing the project and how their data will be used. Participants will be asked to provide written informed consent before participation in the project. The collected data will be imported using ELAN and NVivo software, pseudo-anonymised and stored securely at SDU, AAU, KU and AU. Data will be shared in DeIC (Danish e-Infrastructure Cooperation). Data will be deleted or transferred to the Danish National Archive in accordance with Danish archive legislation 5 years after collection.

Perspectives and practice relevance

The results of this project will create added value for both GPs, their patients – and society at large. Increased knowledge from this project about video consultations will assist GPs in expanding and qualifying their practice in this new area of health service provision with a special view to the special needs for vulnerable patients. The results of this study will be used to develop instructive material that will enable more patients and GPs to become confident users of the video consultation option focusing on clinical safety, relational, organizational and ethical aspects. The material will also be integrated in the educational training of GPs and other health professionals.

A qualified use of video consultations thus has the potential to be an addition to secure the delivery of high-quality health provision in general practice.

Organisation

The project will be anchored at the Research Units of General Practice in Odense (University of Southern Denmark), in Aalborg (Aalborg University), in Aarhus (Aarhus University) and in Copenhagen (University of Copenhagen) where research conducted within related topics provide an optimal research environment. The project is led by a steering committee consisting of the four Heads of research units (professor Jens Søndergaard, professor Per Kallestrup, professor Janus Laust Thomsen, professor Susanne Reventlow) with professor Jens Søndergaard as chairman.

The project is guided by a panel of users consisting of GPs, nurses and patients representing all regions in Denmark. Regular meetings are planned with the members of the panel and they will be consulted regarding the acceptability and feasibility of video consultations in general practice and development of questionnaires.

The project groups at each research unit comprise the following members:

Odense:

Jens Søndergaard – Professor, Head of Research Unit, GP, MD, Clinical Pharmacologist, PhD (expertise in primary care research and in register-based research)

Elisabeth Assing Hvidt – Associate Professor, MA, PhD (expertise in social interaction, digital consultations and qualitative research)
Jesper Bo Nielsen – Professor, Head of Department, MSc, PhD (expertise in health communication, in shared decision making and in quantitative research)
Sonja Wehberg, senior statistician, associate professor, MSc, PhD (expertise in register-based research and in statistical modelling)
Carl J. Brandt – MD, PhD, post.doc. (expertise in tele-health and in general practice)
Anette Grønning - Associate Professor, MA, PhD (expertise in media and communication, qualitative research)
Carole Jepsen – Research Assistant, MA (expertise in multi-modality and in qualitative research)
Nina Primholdt Christensen – Research Assistant, RN, MSc (expertise in tele-health and in qualitative research)

Aarhus:

Per Kallestrup – Professor, Head of Research Unit, GP, MD, PhD (expertise in primary care research and in intervention research)
Linda Huibers - Senior researcher, MD, PhD (expertise in acute primary care research)
Bodil Hammer Bech - Associate Professor, MD, PhD (expert in register-based research)
Morten Bondo Christensen - Senior researcher, MD, GP, PhD, (expertise in primary care research)
Ulrik Bak Kirk – Digital health program manager, MSc (expertise in health care communication)
Line Due Christensen - Post doc (expertise in qualitative research)
Anna Mygind Rasmussen - Senior researcher (expertise in quality improvement research)
Claus Høstrup Vestergaard -Statistician (expertise in register-based research and in statistical modelling)

Aalborg:

Janus Laust Thomsen - Professor, GP, MD, PhD Head of Research Unit (expertise in primary care research and in research on eHealth)
Jette Kolding Kristensen – Professor, GP, MD, PhD (expertise in primary care research and in interventional research)
Camilla Merrild -Associate Professor, anthropologist, PhD (expertise in qualitative research and in social inequality in health research)
Malene Krogh - Research Assistant (expertise in quantitative research)
Lotte Lykke Larsen - Research Assistant (expertise in qualitative research)

København:

Susanne Reventlow - Professor, Head of Research Unit, GP, MD, DMed Sci, MSc (Anthropology) (expertise in primary care research and in qualitative research methods)
Ann Dorrit Guassora, Associate Professor, MD, PhD. (expertise in consultation research and in qualitative research methods).
Christoffer Bjerre Haase, MD, PhD student
Torsten Risør, Associate professor, MD, GP, MA. Med. Ant. (expertise in consultation research, primary care research and qualitative methods)
Tina Drud Due, Post doc. cand.scient.san.publ. (expertise in organizational research and in health services research.)
Edacan Bilici, student Folkesundhedsvidenskab, research assistant.

Timeline

The project is set for immediate initiation. The chart below shows the timeline of the project:

Year	2020 May to Dec.			2021 Jan. to Dec.			
Action	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Recruitment of participants							
Data collection							
Data analysis							
Meetings with user panel and project group							
Communication of results to stakeholders							
Knowledge dissemination: scientific papers							

Budget

The amount applied for will (if accommodated) be divided into four equally large parts and thus shared between the four units.

Year		Seeking	Own contrib.	Grand total
2020	Salaries	1.500.000 kr.	500.000 kr.	2.000.000 kr.
2020	Remuneration (GPs)	100.000 kr.	0 kr.	100.000 kr.
2020	Operating expenses	100.000 kr.	100.000 kr.	200.000 kr.
2020	Publication fees	100.000 kr.	0 kr.	100.000 kr.
2021	Salaries	1.500.000 kr.	500.000 kr.	2.000.000 kr.
2021	Transcription	120.000 kr.	0 kr.	120.000 kr.
2021	Operating expenses	100.000 kr.	100.000 kr.	200.000 kr.
2021	Publication fees	100.000 kr.	100.000 kr.	200.000 kr.
	Total	3.620.000 kr.	1.300.000 kr.	4.920.000 kr.
	Operating budget	362.000 kr.	572.000 kr.	934.000 kr.
	Total + Overhead	3.982.000 kr.	1.872.000 kr.	5.854.000 kr.

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