‘Good Care’ and How Technological Innovations Represent – and Create Changes to – This Notion.

A Case Study of Legevisitt

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Summary

The notion of ‘good care’ – or ‘good patient treatment’ – is something that has been widely debated within the field of Science and Technology Studies (STS). This is especially prominent in care-studies, where scholars have discussed what values that constitute this notion, and how these are disturbed or changed with the implementation of technological innovations. I will in this thesis make further investigations of this this debate by looking at how the values that are associated with ‘goodness’ are prone to change with technological innovations in the health care services and industry.

For this study I have decided to look at one specific case where technology is implemented in medical care. The case I have chosen is that of Legevisitt, which is a business situated in Oslo that offers standard medical consultations. What makes Legevisitt an interesting case is their use of technology. This is not one single technical object, but rather a set of programs that increase their ‘efficiency’ and ‘flexibility’, while at the same time cutting several costs that are usually associated with medical practises.

The combination of these different digital programs makes up an online platform of labour distribution, where approved doctors can do independent work through the business as consultants. In addition to this, the programs eliminate the need of secretaries and nurses, as well as most paperwork. They also offer a variability of medical consultation services, from traditional medical consulting at the office and home-visits, to video-chats and online-forms. In this way, Legevisitt offers an untraditional kind of medical consultation, where the usage of modern technology enables them to offer health services in a manner that is both efficient and flexible.

What I aim to do in this thesis, is to look at how Legevisitt represents a change in what is considered as ‘good care’, as well as how they in turn are creating changes to this notion. I want to investigate how the values that are attributed to care in order for it to be considered as ‘good’, are represented differently at Legevisitt than in the established forms of public medical consulting. I also want to discuss how we are witnessing an example of how technological innovations are in a position to change the ways that we are evaluating care-practises, as well as how they can be a result of such changes.

Key words: STS, care-studies, technology, digital platforms, telecare.

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Introduction

About the Study

What is to be considered as ‘good’ in terms of care? What is a ‘good’ relationship between a doctor and his/her patients? What constitute ‘good’ patient treatment? I find that the answers to such questions are not fixed, but rather they seem to vary within historical and cultural contexts. Claimed by several philosophers and scientific scholars: The concept of ‘goodness’ – something being of ‘good’ quality – seems to be one of great flexibility. It takes place in many different practises and carry with it a large amount of values that vary within different contexts. This is thoroughly discussed within several disciplines: sociology, law, ethics, politics, just to name a few. However, no matter the amount of research and discussion, the concept of ‘goodness’ is still one of fluid kind, and the values attached to it may vary between time, space and/or topics.

We can observe a growing interest in the western societies on implementing new technology in the health care services and industry. This comes in several forms, from new machines used in hospitals to examine and treat patients, to small devices that patients can have at home to decrease the need of actual meetings with their doctors, to devices that medical personal can use to follow the lives of their patients while looking at computer screens and so on. Much of this technology introduces the possibility of caring for patients from a distance. Such innovative practises can be described as ‘telecare’ and enables the treatment of patients without an actual meeting[1].

Of course, not all technological innovations within the health industry falls under the category of telecare, and some might find themselves in somewhat of a grey area. However – being described as telecare or not – most of these innovations arise from issues caused by a gradually aging (and growing) population, and greater expectations for efficiency, cost reduction and quality of health care.

[1] Pols, *Care at Distance – on the Closeness of Technology*, page 11

I will in this thesis take a closer look at the notion of 'goodness' in the treatment and care of patients, and how it changes with the implementation of technology. Since this is a broader question than what can be tackled in a limited amount pages and time, I have decided to look at how this notion is represented in the standard patient treatment of medical consultations. I aim to look at how the use of new technology changes the ways that doctors are operating. I also want to discuss how these changes are representing or generating further changes in the values which are associated with 'good care'. I am mainly interested in the case of Legevisitt, a Norwegian medical business which implement technology in the form of a digital platform of labour distribution in order to increase its efficiency. This new way of facilitating for medical consultations makes the act of 'caring' and 'treatment' take on more of the form of a private service than a public offer.

By looking closer at this case, I hope to contribute to a more general discussion of how implementation of new technology is inclined to make changes to medical professions, as well as the idea of 'good care'. On a more concrete level, I wish to show how the specific technology which is implemented at Legevisitt changes the nature of medical consultations and the ways which the doctors are operating. By analysing these changes from the point of view of Science and Technology Studies (STS), I also hope to show how they represent – and also contribute to – a change of values in what is to be considered as 'good care'.

Legevisitt as a Case

Legevisitt is a private medical practise, which offers medical consulting as well as the creation and renewals of medical prescriptions. It is particularly interesting for exploring digitalization and commercialization of medical care, because it combines the two concepts. By using digital programs, Legevisitt offers a knowledge-intensive digital platform of labour distribution directed towards Norwegian doctors. By implementing innovations of digital programs, telecare and business structures, Legevisitt works as a case to illustrate how the use of new technology enables changes to the ways which medical care can be both thought of and performed.

They offer their customers four types of medical service: The first is a traditional form of medical consulting, which takes place at the clinic. Here, the consulting itself is similar to what is offered by other health-services, but the appointment is scheduled online through digital programs, from the patient's own computer or cell phone. Secondly, patients have the opportunity to order home visits, these are ordered in the same way, but instead of going to the clinic, the doctor will visit the patient at his/her home. Legevisitt also offers medical consulting through online video-chats, which can easily be scheduled and performed online. Lastly, they offer their patients/customers the opportunity to order prescriptions by filling out an online form. So far, these prescriptions are only renewals of birth-control, but there is an intention of the firm to expand this offer to include other forms of medication.

A total of seventeen different web-based third-party applications are used by Legevisitt. These are communicating with each other and constitute a digital platform of labour distribution, which cuts down administrative tasks and costs. A platform of this kind shares certain similarities with digital platforms used in the context of business. For instance, it shares similarities with firms such as Airbnb and Uber in the sense that they offer a triangular network of trade, where both the ones who are selling services, and the ones who are buying them, are connected directly through the platform.

However, the technology that is used by Legevisitt differs from that of Airbnb, Uber and similar businesses, on several points. First off, it is implemented as a part of the health industry, which is of great difference from that of tourism and transportation. Traditionally the Norwegian health services has been of a paternalistic structure, which in recent times seems to have been gradually weakened.[2] However, even if the last twenty years have offered a higher degree of 'choice' in the Norwegian context of medical care, it is still often referred to as a (public) service, rather than an industry. While tourism and transportation are centred around economic gains, care-practises are (for the most part) focused on health, at least in the public discourse. They also inhabit a larger degree of educated employees, which brings me to my second point: The platform is of a knowledge-intensive kind, meaning that it demands a certain level (and type) of education from the people who are using it in order to sell their services. It also seems to be far more restrained in terms of usage, both by the firm that is using it, as well as by public regulations. Due to these differences, other digital platforms of

[2] Heløe, «Fra Paternalisme til Pasientrettigheter»

labour distributions that have developed across the western societies, are not necessarily to be considered as relevant to this discussion.

When it comes to the platform in question, it is important to note that this is not one, but rather a set of digital programs, which all serve different functions so to give room for a new way of offering medical care. It is only when several of these programs are working together that we end up with a digital platform of labour distribution, which creates somewhat of a link between doctors and their patients. Some of the programs are schedules, where the doctors who are working as freelance consultants through the firm can sign themselves up for work. Other programs are responsible for the online booking system, where patients can decide for themselves what kind of consultation they want, and at what time. Then there is the program that offers the possibility of online vide-chats, as well as another program which offer renewal (and possibly at a later time, the creation) of certain prescriptions through an online form. There are also programs responsible for keeping statistics on the daily operations of the firm, and others for following up on former patients and gather feedback from these. Then of course, there are programs which distributes salaries, pay the invoices from medical consultants and take payments from costumers. The combination of these programs is what I will treat as the digital platform of Legevisitt. It is, as I have now explained, not one technology in particular, but rather a set of them, which constitute a new form of distributing medical services and executing these.

In short, the case of Legevisitt represents a new way of offering medical services in Norway. The doctors who are working at Legevisitt are for the most part working as consultants, meaning that they are to be considered as sole proprietors without employees. These are not hired in a traditional way, but rather they are approved by the business, and given the opportunity to take jobs at the clinic when there is a need for this. In this way, both the freelance doctors and the patients are to be considered as users (of the platform), while in a traditional practice, only the patients take on this role.

It seems obvious that this use of modern technology creates changes to the ways which doctors are operating and offers new ways of managing a medical practise. However, the processes in which these changes take place have not yet been mapped out. At this time, there is a too large amount of uncertainty when it comes to how such changes amount and evolve. In this thesis I will be looking closer at what these changes actually are at the current point in

time. I also aim to conclude by saying something about how they might develop, and what further changes they might generate. The case of Legevisitt will serve as an empirical example of these changes, illustrating both the immediate results of these as well as what the motivation behind them are.

I also find it probable that with such changes to the daily operation of doctors, it follows certain changes to the values attached to the notion of 'good care'. What choices that are made by involved actors, are made due to an opinion that they are in some ways 'better' than the alternative. I will also use Legevisitt as a case to look closer at how this notion of 'good care' is represented differently in this form of medical service than in more traditional practises.

Background for the Study

The idea of 'good care' has been discussed by several scholars within the field of STS. Especially within care-studies, scholars have problematized and analysed the fluidity of this notion. In her book, *Logic of Care*, Annemarie Mol writes about how 'care' has a logic of its own. She mentions how simplified values such as efficiency, flexibility or – in her case – the freedom of choice, is not necessarily good when attached to care. The discussion of what constitutes as 'good care' seems to be much more complex. Another STS-scholar, Jeanette Pols, has also dealt with such complexities, and discusses how the use of modern technology shapes the treatment of patients. Here, we can also see that distinguishing between 'good' and 'bad' care is far from a simple task. I therefore find that – although thoroughly discussed in STS – the nature of 'good care' is still in need of further investigation, especially with the implementation of new forms of technology.

In April of 2019, the Norwegian Ministry of Industry and Fishing issued a white paper on the health industry. This is the first of its kind: Where the political interests concerning health care practises are handled by the ministry of industry and fishing, illustrating a change in the way which politicians are treating such practises; from being addressed as collective welfare, to that of an industry. The white paper aims at evaluating national health care practises from

an economic perspective and as a part of the national industry. Emphasizing the importance of widespread public access to health services of good quality, it states that all technological solutions should contribute to better, safer and more user-friendly services that are both sustainable in terms of resources as well as being profitable. To do this, the white paper notes the importance of a collaborative relationship between the health services and private businesses[3]. It claims that this collaboration will contribute to both the effectivity and quality in the Norwegian health services as well as the Norwegian economy as a whole; by facilitating for commercialisation of health care, and in this way increasing the creation of overall wealth within the health industry[4].

A press release from the current government was published on the same date as the release of this white paper, stating that the national Ministry of Health is in support of a collaborative relationship with the Ministry of Industry and Fishing when it comes to the health services. In the press release the Minister of Health – Bent Høie – describes the collaboration as a 'kinder-egg'-solution, claiming that a closer relationship between the public health care services and the private industry will offer the patients better services, which are more sustainable and effective, as well as be advantageous for the national economy by increasing knowledge and increasing the job-marked.[5] Legevisitt – and the technology that is used there – fits this idea of 'good care' that is presented in the statements issued by the Norwegian government. Therefore, an analysis of this case does not just contribute to an understanding of the firm, how their operation differs from that of traditional medical consulting, and their notion of 'good care'. It also works to illustrate an example of what a 'good' medical practice as presented by the current Norwegian government might look like.

Legevisitt is one of very few examples of a medical consulting firms in Scandinavia that uses a set of technology which makes up a knowledge-intensive digital platform of labour distribution directed towards doctors. Such kinds of business models are still in the early stages of development, especially in the Nordic countries where there is an underrepresentation of highly skilled workers – with longer education – who works through digital platforms[6]. The consultants who are working at Legevisitt – as well as anyone who is

[3] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 5:2
[4] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 5:3
[5] Regjeringen «Stortingsmelding om helsenæringen: Sammen om smartere løsninger»
[6] Steen. Et. Al. «The Knowledge-Intensive Platform Economy in the Nordic Countries" 3.2.2

performing work through any kind of digital platform – are at this time to be considered as a minority in the Norwegian workforce, where only about 0,5-1,0 per cent of the working age population is believed to have performed work through such platforms in 2016[7]. Due to the minimal size of this form of work, it seems probable to assume that a larger degree of knowledge about its operation, effects and motivation is lacking from academia, and especially within care practises where digital platforms of this kind are of a minimal size.

By looking at Legevisitt, we can observe a clear example of a commercial actor in the medical field, who implements technological innovations in order to cut costs and increase the efficiency and flexibility of the practise. Most notable is their digital platform of labour distribution, which in addition to creating a new way of administrating work hours also enables an increased accessibility of telecare. Both when discussing such platforms from a general point of view, and when discussing them within the field of health care, I find the topic to be of a controversial kind. Most notably, this use of technology facilitates for a commercialization of health services that generate a lot of both public and scientific debate.

Within STS, several scholars have critically discussed such changes in the ways that care practises are performed. The works of, Hilde Thygesen, Ingunn Moser, Annemarie Mol and Jeanette Pols, are prominent examples of this. While in the public arena, commercialization of health care practises is an ongoing political debate. A quick google-search on the subject will reveal how both people with associations to the health services, and regular citizens have strong opinions on the subject. For instance, the Norwegian Association for nurses writes that the white paper on the health industry is written on the premises of private actors and that the political goals are not related to an increase of quality within the services[8]. A newspaper named 'Velferd' (translated 'welfare') recently referred to a survey suggesting that one in two Norwegians are negative to commercialization of welfare-practises[9]. Although this survey includes schooling and child welfare in addition to care-practises, it is a clear indication that commercialization of medical care and treatments is a subject which divides the population.

I therefore find a combination of technological innovations and commercialization to be of notable societal relevance. As mentioned earlier, the innovation of these digital platforms is

[7] Steen. Et. Al. «The Knowledge-Intensive Platform Economy in the Nordic Countries" 3.3.4
[8] Bjøro, «De helsepolitiske målene lite relatert til kvalitet»
[9] Fjeldstad, «En av to sier nei til kommersiell velferd»

still to be considered as a new – and almost microscopic – phenomenon, but due to their ability to cut costs and increase the productivity of labour I find it reasonable to argue that further development is to be expected. The effects of this might vary across different fields in society. However, some general assumptions can be made by looking at such effects within a single case in the health industry. In the case of Legevisitt, the platform allows for an increased accessibility of telecare, as well as offering a larger degree of commercialization of health care. This new way of viewing medical care is – as already argued – widely debated in both the mainstream media and scientific literature, and an analysis of what these changes actually represent is therefore of both societal and scientific relevance.

From the scientific point of view, there are several arguments amongst scholars within the field of STS that express a need for further investigation of the interaction between health care and technology. This is a large and complicated theme that cannot be fully covered in one study alone. However, by looking at one particular case, and study some of the findings within it, I will contribute to this discussion by showing how one specific form of technological innovation is in a position to change the daily practises of doctors. This will also work as an example to illustrate the fluidity of the notion of 'good care', which is a topic discussed by several STS-scholars. I hope to contribute to their discussions by pointing out how the implementation of knowledge-intensive digital platforms of this kind are contributing to changes to this notion.

Research Questions

To best investigate how the technology that is used by Legevisitt contribute to a change in how health services are conducted, and how this in turn represent a change of values of what is to be considered as 'good' in terms of care, I have developed two research questions. This is because there seems to be two parts to this discussion. The first has to do with the notion of 'good care', how this is of a fluid kind, which varies in different social situations. I want to look closer at how this notion might change with the implementation of new technology by asking the following question:

How is Legevisitt and their use of technology representing a change in what constitutes as 'good' in terms of care and patient treatment?

By answering this, the analysis will first off gain concrete knowledge of how Legevisitt, as an actor in the health industry, is contributing to changes to the notion of what is to be considered as 'good care'. However, it will also provide a deeper understanding of the values that are attached to this notion and the fluidity of these. The question seeks to map out what qualifies as 'good' in traditional medical practises, and how the idea of 'good care' is represented differently at Legevisitt. By looking closer at the motivations behind these changes in daily operations and the implementation of the digital platform, I believe we will see how this form of technology represents a different set of values than what can be found in more traditional care-practises. My goal here is not to discuss whether one set of values is better than another, but rather it is to argue how such values are in a position of fluidity, where they are subject to incremental or radical changes with the implementation of new technology, or how they might be facilitating for such.

The second part of my discussion has to do with the concrete ways in which Legevisitt implement technology into their business-structure, and how this in turn can create changes in the medical professions. I want to ask:

How can digital platforms of labour distribution and telecare-services change what it means to be a medical practitioner?

I believe that by answering this, we will see how this specific form of telecare technology, when implemented in the Norwegian health industry in this way, is offering new ways of both treating, as well as interacting with, patients. We will also see an empiric example of how an implementation of a knowledge-intensive digital platform of labour distribution can affect the professional lives of doctors. One can from this knowledge draw some general conclusions of how the technology which is implemented at Legevisitt is in a position to change medical care practises as well as medical professions. One can also from this point make some logical assumption of what further changes might be if digital platforms of this kind experience further development in this industry.

Clarifications for the study

First off, I want to clarify some terminology. Since Legevisitt is a private practise with an actual office, we need to distinguish between the employees and the consultants. The business has some doctors who are full-time hired and not working exclusively through the platform. Although also to be considered as users of digital programs and telecare devices, these are working in more of a traditional manner. For instance, they are not selecting their own workhours through an online program but are bound to certain timesheets. These doctors are not to be considered as sole proprietors nor are they freelancers. Rather, they are full-time employees of the business that is Legevisitt. The consultants – which make out almost 90 per cent of the doctors associated with Legevisitt – are approved doctors with a contract that enables them to work freelance through the platform. These are not receiving standard salaries, but instead they are billing the company for their own completed work, which they are scheduling through digital programs. The distinction is crucial, since the consultants are using the technology as a digital platform of labour distribution, while the employees are hired – and working – in a traditional way.

I also believe it is important to repeat the fact that the digital platform, which is the subject for this thesis, is not *one* specific technology. Rather, it is a set of digital programs that together form a new way of both distributing labour amongst doctors as well as executing medical consultations. Some of these programs are clear examples of what is to be considered as telecare, others are merely facilitating for this. However, when in relation to each other in this way, I will argue that the platform itself can be described as telecare, because it enables communication between the carers and the cared for from a distance. This means that the medical consultation does not need to be done by a telecare device (such as a webcam or an online form) in order for the innovation to be considered as a contribution to the development of telecare. Even if the patients are to visit the clinic for a consultation there, or order a home-visit, they are still making use of the platform in order to schedule the appointment, just as the doctors are using it in order to organize their work in an effective way.

The digital platform used by Legevisitt is an on-site platform, meaning that even though it is digitally developed, the work that is delegated through it cannot necessarily be performed anywhere and delivered through the digital programs. In other words: The users of the

platform must perform their work at a specific physical space, thereby the term ‘on-site’. The platform also requires high skilled workers and is therefore to be considered as of a ‘knowledge-intensive’ kind[10]. This makes an important distinction from other known platforms such as Uber, where the required skills are more of a lower kind, or Upwork where the services are delivered online. Although some of the consultations can be done online, the platform includes the possibility location-based services that requires a physical presence of the doctors. It is therefore to be considered as an on-site digital platform of labour distribution. The consultants who are working through the platforms, are also subject to strict evaluation of competence. It is therefore to be described as knowledge-intensive, which makes its behaviour and possible social effects radically different from digital platforms such as Airbnb and the like. I will therefore not include any further discussion of platforms of that kind.

Finally, I want to emphasize the fact that this thesis is not a discussion of whether one form of care is any better than another, nor am I interested in evaluating the goodness of the technology in question. My goal is to understand how this form of technology, when implemented in this way, changes how the doctors are operating, and how such changes represent a different set of values attributed to the notion of ‘good care’, than what is normally found in traditional medical consulting.

Structure of the Thesis

In order to understand how the use of technology at Legevisitt shapes the role of the doctors and offer a new way of evaluating the quality of medical care, I have chosen to separate this study into three different chapters. The first one will cover an overview of my applied theories and methods from the field of STS. Here, I aim to explain my use of empirical philosophy as the main method for my investigation. I will also give an account of script-theory, which establishes a theoretical ‘frame’ for my analysis. Then, I will explain some insights from care-studies that I find to be relevant to my study of Legevisitt, before giving an account of the

[10] Steen. Et. Al. «The Knowledge-Intensive Platform Economy in the Nordic Countries” 2.1.1

problematic aspects when it comes to defining the term ‘good care’. After doing so, I will describe my methods for the gathering and treating of information, which are a combination of document analysis and in-depth interviews. The last part of the chapter will be dedicated to a short explanation of its possible ethical issues, and what measures I have taken in order to minimize these.

The second chapter is of a contextualizing kind. The aim here is to look at the societal context that gives room to – and encourages – businesses like Legevisitt and their use of technology. The first part of this chapter looks at how governmental figures facilitate for a commercialization of health care, by delegating the Ministry of Industry and Fishing the responsibility of evaluating the national health care practises as an industry. I will then go on to look at how standard medical consulting is traditionally performed in Norway. After this, I will go on to explain how values which are attributed to ‘good care’ varies within different societal contexts. For instance, how governmental white papers have a different way of treating this notion than actors within the established medical community. From this, I hope to have described a context from where practises such as Legevisitt develops, and how values of what constitute as ‘good’ in terms of care and patient treatment is represented there.

In the third chapter, I will go on to explain how Legevisitt operates as a private actor within this societal context. Where I aim to show how this private business is representing a different set of values than what is traditionally present in public care practises. I will then take a closer look at both the users and the technology at Legevisitt. First off, I will explain the role of users and their relation to technological innovations from a more general perspective. Since the focus of this thesis is mainly to look at how the doctors are affected by this technology, I will go to analyse how their profession might change when they are attributed to the role of a ‘user’. Here I will analyse how this new arrangement of work, that comes with the implementation of the digital platform, changes the ways that they are operating.

I will then go on to look at the technology that is implemented at Legevisitt. First, I am going to analyse their use of digital programs which makes up the platform of labour distribution. Here, I will discuss how this technology behaves at Legevisitt, as well as how it represents a different set of values than what can be found in traditional medical consultation practises. Then, I am going to analyse Legevisitt’s use of telecare, which is enabled by its digital

platform. Here, the goal is to show how such telecare practises represent a new type of care, with new possible challenges and contributions.

For my conclusion I wish to not only specify the findings of my analysis, but also to explain how the notion of ‘goodness’ in terms of care and patient treatment is dependent on technological innovations and societal contexts. I aim to illustrate how this is a fluent idea, which can be both an antecedent for – as well as a consequence of – technological innovations and the implementation and behaviour of these. At last, I also want to say something about how the technology which is present at Legevisitt and the notion of ‘good care’ might further develop and act.

Theory and Methodology

Empirical Philosophy and Multi-Cited Methods

To best understand the impact Legevisitt has on medical professions and the notion of 'good care', I find it useful to incorporate more than one method. By combining empirical philosophy with document analysis and in-depth interviews of involved actors, I believe I will be able to say something about how technological innovations of digital platforms and telecare can change the ways which doctors are operating. I also believe such a combination of methods will facilitate for a better understanding of 'goodness' in terms of care and patient treatment and illustrate the fluidity of this notion. I aim – by using these methods – to show how Legevisitt represents a different set of values than what is represented in other forms of – perhaps more traditional – care practises.

My main method is that of empirical philosophy. What I mean by this is a critical analysis of the gathered data. This include both interviews, documents as well as relevant literature and research within STS, especially within the field of care studies. I have decided to perform this analysis by drawing upon the theory of script, which I consider as a basis for my investigation because it offers a way of treating the technology as an actor, and examining its development in relation to others, both human and non-human. In this way, the theory avoids both the views of social construction and technological determinism. It offers a suitable framework for my analysis by enabling the opportunity of treating the technology as an agent, with the capability of impacting its environment, while at the same time being in a position to be impacted by it. In this way, it is looking at processes of co-construction without declaring either the technology or the society as paralyzed and without further influence.

Empirical philosophy is not a new way of treating data but has been used by several scholars within the social sciences. It is prominent within STS, and this critical way of analysing material can be found in several well-known social scientists. One of them is Michel Foucault, who performs critical discourse analyses of historical texts. He directs attention to a

co-construction of meanings[11], and in such a way he is analysing social phenomena not just as what they seem to be, but also *how* and *why* they develop and evolve into their current state. Texts are not just to be understood as representations of society, but also as creators of it. When doing empirical philosophy and applying such a method to standard text analysis, one has to be aware of a certain 'intertextuality', meaning the "assumption that meanings, like those informing sustaining practices, are produced as a series of relationships between texts, rather than residing within the text itself."[12] This way of understanding and treating texts – when used as source material – seems similar to the ways we treat technology within Script theory, and fits within this framework because it allows for the possibility of texts being in a position of agency themselves.

Script-Theory

As a theoretical frame for my analysis of Legevisitt and the use of technology that is implemented there, I will use the theory of script. This theory was introduced by Madeleine Akrich in her essay "The De-Scription of Technical Objects". The theory problematizes the networks that surrounds technical objects and their content. As several other STS-scholars have noted, every innovation seems to be a product of a set of diverse forces[13], which makes up an environment where the technology develops. The identity of the technology is therefore not an innate part of its design, but is shaped by the understandings of different actors, and their usage of it. One thing that distinguish script-theory from theories of social construction however, is that it is not only humans who can take on the role of actors, but also the technological artefacts themselves[14]. In this way, the technical objects and the environment where they exist, has a symbiotic kind of relationship, where they are shaping – as well as being shaped by – each other.

[11] Hay, *Qualitive Research Methods in Human Geography*, page 289
[12] Hay, *Qualitive Research Methods in Human Geography*, page 293
[13] Akrich, «The De-Scription of Technical Objects" page 205
[14] Akrich, «The De-Scription of Technical Objects" page 206

Akrich describes the behaviour of technological innovations and their influence without entering neither the field of neither social construction nor technological determinism. Rather, she is critical of both these theories, suggesting that there needs to be a way of treating technological artefacts without deeming them as only products of human actors without any influence of their own, or describing them as antecedents for all societal phenomena. When discussing how values are attributed to technology, she makes a comparison to a movie script, thereby the name "script-theory". The argument is quite simple: When innovators are designing the technology, they are in this process 'inscribing' certain visions about the world where the technology is imagined[15]. This inscription involves other actors, their values and relationships between them.

It is argued by theorists of technological determinism, that with the design of a technology it follows certain predetermined ideas about both the environment surrounding the artefact, as well as the behaviours and values of the actors who are interfering with it. However, script-theory is critical to this view, noting that although technical objects define a sort of 'framework' (or a script) of action with other actors within this space[16], users may not take on the roles that are expected of them or they may not act out these roles in the ways that was intended by the designers. The development of a technology and its identity is therefore – according to Akrich and script-theory – not fully dependent on neither the producers nor the users, but rather it is a product of ongoing negotiation between the two[17].

As mentioned above, the theory of script is distancing itself from those of social construction. It does so not only by noting the agency of non-human entities, but also by emphasising the power of the producers and their intended framework. The script which they put forward – although inclined to further changes and manipulation by other actors – has the power of initial definition of 'actors, the space in which they move, and the ways in which they interact'[18]. It also holds the power of delegating which aspects of the development (of the technology) that should be given to the technological innovation itself, and which aspects that should be left to human actors. In this way, the script has the opportunity to decide its own 'strictness', as well as the delegation of responsibility. It might choose to include some actors

[15] Akrich, «The De-Scription of Technical Objects" page 208
[16] Akrich, «The De-Scription of Technical Objects" page 208
[17] Akrich, «The De-Scription of Technical Objects" page 208-209
[18] Akrich, «The De-Scription of Technical Objects" page 216

and exclude others, or it might render certain actors responsible for further development and diffusion, while giving others a more passive role.

However, the script is not in a position of complete power. As mentioned earlier, some actors might choose not to play out their roles in the intended way. It is therefore important for a successful script, not only to define actors, the relationships between them and the networks they form: In order for the technology to develop in the intended way, the script must also establish systems of causality which can channel and stabilize such networks.[19]

It is natural to view script-theory as a version of Actor Network Theory. It emphasises the importance of studying not only the artefact, but also the actors who are – either directly or indirectly – involved with its development, and the networks between them. Script, however, is a theory where the focus is in larger part directed towards technological artefacts and their development and usage in society, while Actor Network Theory is traditionally applied to studies of laboratories and the production of scientific knowledge. Either way, they fit within the same line of thought, suggesting that neither technological determinism nor social construction are offering fully correct ways of analysing science and technology. The argument is that the development of a technology is not done with its implementation into society, but rather that processes of negotiation between actors (both human and non-human) are active in shaping this further. I consider such processes to be of importance when discussing the case of Legevisitt, especially because it is in such an early stage of development – with a script that is far from played out – suggesting that negotiations between actors are still ongoing.

The relationships between users and producers are a crucial part of this analysis, because the case introduces changes to these roles. While it is natural to ascribe patients as initial users of technology in the health industry, the digital platform that is used at Legevisitt also attributes this role to the doctors. In this case, the doctors have moved from being indirectly involved with the technology, which is developed for their patients, to active users of it. By using script-theory as a framework, I will have better basis for understanding how both the doctors and the technology are affected by this change of position. The theory offers a way of analysing the constant balance between how the technology is being co-constructed, and how it is in a position to be an antecedent for new societal developments. This will contribute to an

[19] Akrich, «The De-Scription of Technical Objects" page 220

understanding of how the doctors – as users – are negotiating the script, and in this way taking part in the development of the technology. However, script-theory also offer a way of analysing how the doctors in turn might be affected by it.

The theory of script allows for a thorough investigation of usage, which I will take into consideration when investigating this case. It is applied by several STS-scholars when discussing users and the ways in which they are configured by producers while at the same time being in a position to negotiate with them. One might argue that technological innovations are products of processes of co-configuration between the producers and the users[20]. On the one hand, the producers establish a script with predicted users, with predicted behaviours and relationships, while on the other hand, the users are the ones who are responsible for giving the technology life and implementing it into society. Certain organizations – many of them containing predicted users – can in some situations put certain restrains on the producers, and in this way the configuration might go both ways[21].

Script-theory is closely related to the studies of users, and how they play several parts in the construction of technology. First, they are imagined by the producers as a projected user group, and implemented into the script, or rather; the script is made to fit them and their expectations[22]. However, there are several such user groups, many of them developing after the artefact is introduced to the market. All of these are to be considered as active in the construction and use of the technology, and they might also be affected by it.[23]

While other fields of research might only be concerned with the imagined user, STS-scholars find that the relationships between the users and the technology are much more complex. For instance, both Christina Lindsay and Sally Wyatt draw attention to the non-users. These are actors who are indirectly involved with the technology by not using it, but they are often excluded from the studies of it[24]. Often, the reasons for non-use comes down to costs[25], but there might be other components that are relevant, such as social interests, affiliation etc. Since this is a thesis concerned with the health services and industry, which most people have some sort of affiliation with, it will naturally involve a large spectre of actors, both users and

[20] Pinch, *How Users Matter*, page 8
[21] Pinch, *How Users Matter*, page 8
[22] Pinch, *How Users Matter*, page 31
[23] Pinch, *How Users Matter*, page 32
[24] Pinch, *How Users Matter*, page 69
[25] Pinch, *How Users Matter*, page 73

non-users, which is either directly or indirectly involved with the technology. Since I am mostly interested in the specific case of Legevisitt and the doctors who are working there, the analysis will not concern itself with the study of non-users directly. However, because the technology in question is only used by a small number of actors (so far), the non-users are still of importance to its continuing development. The study of Legevisitt should therefore establish certain implications of non-users, how they are affecting the technology and how they might be affected by it.

In the book, *How Users Matter*, by Trevor Pinch and Nelly Oudshoorn, Anne Sofie Laegran contributes with a chapter where she studies Norwegian users and non-users of vehicles and the internet. She finds that a large part of the motivation of users has to do with freedom and mobility[26]. She argues that this is very prominent in Norway, due to the strong political and cultural emphasis on protecting the countryside from population-decline, as well as the personal right to settle in rural areas[27]. I find her findings to be relevant to my study of Legevisitt. The technology that makes up the business enables both care from a distance, as well as flexibility for the doctors and a higher degree of efficiency. Suggesting that the motivations behind this technology are in large part tied to mobility and freedom, just like with the innovations of internet, vehicles, telephones and the like. Laegran emphasizes that after the introduction of a technology, it follows a contingent and multi-dynamic process of *domestication*[28]. Although she claims this theory differs somewhat from that of script, I find these differences to be of little importance for my case. It suggests that even after the scripting of the technology, it has yet to play out, and actors might accept or reject their inscribed roles, or they might just tweak them a little bit. Laegran's notion of a domestication process only adds to the analytical perspective of the case and notes the importance of analysing how the actors – both human and non-human – perform their roles, and how this in turn might generate further societal changes.

It is not just the behaviour of users, but also the creation of these, which is of importance when analysing the script of a technological innovation and the performance of this. Often, in order to integrate new technologies into the market, producers need to construct new users. Examples of such are also debated by STS-scholars and demonstrate how the users'

[26] Pinch, *How Users Matter*, page 81
[27] Pinch, *How Users Matter*, page 85
[28] Pinch, *How Users Matter*, page 82

relationship with the product is a necessity for its realisation. If a common demand is already established, there will not be much need for this construction, but this is seldom the case. This is where mediators come in. These are important actors within the network of technology, producers and users. Johan Schot and Adri Albert de la Bruheze, implement economic theories presented by Nathan Rosenberg, when discussing their importance. They note that technological configuration takes place also after the phase of initial invention:

> *New technologies are not automatically superior to old ones, they have to be made better in a learning process … it is not only a matter of adopting technology to its environment, but also of adopting the environment to the technology.*[29]

It is clear that the development of a technological innovation is not a straightforward process, but (just like in the logic of care, which I will return to later) it has its twists and turns. It also involves several actors from different environments. The mediators are actors who are narrowing the divisions between these, and in this process, they are both constructing users, but also contributing to further development of the technology, by articulating and negotiating the script.[30] Translations and negotiations of this sort are crucial parts of the technology, since the market is hardly of an ideal and simple neo-classical kind where supply and demand are moving harmoniously as logically predicted. Rather, processes of this kind might take place at several different forums and arenas, where mediators have the opportunity to communicate with consumers, producers or both in order to make the technology *fit.*[31] In modern times, several of such arenas are located online in the forms of commercials, information-sites, internet-forums, scientific publications, articles and the like. A study of such arenas is therefore important to the study of the technology, since its identity is further developed, articulated and negotiated there.

I would argue that in the case of Legevisitt, one must 'create' new users in order to achieve success. By 'create', I mean that one must establish a target-group with a common set of needs and/or desirers. Not only does the business have to establish a set of costumers, they also need a group of doctors willing to participate and use the technology. As argued by Trevor Pinch, new forms of users has the power to make drastic changes to the technology's

[29] Pinch, *How Users Matter*, page 232
[30] Pinch, *How Users Matter*, page 235
[31] Pinch, *How Users Matter*, page 244

place in society, and can even change the nature of professions, like in the case with the Kodak camera that "changes photography from a specialized professional realm to a popular hobby"[32]. Of course, the case of Legevisitt is very different from that of the Kodak camera. However, the latter is a perfect example of how new forms of use and the creation of new user-groups, can create further societal changes. It also illustrates the importance of mediators since the new groups of users and their relationship to the technology, need to be established before such changes can take place.

Pinch also uses the development of a musical instrument called the Minimoog, in order to illustrate how mediators can invent and create new markets. This process is of great difference within different fields of technology, but his example begs the question of how such processes are represented in the case of Legevisitt. In the case of the Minimoog, a standard sales-technique of creating demand is used by mediators in order to create a market for the artefact[33], if a similar technique was used in order to create user-groups for telecare it could be viewed as very problematic, since the creation of demand of medical treatment would in many cases be considered as equivalent to the creation of sickness. However, I do not think this is always the case with the creation of telecare systems and products, since in many of these cases people are already sick, and the demand which is created is not one of medical treatment in general, but rather a form of treatment that both the carers and the cared for perceive as 'better'.

So how comes these new technologies of care to be perceived as 'better'? And are they changing the ways of which we judge whether a form of care or patient treatment is 'good'? With producers and mediators, it follows a 'vision' for the innovation, which can be said to work as a 'scenario' for future development and usage[34], or rather; a 'script'. As mentioned earlier, the script contains a large set of actors, both human and non-human, who all inhabit different sets of values and are inscribed with different functions and behaviours. In order to answer my research questions – and contribute to the discussion of what constitute 'good' care and the fluidity of this notion – I believe it is important to look at both the users and the

[32] Pinch, *How Users Matter*, page 248
[33] Pinch, *How Users Matter*, page 260
[34] Pinch, *How Users Matter*, page 268

mediators (which in some cases can be one and the same actor), and how they interact with each other and the script.

Care-studies

As mentioned in the introduction, the debate concerning 'good care' is widely discussed by STS-scholars within the field of care-studies. They are known to examine care-practises in depth, which is what I aim to do in this thesis. They oftentimes point out how political and/or technological goals are not necessarily in alignment with the quality of the care. Therefore, there is argued for an importance of empirical research of concrete situations where new technology is implemented into care-practises, in order to understand how these might affect each other. To best illustrate these aspects I have chosen to draw upon the analysis given by Annmarie Mol in her book *Logic of Care,* where she looks at care-practises for the people living with diabetes, and another analysis given by Jeanette Pols in her book *Care at Distance, on the Closeness of Technology*, where she takes a closer look at telecare and how it changes the ways of which patients are treated. Both these works are of relevance to my study of Legevisitt, because they are looking at how commercialization of care, and the creation and behaviours of telecare, are changing care-practises as well as general attitudes towards health care. Hilde Thygesen and Ingunn Moser are also prominent within the field of care-studies, arguing that new technology is neither just a support for existing forms of care, nor is it an absolute replacement of it. Rather, it offers *new* ways of performing care, with new ideals, actors, tasks, relations, positions, limits and so on[35]. These new ways therefore need to be mapped out if one aims to evaluate how care practises are shaped by technology.

Annemarie Mol writes about how care has its own logic, which varies from the norms and values found in other disciplines. She argues that, when care is commercialized and the language of the market is mobilised, patients become costumers[36]. This change represents much more than a change in linguistics: when care no longer takes the form of a public offer – or rather; a *gift* – but is bought by costumers, these do no longer feel gratitude towards the

[35] Thygesen, «Velferdsteknologi og teleomsorg: Nye idealer og former for omsorg» page 146
[36] Moll, *Logic of Care*, page 14

received help, but instead they feel entitled to it. This would create a change in health care: Where it is no longer driven by supply, rather by demand[37].

It would seem like such a change is empowering and good for the patients, since it suggests that they are now the ones who are steering and controlling the health services, due to it being driven by *their* wishes and desirers. However, Mol points out several problematic aspects of the notion of *choice*. One of them being that choice comes with responsibility, and that people are not necessarily good at making the right choices for themselves. This does not mean that one should avoid making them or eliminate the idea of freedom of choice. Rather, one should be mindful of how such ideas are implemented into practises.

As Mol notes: "In the logic of choice time is linear"[38], as soon as the choice is made, everything else follow from this, one part at the time. The evaluation of the choice only appears at the end, ones the result of it is ready. A timeline of this sort does not – according to Mol – correlate to the logic of care, where twists and turns appear and reappear, and constant evaluation needs to be done and redone[39]. The arguments given by Mol support the claim that neither the logic of care, the market, innovations, economics nor any other scientific or social discipline, develops in a linear process. An understanding of such domains therefore needs to include an understanding of possible variables of behaviours, which may in turn cause different outcomes.

Mol also points out how individuals tend to form collectives. When understanding an individual, we understand them as parts of these. However, the logic of choice and the logic of care deals with these collectives differently. Where the logic of care views individuals as shaped by the collective, the logic of choice views them as the constructors of it.[40] Such a distinction is similar to that of social construction of technology and technological determinism: Where one theory renders the individual responsible for the development and behaviour of a technology and thereby also its effects on society, while the other perceive individuals as passive bystanders who's life and society is shaped by the technology it inhabits.

[37] Moll, *Logic of Care* Page 14
[38] Moll, *Logic of Care* Page 54
[39] Moll, *Logic of Care* Page 54
[40] Moll, *Logic of Care* Page 57

As argued earlier, it is not the case that one view is right and the other is false. Rather, like argued by Akrich, it is likely that the individuals as parts of a larger collective, are both active in shaping it, while simultaneously being shaped by it. What is important to note however, is that the individual and the collective evaluate 'goodness' differently. They are evaluating their decisions from different levels, for instance: where the collective view health-statistics in large numbers, the individuals are viewing their personal health and health-risks from a micro-level. Mol uses the following example to illustrate this:

> *Take a population in which 100 people out of 10,000 die of a heart attack every year. Say that research shows that, if they all start to go for a daily run, the incidence of a fatal heart attacks decreases from 100 to 70. That leads to an impressive improvement … But what about the individuals in the population?... their probability of not dying from a heart attack in the course of the next year increases from 99 per cent to 99,3 per cent. This sounds much less impressive. While a decrease in deaths from heart attacks of 30 per cent is good for the population as a whole, for an individual with a 0,3 per cent extra chance of avoiding a fatal heart attack is a lot less appealing.*[41]

She notes that this difference in the evaluation of 'goodness' goes the other way around as well. The treatment of one individual – no matter how good – is rarely of importance to the larger collective. Therefore, when discussing the notion of 'good patient treatment' and 'good care', one might achieve different conclusions depending on if one is to study 'good' treatment of the individuals or 'good care' for the collective.

In other words, 'goodness' is a fluid idea, which takes different forms depending on the premises for the investigation of it. Mol's analysis is successful in illustrating this. She notes how ideas of what is to be considered as 'good' *is inscribed into technological innovations*: In the realm of care, where the innovations are made in order to improve lives, these must involve some idea of what counts as improvements[42]. Her arguments seem to be influenced by script-theory, as she notes how ideas of usage and morality are inscribed in technology, which – due to this inscription – is in a position to change societal frameworks.[43]

[41] Moll, *Logic of Care* Page 69
[42] Moll, *Logic of Care* Page 77
[43] Moll, *Logic of Care* Page 78

In her discussion, Mol is critical to commercialization and individualizing of health care. She notes how this field – and the actors within it – operates differently when it is driven by the market. The market, she claims, has a tendency of dividing people into target groups. The communication comes in the form of advertisements, sales and suggestions, in order to give people what they want. Then, there are the ones who want nothing – those whom can't be sold to – but need a lot[44]. Those people stop being a target group, and if the market is responsible for the facilitation of health care, these will not be considered when such facilities are being constructed. The field of health care is not immune to the existence of non-users. While the repercussions of being in this group are often considered to be rather harmless for the individual in other fields – such as transportation, communication etc. – one might miss out on crucial medical assistance by being a non-user of technological innovations within the health care practises.

To put it differently, Mol raises concerns with how commercialization leads to a lack of mediation towards actors who are considered as less profitable. In this way, these 'less profitable' actors are excluded from the negotiation processes of technology. However, Mol also note that it is an inevitable fact that "health-care practises depend on active patients"[45]. If the patient does not consider himself in need of care, there is little that professionals can do to help. Therefore, a certain level of individuality is needed, even if one is to view 'goodness' from the point of the collective.

The problems that are presented by Mol contribute to a larger philosophical debate than what constitutes as 'good care'. The questions she raises, and her arguments, make certain implications of problematic aspects of the notions of both individuality and freedom of choice. Debates concerned with such aspects can often become vague or complicated, and since I aim to keep this thesis as concise as possible, I will not spend too much time analysing the philosophical aspects of such discussions. However, I believe they are important to mention, because they illustrate the large amount of variability found in the term; 'goodness'. Even though Mol is critical towards individualism and liberal values in terms of care practises, I would not argue that she presents herself as anti-choice, or an opponent of personal liberty. Rather, she problematizes such ideas, especially when incorporated into the

[44] Moll, *Logic of Care* Page 22
[45] Moll, *Logic of Care* Page 72

evaluation of care, who's logic – she argues – is far more complicated than a straight-forward line with rigid definitions of what is 'good' and what is 'bad'. This is a central argument in the field of care studies, implying that medical cases often are dissimilar and therefore demand a wide range of empirical studies of these in order to say something about what constitute as 'good' in terms of care and treatment. In the case of Legevisitt, we observe one example of how the notion of 'good care' is changed with the implementation of certain forms of technology. Illustrating how this notion is of a fluid kind and needs to be investigated within different contexts in order to fully understand how it behaves.

Since values of personal choice and flexibility are prominent motivations of Legevisitt, their business model and their technology, I believe a critical view of such values is important to my analysis. Mol raises several concerns with commercialization of health care, and possible changes in values that might be a result of it. Her scepticism will serve to point out possible problematic aspects of the case, which are in need of further discussion.

When it comes to how technology – and especially telecare – interact with health care services, and how STS and care-studies treat such issues, I find Jeanette Pols to be of more relevance. In her book, *Care at Distance, On the Closeness of Technology*, she writes about how technological innovations within health care are perceived as both good and bad. 'Good' in the way that it offers efficiency and reduces costs, 'bad' because it seems to be perceived as 'cold'. This heated and polarized debate is according to Pols more of a juxtaposition: "a contest between 'inevitable' futures".[46]

Again, we are witnessing a critical point of view. However, Pols is neither critical of telecare as a concept, nor is she rejecting the arguments against it. Rather, she is critical to the debate it is surrounded by. She points out the lack of concrete knowledge surrounding the effects of telecare, and notes that: "Promises, nightmares, and dreams of efficiency have taken the place of knowledge and facts in the debate".[47] Some of this, she claims, is due to the close relationship between business and research, which we see in the western health industry[48]. However, she also notes that metaphors of temperature are not the best ways of describing the goodness of care. Instead she introduces the term *fitting*: 'Good care' – according to Pols – is

[46] Pols, *Care at Distance, On the Closeness of Technology*, page 12
[47] Pols, *Care at Distance, On the Closeness of Technology*, page 14
[48] Pols, *Care at Distance, On the Closeness of Technology*, page 14

care that *fits*, (not only by meeting the demands of directly involved actors, but also by maintaining the values that are attached to the idea of something being 'good').[49]

Telecare and other technological innovations of health care is then, not necessarily good or bad, it is rather a question of whether or not they *fit*. This understanding offers a more nuanced and complex way of evaluating technological solutions of care. General assumptions will be of less use when adopting such a view, since what can be judged as fitting in one situation, might receive a different judgement in another. Pols show several examples of this: When discussing webcams, for instance, she notes how some sorts of care are impossible to preform through a screen. Some of these are explicit – gathering of physical tests or handshakes – others are less obvious; "An embodied presence is needed to 'sense' trouble and also to give the right kind of support, particularly when words are running out."[50]

However, these forms of physical presence are not always of great importance when performing care. In some cases, they might be deemed as irrelevant or even distracting for certain actors. With a reshaping of skills, the carers can be able to offer similar services without an actual meeting, in situations where this is not a necessity.[51] In such cases, the costs of incorporating telecare seems small or in some cases non-existent. In addition to the lack of costs in terms of implementation, the technology is also offering a larger degree of efficiency – as well as cost reduction – than traditional care-practises.

Pols is offering a relativistic view of technology and its place in the health services and industry. Her analysis explains that there is simply not the case that technological devices – such as webcams – are 'good' or 'bad' editions to health care, because their effects are not universally fixed. Also, when discussing whether they are *fitting*, this depends on the needs of the patients, whereas some of these can be met better with a webcam, others need a physical interaction with medical personnel.[52] When describing the performance of care as being neither *warm* nor *cold*, but rather judging it in terms of its *fitness*, the webcam is in a position to offer improvements to such practises. For instance, the increased efficiency that is experienced when implementing them, is creating an increase of frequency of contact between

[49] Pols, *Care at Distance, On the Closeness of Technology*, page 45
[50] Pols, *Care at Distance, On the Closeness of Technology*, page 49
[51] Pols, *Care at Distance, On the Closeness of Technology*, page 50
[52] Pols, *Care at Distance, On the Closeness of Technology*, page 114

professionals and patients[53]. This is relevant, since making the professionals more accessible is presented as a large part of the motivation behind the technology which is used at Legevisitt.

I find that the view presented by Pols is arguing towards a more nuanced analysis of the 'goodness' of technology. How the technology acts, and what effects which might follow from it, depends on several other factors than the physicality of the technology itself. Although certain values and functions are inscribed in its initial lay-out, the ways of which the technology is used and mediated, is of importance to its continued success. Whether or not it is *fitting* depends on its inscribed qualities, but also the interpretation and performance of them.

In my analysis of legevisitt, I believe it is important to include the views of both Pols and Mol in order to determine how the technology that is implemented into the business represent a change of values. While Mol presents some problematic aspects of the notion of patient choice, Pols introduces the value of *fitness*. As mentioned earlier, this is not a thesis where I aim to evaluate the 'goodness' of neither the business nor the technology that is used by it. However, I would argue that both the notion of 'choice' and that of 'technological fitness', are present as core values to the technology in question. An investigation of this technology – and what changes it represents or invokes – therefore implies some an understanding of these notions, and how they contribute to its script.

Defining 'Good Care'

The Norwegian Ministry of Health published in December of 2018, a white paper for quality in the health services and the security of the patients. It defines 'quality' as arrangements which are: (translated) 'Effective, safe, secure, involving users (patients) and giving them the power of personal influence, coordinated, offering continuity and exploiting the resources available in a good way, being available and equally distributed'[54]. This definition includes

[53] Pols, *Care at Distance, On the Closeness of Technology*, page 117
[54] Helse- og omsorgsdepartementet «Meld. St. 11 (2018-2019)» 7.

such a large number of values, that it turns rather idealistic and not necessarily possible to achieve in practise. It is questionable whether all of the components can be implemented into the same system, and several of them would need a detailed definition on their own in order to be clear on what values they are actually encompassing.

Hence, defining what is to be considered as 'good care' is not a straight-forward task: Where one sociohistorical context might evaluate the quality of the care based on the patients' probability of recovering from disease, another context might acknowledge how some patients never get well and might judge the 'goodness' of care based on the treatment of these. In some contexts, where there are too many who are in need care, efficiency might be of greater value, than if there is an overrepresentation of carers. Some cultures celebrate the idea of personal liberty and might value care practises where values of this kind are imbedded. While in other contexts, the notion of personal choice is seen to be conflicting with the performance of 'good care'. For instance, as described by Hilde Thygesen and Ingunn Moser, some forms of care (in their example dementia care) do not necessarily *cure* patients in order to be perceived as 'good', but rather they aim to *sustain* them[55]. In such examples, 'individual autonomy is not perceived of as an innate capacity of human in humanist sense, but as *one* possible outcome of concrete relations'[56].

Such examples are prominent arguments within care studies, implying a need for a variety of empirical research in order to understand how ethics in the field of health care behaves in practice. As problematized by Annemarie Mol, ideals of 'patient choice' and 'good care' might in many instances complement each other, but more often they are in conflict.[57] As mentioned earlier, she argues that care has its own logic. It does not necessarily follow the same line of valuation as other domains. Unless one views care from a purely economic perspective, the quality of it cannot be measured in graphs and numbers. Mol notes: "Care is not a transaction in which something is exchanged (a product against a prize); but an interaction in which the action goes back and forth (in an ongoing process)"[58]. Due to this difference in logic, a static judgement of whether a form of care is 'good' is unsurprisingly difficult to make.

[55] Thygesen, "Technology and Good Dementia Care: An Argument for an Ethics-in-Practice Approach" page 130
[56] Thygesen, "Technology and Good Dementia Care: An Argument for an Ethics-in-Practice Approach" page 143
[57] Mol, *The Logic of Care*, page 1
[58] Mol, *The Logic of Care*, page 18

However, I would not argue for a postmodernist view and say that valuing care is an impossible task, or that there is no difference between 'good' and 'bad' care. Rather, as a suitable premise for this thesis, I would argue that the notion of 'good care' is one of fluidity. It twists and turns dependent on its circumstances. It can be inscribed into activities and technologies, which might deliver a different definition of it than what was available before. Mol describes the scripting of care – and the values within it – as a collective process. What constitute as 'good care' within a society, is partly based on stories that are told, or arguments that are made[59]. It might also come in physical form, in the sense that there is seldom one single actor involved in care processes, but rather each practise involves a chain of them.[60]

I will in this analysis treat this notion of 'good care' as something that inhabits values of interchangeable kind. This is not necessarily true for all of them, and some values might be universal. However, the philosophical debate of whether universal laws of morality exists or not, is too large to be incorporated into this thesis. What I aim to look at here, is how modern technology and business models within the realm of health care, represent new emerging versions what is to be considered as 'good' in terms of care and patient treatment. As described in the introduction, I have chosen Legevisitt as a case, and my goal is to illustrate how their use of telecare and a digital platform of labour distribution is representing a new way of evaluating the 'goodness' in health care practises.

Document Analysis

As a part of my investigation of legevisitt and their use of technology, I have analysed several texts of different kind. First off, we have the information presented on the website of Legevisitt. This website is an important actor in the sense that it takes on the role of a mediator and is offering information to users in a way that they will understand. Here, the analysis does not only show what concrete information that is given by Legevisitt and what that is left out, but also *how* this information is given, *why* it might have been given in this way and what effects this might have on the receiver. An analysis of these texts is also helpful

[59] Mol, *The Logic of Care*, page 76
[60] Mol, *The Logic of Care*, page 77

in understanding the values that are implemented into the business and the technology, and how these values are represented. I have also analysed texts that represent the more traditional forms of medical practise in Norway. This includes published articles from the journal of the Norwegian Medical Association (legeforeningen) as well as some articles from the largest medical newspaper in Norway 'Dagens Medisin' (translated: 'medicine today').

The main function of these texts is to get a better understanding of what values that are traditionally associated with 'good care' in the modern medical community of Norway. Although not explicitly a part of their written content, the texts are in part explaining how and why actors such as Legevisitt are breaking with the traditional understandings of 'good care'. They are also in a position to illustrate some reasons why such actors might experience further growth and development. In addition to this, the texts are also capable of explaining some of the most central concerns within the Norwegian medical community. By performing a critical analysis of these, I have been able to find some linkages between such concerns and the development of technological innovations of the kind that is implemented at Legevisitt. In order to perceive and understand these linkages, however, an analysis of these texts has included some investigation of what premises which are already implicit in them.

I have also looked at white papers issued by the Ministry of Industry and Fishing, the Ministry of Health, as well as statements issued by the government. These show the national political interests when it comes to health care as a service and an industry, as well as their use of technology and innovations of business structures. By analysing these, I have been able to look at how the notion of 'good care' – and its relation to both commercialisation and technology – is represented in modern political interests.

This form of critical text analysis is not uncommon in STS. In her studies of political technologies Kristin Asdal uses critical text analysis in order to illustrate how texts are in a position of being actants, and in this way influencing scientific knowledge and the communication of this. She makes the claim that written documents – or texts – are one of the most widespread technologies of politics and contribute to the initial definition of cases and controversies[61]. For instance, she notes how some texts might be perceived as neutral – or 'naked' – in the sense that they avoid from making any controversial or critical statements,

[61] Asdal, *Politikkens natur – naturens politikk*, page 53

but these texts are still inhabiting a distinctive type of mediation[62]. Such texts can be used to dedramatize certain controversies, normalize or change the perspective of them.

Drawing from analysis given by Max Weber, Asdal notes how bureaucratic processes tend to 'dehumanize' texts, by eliminating anything that can be considered 'irrational' or 'emotional' elements that cannot be estimated or calculated[63]. This form of 'dehumanizing' is also present in the texts relevant to this thesis. For instance, the white papers, where health care practises are evaluated from an economic perspective, are stripped of human emotions and personal situations. Although such texts might seem neutral, Asdal's way of performing critical document analysis illustrate how this 'neutrality' is also a rhetorical tool.

In short, I have analysed the texts in such a way that I have not only gained an understanding of what they want to convey to their audience, but also the ways of which they do so. I consider it as important to gain an understanding of what implicit information these texts contain, and how this represent some contingent values of what is to be considered as 'good care' and 'good patient treatment'. From this, I have gained better basis for arguing how Legevisitt, their business model and use of technology, represents a different set of values associated to 'goodness' in terms of medical consulting, than what is found in traditional medical consulting in general practise.

Interviews

I have administered interviews with three different types of actors. First off – and most importantly – I have talked to some of the doctors who work as consultants for Legevisitt. I was mainly interested in understanding their motivations working there, their relationship with the technology, and how they believed it impacted their professional lives and daily operation. I have chosen to do only a few, but qualitative interviews, with doctors who work only as consultants, and are thereby using the digital platform on a regular basis. The interviews have been personal and 'in-depth'. In this way the doctors have had the

[62] Asdal, *Politikkens natur – naturens politikk,* page 54
[63] Asdal, *Politikkens natur – naturens politikk,* page 214

opportunity to reflect upon the questions and give detailed answers. By administering the interviews like this, they have also contributed to the results of the research in a larger degree than what they would have been if they were only to answer a questionnaire or left out entirely[64]. The questions aimed to understand four things: what their reasons for choosing to work at legevisitt were; how their work lives there was of difference there than in traditional practices; how they experienced the use of technology impacted their work and what they believed constitute as 'good patient treatment' (in their field of medical consulting, or just in general).

I also interviewed someone who had the daily responsibility of Legevisitt. This was to get a better understanding of what the motivation behind the technology is. Here, I performed an in-depth and semi-structured interview, where I let the manager inform me of his thoughts on the case. I found it to be informative in order to understand their business model, but also to determine what was represented as core values – in terms of care – within their business and technological implementation.

Even though I was mainly interested in how the technology used by Legevisitt changes the ways which the *doctors* are operating, I found that patients became an implicit part of this discussion. In order to include some representation of these, I decided to talk to representatives from 'Pasientombudet'. This is a national council that has the responsibility of securing the rights and needs of users of the national health services. From them I wanted to get a better grip of what constitutes as 'good care' in legal and systemic terms, and what possible threats this notion is currently facing. I also wanted to ask their opinions on commercialization of medical consultations and the use of digital platforms of labour distribution and telecare, to find out where the council stand on such issues.

My interviews where all following a pyramidic structure. This was mainly due to two reasons: The first is that I wanted to be clear that there were no misunderstandings around the interviewee's relation to the case, it was therefore important to construct some concise questions about the case and their relation to it; the second reason was that it built a mutual understanding of what the interview was about and what information I was seeking, before it required any deeper reflection on the interviewee's part[65]. I wanted to keep the interview-

[64] Hay, *Qualitive Research Methods in Human Geography*, page 150
[65] Hay, *Qualitive Research Methods in Human Geography*, page 156

guide as semi-structured, in order to make room for flexibility to the conversations yet avoiding them from moving too far away from the topics of discussion[66]. I found that when operating with a somewhat free structure, I was able to get information that I would not initially have thought to ask about. I am also under the impression that this gave room for honest and detailed answers, which the interviewees thought out themselves, instead of just agreeing with a point on a checklist.

Ethical Research

In every research project there are certain ethical difficulties that one needs to be mindful of. Especially when using qualitative methods, one often invades the privacy of individuals in one way or another.[67] In this case, since this is a thesis about technological innovations of health care, I needed to be careful when gathering and treating the relevant data. In order to avoid any situations where the health care status of individuals could be made public, I decided not to gather any medical information of someone specific, but to only take statements from people who have a professional relationship with the health services and industry. Therefore, all discussions within this thesis – conducted over interviews or through document analyses – only aim to address medical information and health-related situations from a general and professional perspective.

I have chosen to exclude testimonies of former and current patients from my investigation, and this – in turn – rises a new ethical problem concerned with the representation of different actors. Because I did not include any personal information of any previous, current or potential patients, but only interviewed people with a professional relationship to Legevisitt, the thesis might become inclined to a bias in the favour of professional actors. I have treated this possible bias by doing two adjustments: First, I have tried to conduct the interviews in such a way that they included the perspective of possible patients, by asking some critical questions on their behalf; Second – as mentioned earlier – I have met with and interviewed the representatives from 'Pasientombudet', who are not associated with Legevisitt, but instead

[66] Hay, *Qualitive Research Methods in Human Geography*, page 158
[67] Hay, *Qualitive Research Methods in Human Geography*, page 31

have an interest in the rights and well-being of patients. By doing so – as well as being mindful of the lack of patient representation – I hope to have minimized the possible effects of this bias.

Because this is an investigation of one case in specific, I also believe it is important to note some possible ethical issues in terms of generalizability. I want to be clear on the fact that this is a study of a single case, and that the findings within this case do not necessarily translate to other cases. However, a case study – such as this one – offers in-depth understandings of the nuances within the defined phenomenon[68], and such findings can contribute to larger social theories, or adjustments of these. Meaning that even if the findings are located within this specific case, this does not mean that they will be un-transferrable to other aspects of STS. Rather, I believe it is important to be careful in making assumptions of their transferability, and I therefore try to avoid such actions in this analysis.

This is not to say that the knowledge gained from this case-study is only relevant for this specific case. In STS ethnographic case studies have been shown to have their epistemic advantages[69]. They have the ability to be more than just illustrations. For instance, they are often used to successfully deconstruct claims of universality, but they may also work as building blocks for larger theories[70]. In my conclusion I write about how the technology in question might further develop and present some possible outcomes of this development. Here, the case of Legevisitt is not only an illustrative example of a certain type of technology and its behaviour within this context, it also serves to highlight possible future development and challenges. In order to make hypotheses of this sort, I have not only analysed Legevisitt as an isolated case. Rather, I have investigated it within a sociological discourse, by looking at the political context in which the technological innovations develop and act. This context is presented in the first analytical chapter and contributes to a deeper understanding of the social circumstances that are surrounding Legevisitt. By performing the analysis in this way, I hope to have acquired knowledge, that is not just relevant to Legevisitt in specific, but also illustrates some general findings concerning the technology that can be relevant to different and/or larger discussions.

[68] Hay, *Qualitive Research Methods in Human Geography*, page 130
[69] Beaulieu et al. *Ethnographic Case Studies*, page 675
[70] Beaulieu et al. *Ethnographic Case Studies*, page 673

In short, there have been some ethical difficulties for this thesis, but none too large to interrupt the study. All the interviews who gather some kind of personal information, have been approved by the Norwegian Centre for Scientific Data (NSD). The interviewees who have given information that might make them recognizable, have been warned of this possibility, and given the right to withdraw from the project at any time. Those interviewees who have asked for a correction-reading, have gotten this opportunity before publication. No information concerning the health situation of specific individuals have been included in this thesis. I am aware that by doing to this, there have been a lack of patient representation, and again I wish to emphasize that the study focuses on the *doctors*, and how *they* are affected by the usage of technological innovations in the form of digital platforms of labour distribution and telecare.

The Analytic Chapters

In the next chapter, I aim to look at how the public discourse surrounding health care services and industry is behaving. By analysing white papers issued by the Ministry of Industry and Fishing and the Ministry of Health, I will give an account of how politicians are treating and evaluating the notion of 'good care'. I will also explain how this notion is treated within the Norwegian medical community, by analysing recently published articles from the journal of the Norwegian medical association and 'Dagens Medisin'.

These analyses will together illustrate a societal context that is present in Norway today. Within this context there is a prominent conflict: Where some actors are facilitating for commercialization of health care, others prioritize different sets of values. In this way, firms such as Legevisitt are illustrating a break with some established traditions and values within the Norwegian medical community, while being in cohesion with others. After giving an account for – and analysing – this context, I aim to investigate Legevisitt and the technology that is used there. This analysis takes a closer look at the case in question and will be the second and last analytical chapter of this thesis.

Contextualizing ‘Good Care’ in Modern Norway

About This Chapter

In this chapter, I aim to illustrate the differences of values associated with ‘good care’ at Legevisitt and traditional kinds of standard medical consultations. I will do this by analysing how political instances represent – or in some cases create – changes to these sets of values, by looking at recently published white papers from governmental departments. These white papers show a change in the political discourse concerning the National health services. Such changes can in part be viewed as antecedents for businesses such as Legevisitt. In other words, an understanding of the current political context in the health services, is important in order to gain an understanding of Legevisitt, their use of technology and possible future development and effects of such.

In addition to this, I will show how the current Norwegian medical community attributes certain values to the notion of ‘good care’, and how these are affecting the ways which medical care practises are evaluated. By doing so, I hope to show how this notion is in a position to change, and how there exists a various of ways of treating it. My goal is to show how the case of Legevisitt fits within this current Norwegian context, by explaining how some of these sets of values are facilitating for the business and its use of technology, while others are offering a different – and (in some situations) contradicting – view of what constitutes as ‘good’ in terms of care and treatment. In this way, this chapter aims to illustrate a conflict within the Norwegian medical community. Here, cases such as Legevisitt are perceived as controversies, in the sense that some actors are working towards changes which facilitate for businesses of this sort, while others aim to prevent or change such developments.

From Public Services to Industry

As mentioned in the introduction, the Norwegian Ministry of Industry and Fishing, issued in April of 2019 a white paper concerned with the health industry. This is the first of its kind, with the purpose of facilitating for an increase in the creation of national wealth in the Norwegian economy, an increase in profitable places of work as well as better – and more effective – health care services[71]. The paper calls for a better and more prominent collaboration between the health services and the private industries. It is supported by the current government who reports several future measures that might increase the quantity of such collaborations. In addition to several points on the increase of digitalization within the health services, the government also calls for measures that will increase the productivity of private actors.[72]

This white paper illustrates a change in the way medical care is thought of amongst governmental figures. From being incorporated as a public service within the Ministry of Health, it is now treated as part of the domestic industries and has gotten its place within the Ministry of Industry and Fishing as well. This shift in focus is suggesting that health care in modern Norway is not just perceived as a public offer, but also as an industry, with private actors, profit and costumers. The Ministry of Health is in support of this transformation of focus, and together with the Ministry of Industry and Fishing, they have released a press statement on behalf of the Norwegian government arguing in favour of the white paper and a closer relationship between health care services and domestic industry[73]. This represents a change in the way governmental figures are evaluating care practises, suggesting a larger focus on economic growth and technological innovations within the field of health care. Such a change in focus contains certain implications about the ways that care is valued, and imply that other values might be of higher or lesser importance when compared.

The white paper on the health industry is the first and only governmental white paper that is concerned with health care as a national industry. It describes a way for the government to solve two problems at once. Claiming that by working on reaching the political goals of national public health, one can also increase the national economic wealth, all at the same time and through the same instances[74]. It underlines the fact that the government in no way

[71] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)»
[72] Regjeringen.no «Stortingsmelding om helsenæringen: Sammen om smartere løsninger»
[73] Regjeringen.no «Stortingsmelding om helsenæringen: Sammen om smartere løsninger»
[74] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 1

aims to turn the health services into an industry. Rather, it suggests that private industries – with their own methods of work – can *assist* the health services[75].

The white paper is written in a logical and 'economic' style, meaning that it restrains from using words that are emotionally charge or discussing specific examples and/or situations. As mentioned in my discussion of document analysis, text are themselves political technologies. By evaluating care practises from a purely economic perspective, the white paper dehumanizes the debate. Asdal notes how a so-called 'scientification' of a problem can renegotiate the way we discuss a phenomenon. From being a social or political problem, it gets turned into a scientific question[76]. I would argue that the white paper does something similar: By having a prominent focus on economic concerns, the paper is active in changing the public discourse surrounding national health. It poses the current challenges by drawing upon statistics that show a high probability that every fifth person in Norway will be seventy years old or older in 2060[77]. An aging population of this kind will in no doubt put pressure on the public health care services. However, the paper is not structured in a way that delegates these future patients the position of being lead characters. Rather, the private industry have been given this 'role', and a large focus of the white paper is to communicate how private actors have the ability to develop more effective ways to perform care practises, and how a collaboration with them can be favourable for the public in an economic sense.

Medical Consultations and General Practise in Norway

The main type of patient-treatment that is offered at Legevisitt, is that of medical consultations. Usually this implies an interaction between doctors and patients where they discuss medical problems that are rarely chronic, urgent or severe. Instances of such might emerge, but the patients will in these cases be referred to specialists, usually within the public health services. Therefore, there is not much point to compare the activities of Legevisitt with

[75] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 6.1
[76] Asdal, *Naturens politikk – politikkens natur*, page 63-64
[77] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 3

those of specialized care or surgery. Rather, I will treat this case as a new way of administering and conducting standard medical consultations (not 'health care' in general).

The question then, is: What are the standard ways of conducting medical consultations in Norway, and how is Legevisitt representing a break with these traditions? To answer the first part is a simple task: Since 2001 there has been an arrangement in Norway that facilitates for every citizen – who desirers it – to have their own appointed doctor from the public health services[78]. On average, these offices are visited 2,7 times each year pr. Citizen[79], and will in this thesis be referred to as 'general practise'. There are also (just like in many other western countries) laws that demand national regions to provide emergency medical offices that are always both affordable and open at all times[80]. These are only visited 0,24 times each year pr. Citizen[81], and visitors might be struggling from everything from stomach aches to severe injury. If a citizen is to spend money above a certain amount on public health services of this kind, he/she will receive a card giving them free access to public medical consultation and standard medical services for the remaining of the year[82].

In both cases, several of the consultations offered by these public offices are similar to those offered by Legevisitt (of course exceptions might be prominent at the emergency room, which are not of a standard-consulting kind). Therefore, stating that Legevisitt is offering a replacement to many of the consultations found in the offices of doctors in general practice and emergency rooms, is not a problematic claim to make. So how do these differ from each other?

Values in Health Care Practises

In order to get a better understanding of these differences, it is important to have a clear idea of which values that are incorporated into standard medical consulting. This is a question that

[78] Regjeringen, «Fastlegeordningen»
[79] SSB, «Allmennlegetjenesten, 2018»
[80] Regjeringen, «Legevakt og Akuttmedisin»
[81] SSB, «Allmennlegetjenesten, 2018»
[82] Helsenorge «Frikort for helsetjenester»

is somewhat abstract, in the sense that values tend to change from one person to another, across time, space and a various of situations. Yet, I will try to answer it by looking at the Norwegian laws of patients' rights, and the purpose described there. I will also analyse some articles published in the journal of the Norwegian Medical Association (Legeforeningen) and the largest news-channel for health-personnel in Norway "Dagens Medisin" (translated: 'Medicine of Today'). These articles make up a collection of statements shared by people with professional roles in the Norwegian health services, many of whom are concerned with general practises and traditional medical consulting.

When looking at the civil rights of patients, the Norwegian law on the rights of patients and users makes it clear that its main purpose is to ensure equal access to good quality of health care. It than goes on to state that the provisions of the law should promote a relationship of trust between a doctor and his/her patient, evoke social safety and attend to the respect of the patient's life, integrity and dignity.[83] Equality, trust and respect, are all seemingly intrinsic values to the current ways of performing medical consultations within the public health care services, according to the Norwegian law. It does not concern itself with neither effectiveness nor cost reduction, and even though it mentions the notion of 'quality', it is somewhat unclear in which specific components that should be incorporated in order to ensure this. It therefore looks like the law leaves some parts of its definition up for personal interpretation when it comes to how to achieve 'good care'. What is good for some actors, is not necessarily good for others, and the overall quality can be measured in a large variety of ways.

In order to get a thorough understanding of what is to be expected in terms of the quality of the care from the public health services, I decided to speak with two representatives from 'Pasientombudet'. They stressed the importance of having a personal doctor in the general practise, which the Norwegian government has facilitated for since 2001. Even though Norway has had an ongoing increase in doctors since the nineteenth century[84], and is one of the countries with the most doctors pr. Citizen[85], there is a concern within the medical community that there simply are not enough doctors who are working in general practise. The representatives from 'Pasientombudet' expressed worry with how less doctors take jobs of this kind, and how the ones who are working there are nearing the age of retirement. All of

[83] §1-1 Formål, 24.06.2011 nr 30
[84] Tidsskriftet, «Legefakta»
[85] Hernæs, «Norge nest best i mest, nesten…»

this, in addition to there being new tasks delegated to the doctors who are working as general practitioners.

By analysing recently published articles, I find evidence that this concern is shared within the Norwegian medical community. For instance, several professional actors refer to the situation as a 'crisis'[86]. An editorial article in 'Dagens Medisin' from June of 2018, states that the Minister of Health – Bent Høie – acknowledges that there has been a gradual development that should have been observed at an earlier state[87]. However, in an article that summarizes the national board meeting of the Norwegian medical association in May of 2018, it is argued that politicians are disagreeing whether or not the arrangement of general practise is in a 'crisis', with Høie claiming that this is not the case yet[88]. Nonetheless – being described as a 'crisis' or not – there is evidence that the current arrangement of general practise is unsustainable due to a larger amount of work being delegated to general practitioners[89], without recruiting enough of doctors to the arrangement[90].

The decline in doctors working in general practice is not the subject of this study. Still, I believe the amount of concern shared amongst professionals in the medical community says something about the values that they incorporate to the performance of medical consulting. The value of an established relationship between a doctor and a patient, a sense of 'trust' and the notion of 'continuity', are core attributes to the Norwegian system of general practice, and this is what is to be at stake if this system falls apart or changes. I will come back to this later, but first I want to explain the findings when analysing articles from the journal of the Norwegian medical Association and 'Dagens Medisin'.

Some values are particularly prominent when analysing the articles. Unsurprisingly, 'knowledge' is represented by many actors. One article refers to professor, Jørund Straand, who argues that a medical discipline is made up of three 'building-blocks', namely a clinic, education and a foundation of knowledge gained by scientific research[91]. Several other articles also point to 'knowledge' as a necessary element for the quality of medical care. Scientific research, not just of medicine, but also of the general practise of it, is argued to be

[86] Bordvik, «Fastlegekrisen er lang mer alvorlig nå»
[87] Moe, «Fastlegekrisen»
[88] Bordvik, «Legene grillet helseministeren om fastlegekrisen»
[89] Hermansen, «Viktig enighet om fastlegeoppgjøret»
[90] Wærnes, «- regjeringen gjør ikke nok for å løse fastlegekrisen»
[91] Johannessen, «Allmennmedisin – 50 år som universitetsfag»

of high relevance. Several specialists who are associated with general practise argues in an article in the journal of the Norwegian medical association for the importance of scientific research and knowledge of these practises[92]. There is no clear explanation of why they believe an increase of this type of knowledge is important. Rather, it seems to be perceived as self-evident. However, the article is suggesting that knowledge of common practises is not just favourable for the patients, but necessary for the quality of the discipline.

While doctors in private practise are offering a service to a client, the doctors who are working in the public health care services are a part of a larger public network. Their job is not only tied to patients and the business, but to bureaucracy, the government, the public education system and so on. This statement might seem obvious, but it brings with it a set underlying differences, for instance: Knowledge about medicine and care is of great importance to any doctor. Scientific research – and the knowledge gained by it – of medical practices and performance, might be of great value to medicine as a discipline, and therefore of great public value, but this might not be as valuable for the private practises. This is not to say that it is invaluable for these. Rather, I would argue that while private businesses can measure their success in cash-flow and costumer-reviews, general practise is lacking this opportunity, and (in larger part) needs empirical studies of their performance in order to evaluate its quality. What is important to note however, is that scientific research of care practises in private industries can also be beneficial for society (as well as for the businesses themselves), but that this type of knowledge does not seem to be *as* important for the private actors – in order to calculate their success – as it is to the public discipline of health care.

Just like in the laws concerned with the rights of patients, the values of trust and continuity are present in the articles. In 'Dagens Medisin', columnist Stein Conradsen points out the importance of trust (notably not as the only important value, and not to an extreme extent). He argues that trust – by definition – is linked to the perceived agenda of the person who is to be trusted. He makes the argument that if a patient believes the agenda of health-personnel is based on economic or business minded concerns, then the trust towards these actors decrease. He also points to a study, that suggests that an increase in commercialization of health care, leads to a decrease in trust amongst the patients.[93]

[92] Bjorvatn, «Ny infrastruktur for allmennmedisinsk forskning»
[93] Conradsen, «Tillitt på tilbud»

‘Continuity’ is also mentioned in several articles and share certain similarities with ‘trust’. It ensures a personal relationship between the doctor and the patient, which evidently will generate a larger degree of trust in most instances. However, while ‘trust’ is a subjective concept, ‘continuity’ is more objective and straight-forward. There are certain rules to it, for example: If a doctor only sees his patient once – or maybe twice – throughout his/her life, this will not count as continuity, although one might find examples where singular meetings inhabit a large degree of trust. In addition to building trust, continuity also ensures that the doctor knows the history of the patients, which could be helpful when evaluating his/her needs. The importance of this value in general practice is emphasized in an article published by the journal of the Norwegian Medical Association. The article claims that continuity correlates to the personal satisfaction of patients, declines in the number of hospital admissions as well as the patients’ compliance with both preventive and curative measures[94].

Another article published by the journal, reviews a national survey, where 2090 citizens have answered questions concerning hospital, the system of general practise, and the education of specialists within medicine. The importance of ‘continuity’ is mentioned quite early in the review, which states the importance of doctors being familiar with the patient’s vital history. According to the review, one in three believes the most important part of the relationship between a doctor of general practise and his/her patients, is that the doctor has enough time for them, and that he/she knows the history of the patient’s personal health.[95] One in three is undoubtedly a large number of people, but one might still wonder what the other two thirds of the people who answered the surveyed thought about the subject. This is not a question that the article answers, suggesting that the writers and publishers of it might also value ‘continuity’ and ‘time’ as central to the evaluation of medical consulting in general practise.

In a recent article in ‘Dagens Medisin’, a Norwegian doctor is cited arguing that the large degree of use of substitute-doctors, leaves citizens without their personal practitioner, and that this is one of the problems for the system of general practise[96]. This is not how this public arrangement was intended, with the main difference being that the patients lose continuity in the public health care system when there is a large number of substitutes covering for the general practitioners. The implication does not seem to be that the substitutes are necessarily

[94] Brekke, «Hvordan blir fremtidens allmennmedisin»
[95] Johannessen, «Helse er tilbake på topp»
[96] Bordvik, «Fastlegekrisen er langt mer alvorlig nå»

worse at their job than the original doctor, rather, that 'continuity' is an important variable in order to ensure 'good patient treatment'.

It looks like equality, knowledge (both of medicine itself and the performance of it), trust, dignity and continuity are key words when looking at which values that are represented in the public offer of medical consulting. There is a long tradition in Norway of offering public health care in a way that is believed to be 'good'. However, as I have mentioned earlier, there are concerns amongst professionals on the continued development of this arrangement. This is not just a concern visible when reading professional statements, it also seems probable to assume that businesses such as Legevisitt would be quite unsuccessful – or at the least they would have to change their 'product' to something more specialized – if the arrangement of public general practise had been working as intended in a good way.

In December of 2018 the Ministry of Health published their fifth white paper on quality and security for patients and users of the health services, which notes that Norway is placed in the bottom third amongst the OECD-countries when it comes to patients' personal experiences of waiting-time before seeing – or having a dialogue with – their appointed doctor[97]. Innovation and new technology – with its possibilities of an increase in both effectivity and quality – is treated as one of the key solutions to this problem. It is made clear early on by the Ministry of Industry and Fishing, that if innovations and new technology are going to contribute to a sustainable public health care service, then the rewards of implementing them must be greater than the costs[98]. Suggesting that both the Ministry of Industry and Fishing and the Ministry of Health, consider 'efficiency' and 'innovation' to be core values to 'good care'.

The white paper issued by the Ministry of Industry and Fishing, that is concerned with the health practises as an industry, defines innovation to be: (firms which find) ways of using both new and established knowledge and technology, to produce new products, services or ways of production[99]. It is described as crucial to the increase of both productivity as well as national wealth. From this logic, innovation is also necessary to ensure the productivity of health services. The white paper clearly states that by building down the barriers that prevents the health industry from growing, political goals of both national health and wealth can be

[97] Helse- og omsorgsdepartementet «Meld. St. 11 (2018-2019)» 8.1
[98] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 3.1.1
[99] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 5.1

reached[100]. This would include (amongst other measures): A more prominent culture for dialogue between business, public education and public health services; that health care services will be a more attractive partner of collaboration for private businesses; and facilitating for an increase of commercialization of medical and health related science and ideas.[101]

The gradual decrease in general practitioners is – as mentioned earlier – described as a 'crisis' in the medical community[102]. Concerns of this arrangement of general practise is shared amongst both medical professional and politicians, although to a various degree, where some might describe it as a crisis and others only note the possibility of such an outcome[103]. However, the government's focus when sketching out improvements for the health care services does not seem to be a noticeable investment in the arrangement of general practice. Rather, the white paper which issued by the Norwegian Ministry of Health clearly states that there is a widespread agreement of it being neither sustainable nor possible to solve the current challenges by increasing the amount of public resources and more employees in the public health care services.[104]

It is clear by looking at both white papers that central figures in Norwegian politics aim to increase the collaboration between health care services and private businesses. It seems probable to assume that this would imply an increased commercialization of the national health services, such as medical consultations. This commercialization is aimed to maintain and increase the quality of the services. However, as already argued, defining what 'quality' within health care is a difficult task, and the Ministry of Health is offering somewhat of an idealized definition of this. Nonetheless, they are quite user-oriented in the way that they describe the goal of the government: Claiming that the main purpose is to be creating health services *for* the patients, so that they will receive; 'fast, safe and good help when they need it, and have the experience of being an equal part'.[105] This is far from a paternalistic way of describing 'good care', and also differ from the prioritization of values found amongst medical practitioners in general practise. Rather, the idea of personal choice and effectiveness

[100] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 5.3
[101] Nærings- og fiskeridepartementet «Meld. St. 18 (2018-2019)» 5.3
[102] Moe, «Fastlegekrisen»
[103] Bordvik, «Legene grillet helseministeren om fastlegekrisen»
[104] Helse- og Omsorgsdepartementet «Meld. St. 11 (2018-2019)» 1
[105] Helse- og omsorgsdepartementet «Meld. St. 11 (2018-2019)» 1

are central to the way that the Ministry of Health defines this notion. In this way, one can easily notice how this way of describing ‘good care’ share similarities with a commercial way of offering services, where cash-flow and the satisfaction of costumers are central to the success.

Chapter Conclusion

My main goal for this chapter has been to view the notion of ‘good care’ in the context of the current Norwegian society. I wanted to do a thorough analysis of how the values which are incorporated into this idea interchange through different contexts, and to illustrate some problematic aspects of such changes. The most prominent seems to be the difficulty of providing a clear definition of what constitute as ‘good’ in terms of care, without it being idealized and subject to either vagueness or internal contradictions.

I also wanted to investigate how medical consultations are performed in Norway at this time, and which values that are central in this established type of medical performance. From the knowledge gained by this analysis, I wanted to discuss how the recent white papers issued by the Ministry of Industry and Fishing and the Ministry of Health represent a break with these values, and how their notion of ‘good care’ differs from that which is already present in the public offer of general practise.

In this chapter, I have explained how the medical community in Norway have inscribed a specific set of values when it comes to measuring the quality of health care practises. When studying articles published by the Norwegian Medical Association and statements of general practitioners in ‘Dagens Medisin’, values such as ‘equality’, ‘continuity’ and ‘trust’ were prominent. When analysing the governmental white papers, care is described as an economic concern, which imply a different prioritization in terms of the values associated with it. In the next chapter I will be looking closer at the case of Legevisitt, which values that constitute the notion of ‘good care’ there, and how these fit within this contemporary Norwegian societal context.

Users, Technology and Values at Legevisitt

About This Chapter

In this chapter, I analyse Legevisitt as a private actor in the Norwegian health industry. I aim to look at how they are enacting the notion of 'good care', and how this enactment differs from what is found general practise. In the previous chapter I have showed how there is a political project of increasing the collaboration between private businesses and national health care practises, and how this project changes the idea of 'good care'. Next, I aim to show how Legevisitt behaves as an example of such a collaboration. In this chapter, I will illustrate how a political change in prioritized values in terms of care gives room to the business model that is present at Legevisitt. I will also analyse how this business is in turn is active in changing such prioritizations and thereby changing the role of medical practitioners and the notion of 'good care'.

I also want to discuss how the technical configuration and scripting of Legevisitt takes part in configuring usage and users, and how this process of configuration makes changes to the professional lives of doctors. From this, I am also going to explain how the different types of technology that are implemented at Legevisitt makes changes to the ways which they are operating, and how these offer new ways of both performing and evaluating medical care and patient treatment.

First, I will say something about the configuration of users from a general perspective, before going on to my analysis of how the doctors at Legevisitt are acting as users of the digital platform. Then, I aim to give an account for how Legevisitt uses digital programs in order to save time and cut costs, and how this use of technology represent different values of 'goodness' than what is traditionally associated with medical consulting. I will then look at how Legevisitt offers something that is different from traditional practises, such as affordable home-visits and the usage of telecare devices. Though this analysis, I will have explained how this business is offering a different way of defining and performing 'good care'.

Legevisitt as a Commercial Actor

When you visit the website of Legevisitt, the first image that meets you is of a doctor tending to a child. In the centre of it there is a clear text that reads: (translated) "Get medical help where you are. Avoid lines and waiting-time."[106] The text makes it clear that Legevisitt offers medical services on the premises of the patients, they also offer efficiency and flexibility. Just below the text there is a search-engine that allows you to search for diagnosis' and/or symptoms. It appears to be an easy way to get thorough and direct information about a large variety of health problems.

Several places throughout the website – at the top of the page, under the large image, at the side of the page if you start reading about a disease – you find either direct information about the different forms of medical services that are offered, or links to such. When I type a disease in the search-engine, I am presented with three options: I can visit the clinic, I can order a home visit, or I can schedule a video-chat. In all cases, there is information about how long I would have to wait, or at what time the next appointment is ready. And when I enter a disease or symptom where video-chats are not recommended, the website informs me of this fact. In other words, the website is constructed in a way that makes it nearly impossible not to see the different options you have as a patient. This variety of options makes it clear that the idea of 'personal choice' is crucial to the realisation of the technology and a core value of the business model.

In short, the website is a mediator that presents itself as very user-friendly. It is easy to use and navigate within. By communicating through the website, Legevisitt also – in contrast to more traditional forms of medical-services – gives the impression of being a business that is very much focused on the satisfaction of its users, providing efficiency, flexibility, the feeling of personal choice as well as being easily accessible. Suggesting that Legevisitt is a type of business that values these types of qualities. This amount of user-friendliness would not be possible had it not been for their use of innovative technology and the structure of their

[106] Legevisitt.no

business. Based on my analysis of the white papers from the Ministry of Industry and Fishing and the Ministry of Health, it looks like the type of practise that is present at Legevisitt is in close alignment with the development that the government desirers for the Norwegian medical services and industry. It serves as a great example of how innovations in health care and business structures changes the practise of medical consulting, which seems to be what the politicians were calling for in the white paper issued by the Ministry of Industry and Fishing in 2019 and refers to health as an industry instead of a public service.

The medical offer available at Legevisitt is similar to that of general practice, but – as I explained in the introduction – it differs on several points. The most obvious difference is that Legevisitt is a commercial actor, that is privately driven. However, commercial health care has not been seen to be particularly successful in Norway, especially not in the form of standard medical consulting. The general services are affordable, and ensure a good enough quality, so private actors often need to offer something extra if they want to attract customers. Legevisitt is an example of this: By using their digital platform of labour distribution, they are able to cut off 'middlemen' such as secretaries and nurses and connect patients directly to a certificated doctor in an effective manner.

In addition to their platform, they also incorporate modern telecare devices into their practise, and is one of the first examples of Norwegian practises that offers standard medical consultations without physical meetings between doctors and patients. Telecare has already been present in many different shapes in European countries for some years now, but its development is one of heated debate. One of the reasons for this might be that the notion of 'goodness' is somewhat differently represented in telecare products than in traditional care. Jeanette Pols notes that in the Netherlands, the promises heard most often when discussing or representing telecare concerns improvements in efficiency[107]. I also got this impression when speaking to the manager at Legevisitt, that both cost-reduction and efficiency were important factors for the success of the business.

This is not to say that these are good nor bad qualities, but they differ from those usually represented in general practise, where equality and continuity are very prominent. Pols discusses how telecare in many instances is perceived as 'cold', while traditional care is viewed to be 'warm'. However, she argues that this is a simplified and inaccurate way of

[107] Pols, *Care at distance, On the Closeness of Technology*, page 11

evaluating care. Pols makes the claim that a more accurate way of judging the quality of care and care-practices is to look at whether or not it is 'fitting'[108]. Like mentioned earlier, in some cases certain qualities – for example 'efficiency' – is crucial to the perceived value of care. In other situations, different qualities might be considered as more important. The evaluation of care is not of a straight-forward kind, and – as argued earlier – there are differences in how the individual and how the collective view and evaluate care practises. While the individual might perceive 'effectiveness' as the number of hours he/she spend on waiting for an appointment, the collective might perceive it as a measure to cut financial costs. When arguing whether a form of technology is 'good' for the care practises, one therefore needs to view it within a certain context.

Because of differences in prioritized qualities between societal contexts, there is a high degree of variation of what constitute as 'good care'. Due to this amount of variety, the question of how to achieve complete equality amongst patients should be raised. 'Equality' is – as mentioned in the previous chapter – argued to be one of the key components of 'good care' according to both Norwegian law, government and central figures in the medical community. Yet, in order to ensure it one would need a solid definition of what exactly decides the overall quality of the care. This does not seem to be available, especially not if one is to judge the care based on its 'fitness', since this would imply that the components that determine the quality of the care may vary from one situation to another. There seems to be a conflict here, where on the one hand we have the value of 'equality', while on the other hand we have values like: 'flexibility' and 'fitness'.

With 'flexibility' there follows a high degree of 'choice', often related to patients when viewed from the perspective of care. This is prominent in Legevisitt, and in addition with 'efficiency' it is a large part of the success of the business. The notion of 'patient choice' is somewhat criticised in care-studies, most notably by Annemarie Mol. Central to her criticism is how it changes the role of the patients and turns them into costumers. When talking to the representatives from 'Pasientombudet', I was met with somewhat of the same concern. They informed me about an international initiative called 'choosing wisely', that aims to promoting conversations between patients and clinicians in order to decrease the number of unnecessary

[108] Pols, *Care at Distance, On the Closeness of Technology,* page 45

medical treatments, tests or procedures[109]. When discussing the increase in the availability of medical treatments (or consultations), as well as their variability, 'moderation' is a value that tend to be in conflict with that of 'choice'.

Legevisitt and the analysed white papers are promoting qualities of care and patient treatment that is somewhat different from – and in some cases contradicting to – those found amongst the public medical community. Of course, the two white papers mention many qualities that one can relate to health care, also in the situations where these (on further inspection) contradict each other. However, one of the most prominent opinions argued in these papers has to do with the importance of a greater collaboration between public services and the private industry, as well as an increase in the use of new technology and innovative solutions. In this sense, as mentioned in the previous chapter, businesses such as Legevisitt can be understood as a representation of a larger political project. Namely that of facilitating for private actors, innovation and new technology in Norwegian health services and industry, in order to solve modern problems of national health care. At the same time, the technology that is used by Legevisitt is in part creating a friction with the traditional notion of 'good care', by inscribing 'flexibility' and 'efficiency' as core values.

Configuring Users

It is an obvious fact, that businesses need costumers in order to make a profit. These rarely appear out of nowhere and in most instances the costumers – or users – need to be found and/or configured. When it comes to technological innovations, the users are seldom ready to implement the technology into their lives without some introduction, neither are societies. New technologies often need to be made so that their fit into the established societies, yet this does not mean that they are complete products of social construction.

Marianne de Laet and Annemarie Mol describes how actors can be both non-rational and non-human, yet still fluid in the way that they act[110], by referring to a Bush Pump in Zimbabwe. In

[109] choosingwisely.org
[110] Laet, "The Zimbabwe Bush Pump: Mechanics of a Fluid Technology" page 227

short, the Bush Pump is described as a 'flexible' object, which is good because it 'incorporate[s] the possibility of [its] own break-down, […] have the flexibility to deploy alternative components, and […] continue to work to some extent even if some bolt falls out or the user community changes'[111]. They describe an innovation that is configured in such a way that its identity is fluid and can easily be made to fit in different situations. Although this is not necessarily true for every technological innovation, the example indicates that there are several such cases where the development of certain technologies are ongoing processes, that takes place within the relationships between different actors. There is a co-configuration that takes place, where the technology is not only configuring users, but is also configured by them. One of the consultants at Legevisitt informed me that they were welcome to suggest changes to the product – for instance by contributing to the web-page – and in this way, they are active in shaping the technology – after its initial release – in order to make it fit.

Akrich argues that a product might inhabit certain inscriptions about the world, which can be either accepted or rejected by society and imagined users.[112] According to script-theory, the development of an innovation includes both configuration of technology and configuration of users. In other words: the two are being made to *fit* each other, which is not an action but rather a *process*. Although the case of the Zimbabwe Bush Pump is drastically different than the case of Legevisitt and the technology implemented here, they share the similarity of being innovations within the domain of public welfare. What the example of the Bush Pump works to illustrate, is how even amongst these kinds of innovations, there needs to be certain processes of configuration, in order to make the technology fit within the (various of) societies and create users.

The users of the technology at Legevisitt are imagined by the business but are also active in shaping its further development: If the imagined users were drastically different from the real ones, there is reason to believe that there must have been made radical changes to the product in order to make it fit the needs of the costumers; however, if the differences are small or non-existent, simple adjustments and/or mediation might be enough to attract them. Rose and Blume argue that within medicine, where the imagined users are patients, specifications are in many cases not too precise. This is because 'human variability' is a sought-after trait within

[111] Laet, "The Zimbabwe Bush Pump: Mechanics of a Fluid Technology" page 252
[112] Akrich, «De De-Scription of Technical Objects" page 208-209

many health-technologies.[113] They are especially referring to the fields of pharmacogenomics and tissue engineering, which are obviously very different from the type of medical work performed at Legevisitt. Nonetheless, their premise for this argument is relevant; that patients initially have little in common. If this is true within fields of pharmacogenomics and tissue engineering, it must certainly be true for patients whose consultations falls under the category of 'standard'.

The people who need medical consultation of this 'standard' kind might vary drastically. Because of this, 'variability' is a quality that in many cases is necessary in order for the technology to attract enough users within this field of medical treatment. The manager at Legevisitt confirmed this impression, yet he pointed out that some groups might be represented to a larger degree than what others might. For instance, he mentioned a group called 'early adaptors'. These being the type of people who would chase new technological innovations: Being the first to use Uber and Airbnb, buying the first iPhone or electrical car, and so on. This user-group inhabits some power when it comes to the development of the technology. At an early stage, it still needs some further configuration in order to fit, and due to the technological interest amongst the people within this group, they can oftentimes take on the role as both users and mediators. In this way, the further development of the technology is not only dependent on its initial scripting, but also the behaviour of its early adaptors.

The manager also noted that even though they had a portion of elderly patients, especially when it came to the home-visits (which I will return to this later), they were usually under-represented because many of them had enough health-problems to qualify for the free access card to the public health services. Nonetheless, Legevisitt inscribe a large degree of 'variability' – or 'flexibility' – into their technology and business model. Even if 'early adaptors' are represented to a larger degree, the manager at Legevisitt described the patients as 'most kinds of people'. In other words, the imagined user at Legevisitt is not too specified, and the technology is constructed in such a way that it allows for a large amount of variability amongst its users.

[113] Pinch, «How Users Matter, the Co-Construction of Users and Technology" page 104

Doctors as Users

An important aspect of Legevisitt as a commercial actor, is how the users of their technology are not just patients, but also doctors. In the introduction I explained how only a small portion of the doctors who are offering medical services through the business are fulltime employees, while almost 30 doctors are working freelance as consultants. This makes Legevisitt not only a business that is offering services to customers, it also offers independent job opportunities to doctors. In this way, Legevisitt works as a platform that connects doctors with their patients through a various of digital programs.

This platform is not only used by patients, but also by doctors in order to find work. What is important to note however, is that the unemployment rates are quite low in the Nordic countries according to recent research, this being especially true of professionals with higher education[114]. It is therefore logical to assume that the doctors who are using this platform, is not doing it due to a desperate need of employment. Rather, the digital platform seems to offer certain advantages that are not available at traditional offices.

My interviews with some of the doctors – whose relationship with Legevisitt was exclusively situated through the platform – confirmed this suspicion. They were mostly using Legevisitt as a 'side-job' and found that their working days often felt more comfortable and less stressful than at their other places of work. They also noted that the platform offered them a high degree of flexibility. They were able to work at times that fit with their personal schedule, a perk that apparently is rare in the medical community. I was also informed about the strict rules of specialized medical education in Norway, which requires the doctors to work at public hospitals relevant to the field where they are being specialised. Both the manager and one of the doctors, noted that this might be one of the reasons why Norwegian professionals wanted to do freelance work on the side.

When it comes to the salaries, the manager at Legevisitt explained that they are using a standard hour-based salary for their consultants. Whether or not this is higher than at other offices varies, but he acknowledged that it would in most cases be lower, especially with older – more experienced – employees. However, the difference – he said – was in most cases quite small. None of the doctors who I interviewed seemed to be concerned with the salary, which

[114] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.

gives the impression that – at least in *this* case of freelance work through digital platforms – the amount of payment is neither a concern nor a motivation amongst the consultants. (This is not always the case with digital platforms of labour distribution, which I will come back to later).

It is natural to assume that since the technology that enables the digital platform is used by both doctors and patients, that it makes changes to the doctor's role. The manager at Legevisitt noted that his consultants probably need to be more accustomed with technology than what they would have to be in general practise. Which might be one of the reasons why a majority of their workers are younger doctors. He also explained that their work will be more directed towards their patients, and that most of the paperwork that they would have had to do at other jobs is eliminated at Legevisitt. The doctors whom I have talked to were in support of these remarks, claiming that their work is different at Legevisitt, largely due to its use of technology.

They mentioned several aspects of their profession that was different than in traditional practices. The differences were usually a consequence of either modern technology and/or commercialization. One doctor noted that the role as a doctor was different at Legevisitt, in the sense that the help one offered took more the shape of a 'service'. The doctor emphasized that they were not 'selling health', but that the patient should still feel like he/she received some sort of 'value'. It also seemed to be a consensus amongst the interviewed doctors that one would often be a bit more service-oriented in a commercial practise. This is not surprising, since communication of high quality amongst health personnel is both a motivation for implementing the technology, as well as a necessity for it being used in a 'good way'.

At Legevisitt the use of technology allows for more consulting time between the doctor and the patients. This extra time – if used in a good manner – would enable for better service and satisfaction amongst the patients. The patients would leave the offices or video-chats, with the impression of having all relevant information. This is crucial to the quality of the consultations, since it gives the doctors time to explain their decisions to their patients, which is especially important in situations where the two may disagree. For instance, if the patient was denied a prescription or a medical certificate, the doctor would have time to explain his/her reasonings behind this decision. The lack of such time could amount to doctors being

hesitant to make such choices, or unhappy patients (which would in no doubt be bad for business).

Of course, technology and efficient structures alone is not enough to secure clarity for the patients. The doctors also need skills, which are not necessarily a central part of their medical curriculum. Communication skills was therefore described by the manager as an important element to look for when hiring doctors, both full-time hirers and consultants. Because Legevisitt is a private business, it is important for them to be extra careful with initiating unnecessary treatments – especially when it comes to prescribing antibiotics and sick-leaves – in order to disprove certain prejudices that exists within society, and especially the medical community. The manager assured be that they keep statistics on all of their treatments, prescriptions and certificates. One of the doctors also named these statistics as one of the main reasons to why he/she decided to work for the business. The statistics seemed to take the edge off, and make this private business seem more ethical. The manager also noted that they manage keep the numbers on antibiotics and sick-leaves very low, and that this is somewhat due to their doctors being 'socially competent, and good at communicating', as well as them having more time with their patients.

Legevisitt is therefore not a business that is open for all kinds of doctors. Rather, it demands a set of skills that also incorporate expertise usually associated with other – more service oriented – professions. The role of the doctors is not just different due to the technology by itself, the technology also attracts a different kind of doctor. These being doctors who prioritize flexible schedules and additional time with patients above secure full-time hirers, or additional salary above personal time-off.

In addition to this, the business model of Legevisitt also require doctors of this 'different kind' in order to have success. The manager emphasized the importance of the correlation between communication skills amongst the doctors, and the business' responsibility of securing enough time for each patient. This is a crucial part of their business model, and without any of the two parts, the other one seems useless: If – on the one hand – the technology enables for more time between the patient and the doctor, this will only be useful if the time is spent in a good way, so that the patient can leave the office feeling like he/she has enough relevant information. This requires some (in certain cases more than others) communicative skills on the doctor's side; while on the other hand, no matter how good a

doctor is at communicating, there needs to be set aside a certain amount of time for whatever needs to be communicated.

The technology implemented by Legevisitt is therefore not just giving opportunities to doctors; it also requires a set of skills from them, that goes beyond those of medicinal kind. The configuration of users is therefore not just of introducing them to the technology and making them interested in it. There also needs to be a process of mediation where the doctors who use the technology take on new qualities that *fit* the area where the technology is situated. Jeanette Pols describes this phenomenon, referring to examples where nurses could provide 'good care' through telecare devices with 'some reshaping of new skills'[115].

The example(s) used by Pols is obviously different from the case of Legevisitt. For instance, most of her examples look at how nurses interact with telecare, not doctors. She also seems to be more focused on care-practises for the old or terminally ill, than standard medical consultations. However, some of her findings seems to be transferrable to the case of this thesis. One of them being how different kinds of care requires different sets of skills, and how the implementation of certain technology could – in this way – induce the need for a reshaping of medical professions. Although the consultants at Legevisitt still are professional doctors who performs medical consultations, the technology is making changes to their profession. It does so not only by introducing new tools, but also by requiring new skills, or at the least, new versions or improvements of old ones.

In this way, the doctors who are users of the technology are in part configured by it. Not only does the business structure requires a focus on communicative skills, it also facilitates for a type of 'freelance' work. This change in hiring-profile also influence the relationship that the doctors have with the practise where they work. One of the doctors whom I talked to, told me how the platform was great if one wanted a side-job, but if this was the only form of income, one would probably have to be very persistent. On the one hand, the consultants had almost no paperwork and did not have to work on the days that you did not want to. While on the other hand, there was no guarantee that one could get a shift. At a traditional office, doctors would follow a pre-set schedule, while at Legevisitt the consultants have to apply for work. I would argue that this independent type of work would attract doctors who, not only value 'flexibility' to a high degree, but also those who are skilled at structuring their own economy

[115] Pols, *Care at Distance, on the Closeness of Technology*, page 50

and work-life balance. My impression from interviewing some of the consultants at Legevisitt, was that doctors who do this form of platform-based work, should be *on* in order to be successful at it. Meaning that they should be early in terms of checking if new shifts are available, and quick to decide if they want to work them.

To put it shortly, the technology that is implemented at Legevisitt is not only used by the patients, the doctors are also active users of it. As argued earlier, when technology develops it does so in between the different relationships that it is surrounded by. When it comes to the doctors at Legevisitt, they are active in the configuration of the technology. They have explicit opportunities to contribute to- and shape the business. But even if this was not the case, the way they interact with the technology would contribute to the development and behaviour of it. Nonetheless, they are in turn configured by it. With new technology it also follows new priorities, new ways of doing things. Some qualities that used to be of lesser significance might become more important, and vice versa. In the case of Legevisitt, we can observe how both skills in communication and assertiveness are valued to a higher degree with implementation of the certain forms of new technology.

Time-Saving Technology and Digital Platforms of Labour Distribution

The most notable effect of the technology, that is implemented at Legevisitt, is how it cuts costs by increasing the efficiency and flexibility amongst both doctors and patients. One of the most prominent cuts is that of 'middlemen', which includes everyone from secretaries and service-personnel to nurses. In this way, they create a direct access for patients to get in contact with professional doctors, that is supposed to be experienced as 'smoother' for both parties.

There are several aspects that render the business model at Legevisitt more efficient. One of them is their use of a digital platform of labour distribution. As I have explained in the introduction, it is – to put it shortly – a set of digital programs which enables doctors to do independent work as freelance consultants. In this way, the doctors can control their own work schedule, and have little to no paperwork. While at the same time, the business can cut

costs related to full-time hirers and can regulate the number of available shifts depending on costumer-demand.

Critics have argued that platform work is usually associated with 'detrimental working conditions in precarious work situations, with low pay'[116]. However, when it comes to platform work amongst professionals, the personal economic advantages – or disadvantages – of this can be difficult to measure. According to the report issued by 'Economics Norway' on behalf of 'The Research Foundation FaFo', the results of such investigations might vary with a numerous of variables. When surveying individuals who are working through digital platforms of labour distribution, there are large differences between them, their education and their professional experience. The report notes that typical generalizations does not apply to all kinds of platform work[117]. In their report they look at a survey that target independent workers with education (more than 90 % of respondents have completed at least some education at university level[118]). The survey shows that professionals report hourly fees between 50 and 130 EUR in the Nordic Countries. This indicates that current professional platform workers have quite high earning opportunities, with workers situated in Norway and Denmark reporting especially high numbers.[119]

However, the report acknowledges that these numbers are not necessarily absolute. For instance, the survey does not include any specific information of how the workers are billing their clients, and how much time they spend searching for work. Potential benefits and perks are also not included, neither are costs in case of illness etc. The respondents report having at average EUR 53 000 as a yearly salary, which is much lower than if they had been working full-time with their reported hourly fees[120]. This is a clear indication that a precise definition of their actual income is difficult to make. Nonetheless, even with this 'drop' in reported yearly income compared to income pr. hour, the survey shows that professional platform workers within the Nordic countries, have personal earnings that are barely lower than the national average of professional workers in Denmark (with at least some education from University level).[121]

[116] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1
[117] Steen. Et. All. «The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1
[118] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1
[119] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1
[120] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1
[121] Steen. Et. All . "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1

The report notes that there are large individual differences, and stresses the possibility that average income of self-employed can be equal to that of employees, yet still have a higher degree of income inequality.[122] It refers to research suggesting that platform workers who are unsuccessful usually earn less than what employees do, while successful platform workers earn more.[123] This is not as much the case when looking at the digital platform implemented at Legevisitt, since they are operating with standardized hourly payments. However, the research points out a possible obstacle with knowledge intensive platforms of labour distribution in general. It seems that certain regulations – such as pre-set rates, or minimal wages – need to be in place in order to avoid possible wage inequality amongst professional platform-workers. The report also notes that measures of this kind 'are only able to regulate the income from a specific hour of work'[124]. This would suggest that wage inequality can still be present if one is to look at the yearly income of platform workers, since their possibilities of workhours relies on overall demand and their ability to find and perform work.

At Legevisitt, most of the doctors are performing platform related work as a 'side-job'. Since the hourly rates are pre-set, and the platform is incorporated as a part of the structure of one specific business, they are not in a position where they need to spend a lot of time looking for work or negotiating their salary and time. When interviewing some of them, I got the impression that they perceived the platform as easy to use, flexible and a good way to increase their overall income. However, I also found out that the business-structure needed them to be more *on* than they would have had to be otherwise. Although positive to the platform, a couple of doctors noted that one often had to be rather quick if they wanted to work. This suggests that the platform – even with regulations – requires certain skills from its users if they are to use it successfully, while more traditional places of work do not require these to the same degree. Most notably, the platform workers – or consultants – need to be assertive and take charge of their own schedule. If they do this, they are likely to get more appointed work – and thereby higher yearly earnings – than if they do not.

The digital platform of labour distribution is not the only way that Legevisitt saves time by using technology. As mentioned earlier, a lot of their increased efficiency is due to their lack of so-called 'middlemen' and paperwork. The digital platform of labour distribution is of

[122] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.1
[123] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.2
[124] Steen. Et. All. "The Knowledge-Intensive Platform Economy in the Nordic Countries" 6.1.2.

course partly responsible for these cuts, by facilitating for independent work of outside doctors, and creating a system where they can easily sign up for shifts and billing the business in arrears. This cuts down administrative costs that comes with full-time employees with rotating schedules, as well as enabling the opportunity to increase the number of doctors in situations of high demand.

However, the various of digital programs do more than facilitating for this platform. They also enable patients to sign up for consultations through the website, with concrete information of when the next appointment is available. If a patient orders a consultation at the office, there will be an iPad available for he/she to announce his/her arrival. All of the bookings are done through these programs, so that no time is wasted on personal e-mails or phone calls. (There is both a public e-mail and a phone number present at the website, however, these are intended only as contact-information of the firm, and not as ways of booking consultations.) After the visit, the patient receives an e-mail with a form that he/she can fill out if desired. In this way, the digital programs have eliminated the need for both secretaries and customer service personnel. Administrative costs are also cut by implementing programs that handle standardized bills from consultants. Since all of the programs used by Legevisitt 'speak' the same digital 'language', the process of translating information from one program to another is almost none-existent and reduce time-related costs.

The last part it crucial. Without a standard for the digital language, the technology would demand more time from human actors in order to translate information between and within the digital programs. This would decrease the amount of time that was initially supposed to be saved by the implementation of such technology. When speaking with the representatives from 'pasientombudet', they name a lacking digital co-relation to be one of the key obstacles in Norwegian medical services. Different hospitals and medical offices use a wide range of digital programs that are coded in their own digital language, and oftentimes these are not relating to each other. This creates problems when transferring information from one office to another, which again can facilitate for both delays and misunderstandings. As argued earlier, 'continuity' is a core value amongst the Norwegian medical community. Nonetheless, this notion is threatened by a lack of digital consistency.

Even though the programs used by Legevisitt are mainly constructed to be efficient ways of passing information within this business – and are not necessarily communicating well with

programs used by the public services or other practises – they illustrate how technology – if used in a correct manner – can cut costs of administration. One of the doctors noted how one could find relevant information, make referrals and write prescriptions efficiently through a company iPad, that could be used both at the office or brought to the patient's home. The doctor described this use of iPads as an efficient way of gathering and saving information, that required a minimal of digital skills while eliminating much of the typical paperwork.

These cuts in administrative tasks, creates more time for the patients. This is a value that is widespread across the Norwegian medical community. Nonetheless, it is also argued to come with several challenges. First off, an increase in availability of medical services can be an antecedent of unnecessary treatments. This can be anything from prescribed medications, referrals to specialists or medical certificates, for instance in the case of sick leaves. Legevisitt keeps statistics on their performance in order to avoid such problems. However, there are no juridical guidelines that demand them to do this, and it is therefore not a certainty that medical practises implement such strategies.

Secondly, there is an ethical challenge in terms of how we value care. Should we value care in terms of how it facilitates for personal choice? And how does the use of technology fit with the logic of care and the logic of choice? Annemarie Mol raises such concerns, arguing that technologies might act different from what is expected of them and may also change expectations[125]. Before cars were available – or cell phones for that matter – people had lower expectations when it came to the efficiency of transferring information. This might seem like an obvious fact but inhabit certain implications about technology in general, when it comes to how it changes our impression and expectations of things and services. Mol stresses the unruliness of technologies, and notes that they have the habit of changing much more than what they were initially intended to and might very well be changed themselves[126].

In the case of the technology that is implemented at Legevisitt, it seems to offer both efficiency and personal choice amongst both patients and doctors. The ways of how this interferes with the treatment and care – both at Legevisitt as well as in medical practise in general – are dependent on several factors. For instance, the statistics kept by Legevisitt contribute to monitoring medical prescriptions, certificates and referrals, and should – at least

[125] Moll, *The Logic of Care*, page 49
[126] Moll, *The Logic of Care,* page 50

in some part – avoid unnecessary usage of such. However, they are not legally obligated to do this, and the technological innovations might behave differently – and cause other results – if implemented in a different business with different prioritizations.

This is not to say that neither ‘efficiency’, ‘availability’ nor ‘choice’ are bad qualities. In many situations, they are deemed good or necessary. Nonetheless, like discussed earlier, the notion of ‘good care’ is one consisting of a large variability of values. Many of which contradicting each other in some situations, while complimenting each other in others. With Legevisitt, we can observe an example of how technological innovations that facilitate for an increase of ‘efficiency’, ‘availability’ and ‘choice’, develop and behave in this medical setting. From this knowledge, we can draw some assumptions in how it might behave in similar situations, and what possible variables that could facilitate for differences in this behaviour.

As argued earlier, there is evidence suggesting that the doctors would need a reshaping of their skills, in the sense that the focus on communication and service is essential at practises such as Legevisitt. They also need to be familiar with technology in a different way than before and assertive when it comes to assigning shifts for themselves. In addition to making changes to the professional performance of the doctors, the use of technology also facilitates for various of kinds of medical consultations, which differ from the standard one that is a personal meeting at the doctor’s office.

Home-visits, Video-chats and Online Forms

The technology implemented at Legevisitt facilitates for more time for doctors to spend with their patients. How this time is distributed might vary between practises, and individual investigations should therefore be done is one wants to understand the overall effects of this. However, it is clear that it offers the patients a greater variability in terms of medical consultations. One of them being the possibility of having a home-visit from the doctor, without the costs of it exceeding what a regular citizen can afford.

A century ago, home-visits were not rare in the medical community, but in recent times, such visits are often deemed as costly and inefficient. It is therefore interesting, that by cutting in other costs, the possibility of affordable home-visits has made a comeback. It is for obvious reasons more expensive to order the doctor to your home, than it is to visit a clinic, but some people are still willing to pay for it. From interviews with doctors and the manager at Legevisitt, I got the impression that some patients could be either tired of hospitals and/or waiting rooms or have a schedule that is so busy that they are willing to pay more to have the doctor come to their own house. This is a luxury that is rather rare in Norway, mostly due to it being perceived as inefficient and expensive. However, as seen with Legevisitt, the implementation of digital programs can be used for facilitating for home-visits in a more effective – and therefore more affordable – manner.

Nonetheless, even if it is quite affordable, physical home-visits are still the most expensive form of medical consultation offered at Legevisitt's website. They are also only available in certain parts of Oslo and Bærum at this time. However, that does not mean that patients need to leave their house if they want to speak with a doctor. As mentioned in the introduction, the digital programs implemented at Legevisitt also enables for commercial telecare, by either facilitating for video-chats with a certificated doctor, or the possibility of filling out a form online. The last offer is still rather underdeveloped and can only be used for the simplest forms for consultations (for instance, when it comes to renewing a prescription of birth-control). However, the video-chats offer a way of performing medical consultations without a physical meeting, while still having the opportunity to see and talk to each other.

The doctors whom I talked to seemed – for the most part – positive this offer, one of them claiming that there are a lot of situations where people visit doctors in general practise without any need of physical inspection. Another doctor noted that there was a 'surprisingly' high amount of problems that could be detected and – in many cases – solved through a web-cam conversation. Of course, as discussed earlier, the doctors would need some reshaping of skills in order to perform this form of medical consulting in a good manner. They have to be able to connect with the patients through the screen and selecting questions that can compensate for the lack of physical presence.

In order to make this form of telecare fit our societal expectations of the quality of health care, the doctors need to inhabit communicative skills, as well as some technical and creative. I

mention technical skills, because they are in large part working with technical objects. If there is a lack of understanding of these – and the digital programs that they are dependent on – delays and technical problems might arise. These are both frustrating and time-consuming and would in no doubt decrease the quality of the care. I also mention creativity, mainly because this form of telecare is rather new, and most doctors have not been initially educated and trained to perform their consultations in this manner. It is therefore still a learning-process, and they would need to be creative in shaping their consulting techniques in order to get information that would normally be accessible by physical touch.

One of the doctors also mentioned how consultations should ideally be in the form of a physical meeting. One can simply not examine a patient in the same way through a screen, and several questions would need some physical contact in order to be answered properly. It is therefore important not to make consultations over video into a norm, because in many cases such sessions would only end up with a referral to the actual clinic. If this were the case, the use of technology would not cut middlemen and additional stops, but rather create new ones. When entering symptoms and diseases at the website of Legevisitt, one might be advised not to try to seek treatment of them by video-chat. This suggests that the business is aware of this problem and try to direct its patients towards choices that are more suitable to their needs. However, the choice is still in the hands of the patient, and he/she could choose to prioritize time, money and quality differently than what is advised.

Chapter Conclusion

In this chapter I have analysed how Legevisitt represents a new way of performing medical consultations that is in alignment with the political project of increasing the collaboration between public services and private industry. I have argued that both patients and doctors are active users of the technology at Legevisitt, before discussing how this affects the doctors' professional role and the daily operations of the business. I have also given an account of how the use of technology contributes to the business and influence the prioritization of the values that are attributed to the patient treatment in order for it to be considered as 'good'.

When speaking to Legevisitt and looking at their website, ‘efficiency’, ‘flexibility’ and ‘choice’ are core-values in terms of the quality of the care. This is not to say that other qualities are ignored by the practise, rather that Legevisitt are prioritizing these values differently than what is typically found in traditional medical consulting. We can observe that their use of technology inscribes certain values to their performance of care, by facilitating for a larger degree of personal choice.

It is not only Legevisitt who advocates for the importance of ‘efficiency’ and ‘flexibility’. The Norwegian government is also looking for ways of making the national health care services more efficient and flexible. In the previous chapter I have analysed the white papers issued by the Norwegian Ministry of Health in 2018 and the Ministry of Industry and Fishing in 2019, it is clear that there is a political interest in meeting the modern health related challenges by facilitating for innovative solutions and private actors within this field. In other words, businesses similar to Legevisitt do not seem to be developing in a vacuum – out of nowhere, by themselves – but are representing a change of values within various instances in society.

Since the technology at Legevisitt is still in the process of development, its users also have the opportunity to make incremental changes to it. In this way, the relationship between the technology in question and its users is one of co-configuration, where each part is in a position to affect the other. We can for instance see this with the so-called ‘early adaptors’ who – in addition to being users – can take on the role as mediators of the technology. Additionally, the doctors who are using the digital platform of labour distribution, are also in a position to contribute to the business-model, somewhat due to them being early in adapting this technology into their professional lives.

When it comes to the platform, I have argued that although it is modified in order to fit with traditional expectations of the health care services (for instance by offering standardized hourly fees for its consultants), it demands a different combination of skills from its users than what is found in general practise. Most notably, the doctors need to be accustomed with technology and inhabit good communication skills. They also need to be assertive when it comes to scheduling their work lives. On the other hand, the platform offers the doctors more flexibility to their professional lives, as well as the opportunity to earn extra income on their spare time. From the perspective of the business, the use of these digital programs is cutting time and administrative costs, which enables them to offer patients more time with their

doctors, less waiting-time at the office and the possibility of ordering affordable home-visits or video-chats. In this way, the programs are facilitating for their users (both doctors and patients) in a way that provides them with both 'choice' and 'efficiency', inscribing these to be important values when evaluating the care practises.

The telecare devices at Legevisitt are also scripted with such values, offering the costumers a large variety of ways to consult with a doctor. Although one of the interviewed doctors noted that *ideally* a medical consultation should take place in person, there is still evidence suggesting that the use of video-chats could cut both time and costs by solving medical problems where physical touch is not required. This would require some reshaping of skills amongst the doctors, since the possibility of touching the patient – and performing physical tests – is eliminated. Still, several of the doctors claimed that many problems could be solved through online chats, suggesting that the implementation of such telecare devices can make medical consultations more effective for the patients by allowing them to speak to a doctor from their own home. Nonetheless, such devices are only increasing the effectivity if one actually solves the problem through the screen. If the patient needs physical inspection, video-chats – and similar forms of telecare – only take the form of another 'middle-man', which is exactly what Legevisitt aims to cut.

In short, it is reasonable to argue that the technology that is implemented at Legevisitt creates changes to the ways which the doctors are operating, by giving them the roles of active users of the digital platform, as well as incorporating telecare devices into their practise. By using this technology, Legevisitt cuts costs of both time and money, and can in this way offer its customers a more efficient and flexible medical service, than what is found in general practise. On the other hand, the values of 'continuity' and 'equality' are not prioritized to the same degree.

Conclusion: Future of Technology and 'Good Care'

When talking to representatives from 'Pasientombudet', they noted how technology was an inevitable part of the future. This view is also prominent when analysing the white papers issued by the Norwegian government. The Ministry of Industry and Fishing clearly states that the public health care services can benefit from private industries, and vice versa. Claiming that a more advanced degree of collaboration between public and private offices in health care will be an overall improvement for both business and public health. They finish their paper noting that 'we [Norwegian politicians] must be in support of science, innovation and technological development'[127]. This should, according to the white paper, also be the case in the health services.

Nonetheless, technological development is not an action that takes place first and diffuse second. It is an ongoing process, and new technological innovations might continue to develop after their initial introduction to society. The study of new technology is therefore not only the study of the technology by itself, but its interaction with society, and how this in turn might shape the technology's behaviour, but also the other way around: How the behaviour of the technology might shape society.

Legevisitt is still only a start-up, and with its limited size the effects of the technology are still to be considered as minimal in a societal setting. However, even though the case is small now, it might very possibly continue to grow into a larger size. Not only might the business of Legevisitt grow, their structure and use of technology can be implemented at other practises as well. If this is to happen, what we are observing when investigating the case of Legevisitt is a small example of what can later become a larger phenomenon.

The technology that is used is not fully developed. Even after being introduced to the marked, its behaviour and the effects of it might change. However, by investigating it while still at the early stages of development, we are able to say something about which effects it may have, and what changes it is currently representing. After looking at Legevisitt's website, meeting with their manager and interviewing some of the doctors who works as consultants at their practise, I can already point out some ways that technological innovations of this kind

[127] Nærings- og fiskeridepartementet, «Meld. St. 18 (2018-2019)» 10

changes the nature of medical consultations. Most notable is how the digital platform of labour distribution and the usage of telecare devices contribute to changes in the doctor's profession and requires a reshaping of their skills and priorities. The technology at Legevisitt requires the doctors to be skilled at communicating, as well as being assertive in terms of applying for shifts and administrating their own schedules.

It is natural to assume that if Legevisitt is successful and grows in size, so will its business structure and the technology that is implemented there. This would suggest that there is a public demand for this type of telecare, and the values that it represents. If this is the case, we will likely see a growth in the ways which Legevisitt implements technology into medical consultations, by offering a digital platform of labour distribution to its doctors, and a various of types of medical consulting for its patients. Such changes will generate a higher degree of 'choice' in the health care services, an action that facilitates for more personal responsibility being delegated to the patients.

It is important to note however, that this does not necessarily amount to more individual 'freedom', but instead it works as a 'restructuring' of liability. Whereas, in the logic of care health is a public concern, the logic of choice delegates personal health to be an individual responsibility. So even if we can say that the technology at Legevisitt facilitates for a higher degree of flexibility and choice, this does not necessarily mean that this new way of offering medical consultations leaves the patients more autonomous. For instance, even if a patient wishes to have the consultation by video-chat, the website might recommend him/her to order an actual visit. The patient has the choice to order a video-chat anyway and is in that sense responsible for this particular choice. Nonetheless, he/she is likely to follow the recommendations given by the professional. Another example is that of medical prescriptions and certificates, where Legevisitt tries to keep these numbers low and manages this by enabling more time for doctors to consult with their patients. In other words: The case of Legevisitt suggests that the increase in 'patient choice' does not necessarily amount to an increase in prescribed prescriptions. Statistics on professional performance is a prominent measure in order to keep these numbers low, and in this way, they can be said to be limiting the patient freedom over individual health. However, the statistics needs to be accompanied with communication skills amongst the doctors – as well as more time for them to spend with their patients – in order to provide a service where the patient can leave with the impression of being taken seriously.

The scripting of a technology at Legevisitt is not absolute but will likely continue to develop when it engages with society. However, by analysing such scripts at an early stage of development, we can make some natural assumptions of how it might unfold. When investigating the report issued by 'Economics Norway', it seems clear that the possible long-term effects of implementing digital platforms of labour distribution are somewhat ambiguous and dependent on several factors. However, the report concludes that in the cases of knowledge-intensive platforms – such as the one used by Legevisitt – they would probably increase professional effectivity and reducing costs of transaction[128]. This is also visible when investigating Legevisitt at its current state.

From this, I will argue that the technology that is used by Legevisitt will – if developed further – increase the effectivity in the health services and industry. The long-term effects of this is unknown, but it is very much in alignment with current political project. Both the Ministry of Industry and Fishing and Ministry of Health – as well as statements given by the government – are asking for a higher degree of efficiency in Norwegian health care. The Ministry of Industry and Fishing are pointing towards an increase in technological innovation as a procedure in order to achieve this goal, and this view is supported by the government and the Ministry of Health in a public statement[129]. It is safe to say that with an increase in technological innovation within the health care services and industry, we will experience changes in both the daily medical practises and the values associated with this.

So far it is difficult to predict such changes with complete certainty. However, I would argue that they are motivated by a need for an increase of efficiency. This is not a value that is new to the health services, but with Legevisitt and the white paper issued on the health industry we can observe interests in optimizing this. It is noticeable by analysing both the white paper on the health industry, as well as the white paper on quality and patient security, that there is a political project of making the health services more user oriented and improving the users' perceptive of the effectivity. This suggests that not only is 'efficiency' an important value within the Norwegian health services and industry, it is also supposed to be effective for the users. The white paper on the health industry requests a larger investment in commercial health care providers who are implementing technological innovations in order to achieve this

[128] Steen. Et. All. «The Knowledge-intensive platform economy, in the Nordic Countries" 8.1
[129] Regjeringen «Stortingsmelding om helsenæringen: sammen om smartere løsninger»

goal, which is exactly what Legevisitt is doing: By implementing a digital platform of labour distribution, as well as telecare devises, they are offering medical consultations that are more effective and flexible for the users than general practise.

When it comes to digital platforms – like the one implemented at Legevisitt – we can observe a gradual increase, yet this form of work still only makes up a small percentage of the national work force. If it is to expand and become a larger part of society, it will most likely generate changes to several professions. Like discussed earlier, it might expect more from doctors in terms of their ability to supply a 'service'. It is also probable that although the average salary of professionals can remain the same – or even increase – the yearly earnings amongst them can experience an increase in inequality, depending on which professionals that are good at managing their own schedule and securing enough working hours, and which professionals that are not.

With medical consultations taking more of the form of a service, it is also natural to assume that this will generate changes to what is to be considered as 'good care'. As mentioned, communicative skills will be of more importance, due to it being necessary for the satisfaction of the users. My analysis of Legevisitt suggests the especially 'effectivity' and 'flexibility' are values that are central to this way of offering medical consultations. While in general practise, the users' experienced waiting time is one of the areas where Norway is of low international rank, suggesting that 'efficiency' – especially in terms of how the users experience their treatment – is valued to a lesser degree there.

As a final conclusion for this thesis, I would argue that Legevisitt and their use of technology are illustrating both a change in the performance of medical consultations and the evaluation of these. They should be understood as both an antecedent and a consequence of such changes: On the one hand, they are not emerging out of nowhere, but from a societal context that have facilitated for them. For example, an aging population and political interests in an increase of wealth and technological development in the health services; On the other hand, the innovations that are implemented at Legevisitt also holds the power to generate further changes. These changes are somewhat unclear at this stage, and further research should be done in order to see how such forms of technology behave when developed further and implemented in different ways. However, there is evidence to suggest that it will likely inhabit different ways of performing and evaluating the notion 'good care', for instance by

attributing this notion with a higher degree of ‘choice’ and ‘efficiency’, than what is found in more traditional care-practises.

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