Looking Inside the Out-of-Hours Primary Care Consultation: General Practitioners’ and Researchers’ Experiences of Using Video Observations as a Method

Annelies Colliers, Samuel Coenen, Roy Remmen, Hilde Philips, and Sibyl Anthierens

Abstract
Video recording primary care consultations is a promising and valuable method to provide rich data on actual patient–doctor interactions. Video recording for research purposes has not yet been used in out-of-hours (OOH) primary care. To obtain a high grade of participation of general practitioners (GPs), a good understanding on how to organize such a study is essential. We performed qualitative research to explore in what way it would be acceptable to GPs to video record their consultations in OOH. We used semistructured interviews with 17 GPs before setting up video observations. Using this input, we then conducted video observations with an evaluation afterward. We reflected back on the video recordings through a written open-ended questionnaire and during face-to-face elicitation interviews with the 21 participating GPs in the video observations. In addition, we share our experiences from a researchers’ view, by describing experiences, advantages, and disadvantages of choices made during the video observations. The stakeholders were involved from the beginning of the setup of the study and it was codesigned with them. Taking into account, their suggestions and concerns led to a high level of participation and successful data collection. We learned that most GPs are willing to participate in a video observation study as they think it could be educational for themselves and research. Nevertheless, because their personal identity is often intertwined with their job as a GP, they feel a bit exposed to criticism but at the same time they are willing to overcome this fear for the purpose of the study. There is also a fear of being judged against a standard way of consulting. GPs describe certain conditions that must be addressed in order for them to participate such as no extra burden to the workload, discrete camera position, and a safe environment for themselves and patients.

Keywords
interviews, out-of-hours care, participatory action research, primary care, video recording

Background
Studies using video observations as a data collection method are being used more frequently in primary health care to learn about doctor–patient interactions (Asan & Montague, 2014; Jepson et al., 2017; Knoblauch, 2012). They deliver a unique opportunity to gain insight into real-world doctor and/or patient behavior, communication style, nonverbal communication (e.g., facial expressions, body posture, gestures, eye contact, embodied actions), use of computer/electronic health record, clinical approach, and others. Moreover, it can be used to deliver detailed feedback, as a learning tool for doctors or doctors in training, to assess or improve the quality of care, and to identify successful practices, devise interventions, and so on (Heath, Luff, & Svensson, 2007; Rosenstein, 2002; Yanes et al., 2016). Using video as a data collection tool enables researchers to answer a variety of research questions. The research question will determine which analytic approach is more suitable to analyze the data in order to formulate an answer to the question such...
as conversation analysis, discourse analysis, content analysis, or a quantitative approach (Asan & Montague, 2014).

Reviews have shown that most patients and general practitioners (GPs) regard video observation research acceptable and valuable (Parry, Pino, Faull, & Feathers, 2016; Themessl-Huber et al., 2008). When setting up video observations in primary health care, the advice given in the literature is to consider legal/ethical issues (in particular privacy and storage/access of videos), recruitment strategies, time investment for participants/workload, intrusiveness, and so on (Hannes & Parylko, 2014; Parry et al., 2016; Rushmer et al., 2011; Spelten et al., 2015; van Dulmen, Humphris, & Eide, 2012), and to undertake discussions and negotiations with the relevant stakeholders on the different elements of the study design (Pino, Parry, Feathers, & Faull, 2017). For GPs, participation potentially elicits anxiety or distress. Rushmer et al. (2011) studied GPs’ attitudes toward routine, longitudinal recording of primary care consultations for research purposes, but it was not based on GPs’ actual experience of being video recorded. In a pilot study from Williams et al. (2010), a small group of GPs who participated in video recording their primary care consultations evaluated the video method as acceptable and worthwhile. We did not find any studies that described in depth the specific barriers, concerns, ideas, and experiences of the GPs who have taken part in a video observation study using a qualitative research approach.

It is essential to understand which conditions must be met for the participants to enhance participation and successful implementation of a video observation study. For this purpose, we used the Better Antibiotic prescribing through Action Research (BAbAR) project as an illustration to set up a video observation study in out-of-hours (OOH) primary care (Colliers, Coenen, Philips, Remmen, & Anthierens, 2017). OOH primary care provides urgent primary care when primary care physician surgeries are closed, most often in the evenings on weekdays and all day on weekends and holidays. As far as we know, video recording for research purposes has not yet been used in OOH primary care. In a previous questionnaire study, we learned that almost 80% of patients would consent to video recording their OOH consultation, without the physical examination on camera (Krug et al., 2018). Video recordings could give us insight into the explicit and inexplicit elements during a doctor–patient interaction, which might give us more insight into how we could facilitate these consultations to improve for example prescribing behavior of antibiotics. Therefore, this study sets out to explore GPs’ views on using video recording of consultations in OOH care. In this article, we also discuss our experiences with setting up a video observation study in this setting from a researchers’ view and provide practical guidelines for future researchers.

Method

Study Setting and Population

OOH primary care ensures medical care outside the daytime practice schedule of the GPs. In Belgium, it is mostly organized in general practitioners cooperatives (GPCs), a large-scale organization of GPs in one location, who collaborate and take turns in being on OOH duty for the patient population of all participating GPs of a specific region. All Belgian GPs have an obligation to cooperate within this system. Hence, it forms an ideal location to reach a large group of different GPs all working in the same setting and location to work on quality improvement. The GPC of the Antwerp city center covers more than 187,000 inhabitants. There are about 170 GPs who are on call in a rotation-based system during the weekends. They work in shifts of 12 hr. The average age of the GPs is 49.3 years old, 78 are men and 92 are women, and 21 of them are GP trainees. The GPC is one of the GPCs involved in the BAbAR project, that uses a participatory action research (PAR) approach, to improve the quality of antibiotic prescribing of GPs in OOH care (Colliers et al., 2017). In the spirit of a PAR approach, we felt the need to discuss the setup of video observations in detail with the involved GPs (i.e., GPs of the specific OOH center).

Preobservation Phase

Before the setup of video observations in the OOH GPC, we conducted a qualitative study using semistructured interviews to explore the views of GPs on using video recordings of their consultations in OOH care as a research and learning tool. We explored GPs’ previous experiences with video recording of consultations, their feelings about participating in this type of research, what conditions must be met before using this method, whether they would like to receive feedback on their consultation and for which purposes, and in which setting the videos can be used. The interviews followed a semistructured interview guide (Supplemental Material 1).

The preobservation interviews consisted of three parts. Only the third part on questioning the idea of using video recordings of their consultations is described here. The first two parts questioned the experience of antibiotic prescribing in OOH care and the use of PAR and are published elsewhere (Colliers et al., 2017).

For this phase, GPs working in the GPC were purposively sampled to reflect the variety of the GPs’ own practices. Our intention was to recruit between 15 and 20 GPs and to stop when data saturation was obtained and we had a sufficient reflection of the heterogeneous group of GPs at the GPC (Moser & Korstjens, 2018; Saunders et al., 2018). The findings from this phase were then used to set up video observations in the OOH GPC.

Video Observation Phase

Then, we conducted video observations of consultations in the OOH GPC using a small web camera with the specific goal to develop a better understanding of why antibiotics are prescribed in this setting and to identify which determinants play a role in the decision-making process.

In total, 160 videos were recorded of 21 GPs. We used a convenience sample out of the GPs on call during the study
period (August 25, 2018, until November 10, 2018). Within this sample, we selected GPs to reflect the variety of GPs at the GPC. One GP participated in both the pre- and the post-observation phase.

Patients were informed and asked whether they were willing to participate by a medical student in the waiting room. Forty-four patients refused to video record their consultation for various reasons, for example, nonnative speakers.

**Postobservation Phase**

All of the 21 GPs who video recorded their consultations evaluated their participation in the postobservation phase. For this phase, participating GPs were asked to fill in a questionnaire with open-ended questions right after the consultations, reflecting on the method of video observation (Supplemental Material 2). Within the following 2 weeks, a video elicitation (also called video stimulated recall or video reflexive ethnography) interview took place with the participating GPs. During this interview, not only questions were asked on the approach and treatment of infections (which will be presented in a separate paper) but also on the experience of video recording their consultations.

For all parts of the study, interviews were digitally recorded and transcribed verbatim. The GPs were invited by e-mail or telephone contact. The GPs received a summary of the main conclusions of the study and were asked to feedback any remarks.

GPs were interviewed face-to-face in their own practice by A.C. Most participants know her as a former colleague, as she used to work as a GP in the same region. Now she is a researcher on the BABAR PhD project (Colliers et al., 2017). We added our personal reflection as researchers on setting up this study. An overview of the used data collection tools is available in Table 1.

**Analysis**

The interview transcripts were analyzed using an inductive thematic analysis approach, using the following steps: familiarization with the data, coding, theme development, and reviewing and defining themes. This flexible approach fits well with our research question by searching for important or interesting patterns and themes in the data (Braun & Clarke, 2006). The first three interviews of the preobservations study were coded by two researchers independently: A.C., who is a GP, and S.A., who is a postdoc medical sociologist. Following the independent coding of the three interviews, codes were compared and similarities and differences were discussed. During a data session discussion, A.C. and S.A. identified relevant potential themes and an initial thematic framework was developed based on the independent coding. This flexible framework was used throughout the further analysis of the interviews by A.C. and further amended and adapted. The interim analyses were critically looked at and discussed with the entire research team and adapted after their feedback. H.P. and R.R. are GPs with experience in research on OOH care, S.C. is a medical doctor with research experience on infectious diseases. By having two interdisciplinary coders in the first phase and the entire team looking at the themes in the next phase of the analysis, trustworthiness and reflexivity were enhanced. For the postobservations phase, we continued analyzing with the same thematic framework and the same approach. Data were managed and analyzed using Quirkos (www.quirkos.com).

Scientific rigor was ensured by using researchers’ triangulation and member checks involving the participants of the interviews (Creswell & Miller, 2000; Morse, 2015; Morse, Barrett, Mayan, Olson, & Spiers, 2002). The GPs who have contributed to the interviews received a summary of the main provisional conclusions of the study and they were asked to give feedback or to send us any remarks they had on the provisional analysis. This can be seen as an extra step in the analysis process to enhance the trustworthiness of the results.

**Ethics**

The study was approved by the Ethics Committee of the Antwerp University Hospital/University of Antwerp (reference number 17/08/089) and registered at clinicaltrials.gov (NCT03082521). Permission for recording of the videos was
obtained from the Belgian Committee of Health of the Commission for the Protection of Privacy (SCSZG/18/067).

Written informed consent was obtained from every participating patient and/or GP. To ensure anonymity of participants, the age of the interviewee mentioned under the quotes will be related to a certain age-group (25–29 years, 30–34 years, and 35–39 years) and there is a referral to the preobservation phase (Pre) or postobservation phase (Post). All participants could have their data removed if they wished to do so, but preferably within 3 weeks after the data collection.

Results

Seventeen interviews with GPs were conducted in the preobservation phase and 21 GPs in the postobservation phase (Table 2). Three GPs who were asked to participate refused due to lack of time, all others agreed to participate in the preobservation study.

Three GPs who wanted to participate in the video observations could not participate because of the absence of the logistical help (a medical student who assists in the study to lessen the workload for the participating GP by obtaining informed consent of the patients and explaining the study to the patients) due to illness that weekend. Three GPs could not be reached by e-mail or telephone and seven GPs refused to be video recorded, mostly because of personal reasons (“it gives me too much stress to be filmed,” “I’m not feeling well at the moment,” etc.).

For both studies, a good range of the different districts of Antwerp, gender, and years of experience was obtained. For the postobservation phase, more GPs from group practices (often with a GP trainee) participated.

The mean duration of the complete interview in the preobservation phase (including Parts 1–2 on antibiotic prescribing in OOH and PAR) was 48 min, and in the postconsultation phase (including elicitation interview), it was 43 min.

Table 3 shows the choices made to set up the video recording study based on the preobservation interviews and the advantages and disadvantages from the researchers’ point of view.

When discussing the idea of participating in video recordings of their consultations during OOH care, most of the participating GPs were open to the idea, but at the same time, there was always the feeling of having to pass a hurdle to actually participate. Three overarching themes were identified: “views on video recording consultations in OOH care”, “conditions to enhance participation of GPs,” and “use of the videos for research and/or educational purposes.”

Theme 1: Views on Video Recording Consultations in OOH Care

Previous Experiences

Younger GPs had the experience of video recording consultations during their traineeship. Some of the older GPs had the experience of discussing the video with their trainees, but not the experience of being the one who is recorded.

Since we have the cameras in the practice we discuss the videos with the GP-trainee, but it is never my own, so maybe it would be funny to reverse the roles. (Pre 01, female, 50–54 years)

In most cases, they had positive experiences with this method, and they had the feeling that it contributed to their education.

Table 2. Characteristics of the Interviewees.

| Preobservation Phase | Postobservation Phase |
|----------------------|----------------------|
| Number of participating GPs | 17 (Pre 01–Pre 17) | 21 (Post 01–Post 21) |
| Age (years) | | |
| Mean (SD) | 48.2 (12.75) | 43.1 (13.69) |
| Median | 51 | 39 |
| Range | 26–63 | 26–64 |
| Years in practice | | |
| Mean (SD) | 22.1 (12.5) | 15.7 (12.96) |
| Median | 23 | 12 |
| Range | 2–35 | 1–38 |
| Gender distribution | | |
| Male | 5 | 8 |
| Female | 12 | 13 |
| Type of practice during office hours | | |
| Solo | 4 | 2 |
| Duo | 4 | 1 |
| Group | 8 | 17 |
| Community health center | 1 | |
| GPs with a GP trainee in their practice | 8 | 16 |
| during office hours | | |
| GP trainee | 1 | 2 |
| Mean duration of the interviews (minutes) | 48 | 43 |

Note. OOH = out of hours; GPs = general practitioners.

*Parts 1, 2, and 3, with Parts 1 and 2 on prescribing antibiotics in OOH care and participatory action research, and Part 3 on video recordings of consultations.

Combining the reflecting on using video recording and the elicitation interviews.
Some of them have had the experience of being observed live during a consultation, before it became current practice of using videos. Live observations were seen as distracting.

... I don’t know, but I think it would be nicer if there would be a camera than having someone next to you, because that is always so distracting in relation to the patient, ...” (Pre 13, male, 60–64 years)

... we sat there with 5 people, and it was elucidating to see of one and the other how they run consultations. And that you

![Table 3. Setup of Video Observations in OOH Care: Choices Made Based on Preobservation Interviews and Researchers’ Experiences Postobservations.](image)
were all struggling with the same feelings, the same frustrations and the same positive and negative things. (Pre 11, male, 60–64 years)

Some GPs said that because they have grown professionally throughout the years, it would give them less stress than when they were a GP trainee as they feel more confident in themselves as professionals. Others mentioned the fact that there was no more need for change anymore at the end of their career and felt more reluctant to the idea of being filmed.

**Vulnerability and Identity**

GPs express themselves in several different ways about video recording consultations. They express feelings of insecurity, stressfulness, fear, not being at ease, being nervous, and so on. All these feelings can be related to being exposed and showing their vulnerability. Although most of the GPs we interviewed would give consent to participate, they all speak of certain barriers they would have to cross.

Yes, I think I would be a bit nervous. Euh… despite of my expertise. Euh, yes, you put yourself out there, people will see you in a different way. (Pre 01, female, 50–54 years)

Being observed during your consultation is giving up nearly all privacy and making yourself vulnerable toward others and there is the fear of being judged. For GPs working in group practices, it feels like they have already given up a little bit of their privacy, by sharing patients and their respective medical files.

It’s about insecurity, in the end, with your patient, it’s always very private. There is nobody else. By working in a group practice you put yourself out there a little bit more, because we fill in our files, we all do that, so it can be judged as well. (Pre 07, female, 45–49 years)

For some GPs, the vulnerability is related to their identity of being a GP. For some GPs, “being” a GP is more than just a professional identity, it defines who they are. Questioning their own behavior and the way they have been practicing medicine for years is a difficult thing to do, when their job has become their identity. Reflecting on their own work has large implications because they are not only judging their work but themselves as a person.

Sometimes, I have the feeling, and I put it as an extreme, when the GP trainee comes in as a human, he puts on his white coat, and he works with those detailed communication models, and when the consultation is over, he puts off his white coat and he is human again. While I have more the feeling of not having any boundaries, I come in as a doctor and I go out as a doctor. (Pre 04, female, 50–54 years)

I don’t know, in one way or the other, you let people look into a form of your identity or so. (Pre 03, female, 30–34 years)

One of the younger GPs talked about her previous negative experience of video recording her consultations as a trainee due to insecurity and therefore wouldn’t give permission to repeat it. The fear of being criticized and the need of perfectionism can hold people back of giving consent. Selection of “their best” video can give the GPs a sense of control.

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...because I’m very insecure as a person. And because of…(thinks),… I’m really scared of being judged… (silence), and yes because it is confronting for myself, and yes it could be educational for myself, but to have to show it to an external person, so that they can point out everything I do wrong?... only the idea itself gives me stress already… As a GP trainee, I recorded as many videos as possible, so I could choose the best one out of them to show. (Pre 12, female, 25–30 years)

When inviting GPs by phone or e-mail to participate in the videos, we stressed we would not judge, that they could be themselves and we situated it within a learning environment. In our information sheet, we stated:

The interview afterward will be held in an open and nonjudgmental way. We want to learn from your experiences and we want to learn how to find solutions to improve antibiotic prescribing. We respect your unique style as a GP.

After the video observations, we organized elicitation interviews with every participating GP. GPs could choose themselves which video they wanted to discuss with the researcher. All of the 21 GPs chose their most difficult or challenging consultation. They chose the ones they perceived as more difficult (the one they struggled with, were in doubt, didn’t know exactly the diagnosis, and so on) because these were the ones they could learn from themselves by reflecting on it.

Also in those interviews, vulnerability and giving up privacy was raised. As a GP, the consultation room is a private work place in which they interact with patients, make choices, and they do not feel they have to justify their decisions to the outside world.

You know, that someone is going to watch it, and you think I don’t want to make a fool of myself, … so I had the feeling I had to be a bit of a serious doctor. (Post 01, female, 25–30 years)

**Fear of Standardization of Consultation Style**

GPs discuss the fear of their consultation style being compared to a standard theoretical academic frame and of being judged on their own personal style that they acquired through experience and which works well for them. If the videos would be set against a standardized checklist, they say they would not be able to meet the set criteria. There is a sense of pride of their own unique style of being a doctor that was built throughout many years of practice and they are afraid that these will be critiqued.

You have your own style of working of course after 35 years of practice. If you talk to those younger doctors, … there is the new
concept of how to do a consultation, how that has changed throughout the years. … I think in my daily practice to do all of that, I struggle with that. Then I think if you are going to film that, and compare it to the current way of practice. Pff, I don’t think that. … (laughs). (Pre 15, male, 55–60 years)

During the postobservation interviews, GPs do feel that the video shows their usual way of communicating with patients and how they practice medicine. So being recorded did not have a major effect on the way they performed their consultation. Some of them say they were a bit more on guard than otherwise.

I know I was thinking I shouldn’t blurt things out, and maybe I was a bit more formal than I normally am. But I didn’t hold back or anything. (Post 01, female, 25–30 years)

**What You Can Learn From It/Reflecting on Your Own Practice**

Videos can confront GPs with their blind spots, things that GPs are not really aware of. It can show good practices, but it can also uncover the “faults” and it can be confronting to reflect on your own work.

“I think it can be very useful, to see your shortcomings, to see “Oh I lost that patient and I keep on talking and going” … My medical intern said yesterday “but didn’t you see that the patient . . .”, and I suddenly thought: “No sorry, I didn’t see, I was being occupied with all other things,” but you would see that on a video. (Pre 09, female, 35–40 years)

It can also make nonverbal communication visible. As this is a large part of every interaction with patients, it could be an important asset of this method.

For example, am I constantly typing on my computer instead of looking at my patient? You won’t know that unless you see it on camera. (Pre 01, female, 50–54 years)

Most remarks during the postobservation phase were on how and how long they handled the computer and that this was an eye opener for them. GPs made lots of comments on their nonverbal unconscious behavior when reviewing their videos.

I find it really hard to say no to patients, …, and you see I’m not reacting on what she’s saying, …, (she’s biting her lip) That’s indirect a sign that I’m not happy. The patient must have seen that too. I have to work on that. … Oh no, I’m doing it again, … I’m biting my lip again. Wow, …, that’s super informative. (Post 06, female, 35–39 years)

Learning from peers and learning from your own behavior can form a strong educational element. In daily practice, a lot of the work is done routinely. Explicitly reflecting and questioning your own practice was enlightening for participating GPs and can help to improve their work.

**Theme 2: Conditions to Enhance Participation of GPs**

**Safe Environment for the GP and the Patient**

It is important to use the video recording method in a safe environment for the patient and the GP. They would like the opportunity to stop the recording at any given moment. GPs could stop recording at any given moment with a simple mouse click but never used this option throughout the study.

One of their main concerns is that the anonymity of their patients has to be guaranteed. A suggestion was made to not have the patient in the picture. Although others mentioned, this could be an added value to see the nonverbal communication of the patient. We chose to position the camera to the GPs and not to the patients. A pragmatic choice to enhance patient participation, obtain ethical and legal approval for the study, and to be able to use a small webcam making it as unobtrusive as possible. But by doing this, we miss all of the nonverbal reactions of patients. Depending on the research question, the advantages need to be weighed up against the practical issues.

GPs do not want to be judged. This refers again to what we have found about the feelings of vulnerability. They don’t want the videos to be used to point out everything that they’re doing wrong, but it should be used as a tool that supports their learning and improves the quality of their work.

… that is one of the conditions, that it is used for research, and not to sanction us or that it is pedantic. We get followed enough, I will do it because it is important for ourselves and not for the government or anything. It’s about your own functioning. (Pre 16, female, 50–54 years)

We made clear from the initial stage in what way the videos would be used. We explicitly stated, for example, that videos would solely be used for research purposes on infections and only people from the research team could access the videos.

**No Burden to the Workload**

Working at the GPC can be very stressful and busy for GPs. They feel that the normal workflow should not be disrupted. They don’t want any technical hassle with the cameras. They would prefer it if somebody else asked informed consent to the patients. A medical student set up the camera and was positioned in the waiting room to inform and ask patients consent.

There were no problems, thanks to the preparations of the student it went smoothly. (Post 13, female, 35–40 years)

**Awareness of the Camera**

If they are reminded constantly that their consultation is recorded, they are afraid they might act differently than in their natural setting. One of the suggestions that was made was to position the camera discretely. Someone suggested to leave the
camera on all the time, so that they do not have to worry about starting or shutting down the camera.

It would be more natural, if the camera just keeps on rolling... I think it could alter my way of acting. If the camera... if I had to put the camera on and sorts of things. (Pre 02, female, 30–34 years)

Because of ethical and practical considerations, we opted for the possibility to turn the camera on and off by the GP. The student could be asked to turn the camera on and off, but because it was an easy to use camera, most GPs opted to do it themselves. However, a few times the GP turned on the camera a bit too late when the consultation had already begun. Consequently, this leads to missing data on the initial phase of the consultation. Two times a GP forgot to switch off the camera; therefore, we had to delete some video material that was not consented for. Some consultations were interrupted, for example, by a telephone call. Because of privacy reasons, the telephone call itself had to be cut. These interruptions were part of daily consultations and as such interesting material as well, for example, on how a GP dealt with such an intrusion and followed up the consultation afterward.

Some of the GPs kept being conscious of the camera throughout the entire recording day, but most of them said they forgot about it after the first recordings and their stress level dropped. They knew that we were interested in infections and the use of antibiotics so they were on guard to adhere to the guidelines.

I know I thought: “shit, I prescribed antibiotics.” But I tried not to overthink it, and it were really kissing tonsils, with a bad smell, so... (Post 15, female, 25–29 years)

Even after the study when the camera was removed, the effect lasted and even colleagues working at the same time who weren’t being filmed were more conscious of their prescribing behavior.

It was funny. Even my colleague was thinking more on the appropriateness of her prescribing behavior that day. (Post 20, female, 45–49 years)

At night, I saw someone with a sinusitis, and I’m always balancing on should I or should I not?... A kind of laziness. But now I thought, no she is not sick enough,... so yes it made me think more. (Post 16, male, 55–59 years)

**Theme 3: Use of the Videos for Research and/or Educational Purposes**

It is important to be clear whether the videos are used for research purposes only or for continuous training with peers as well. For some GPs, an extra barrier would be if other GP colleagues would view their video.

Gosh... euh... I don’t know (laughs). Euh yes. But I wanted to be asked up front if you would do that. To say no per definition, no,... but to say yes... It’s purely emotional. Because actually, I think... yes. Even if it is a good consultation. But you expose yourself, I feel. (Pre 07, female, 45–49 years)

Some GPs would like to have a say in which videos can be shared with their peers. They would prefer to show their “good” consultations. Others thought it would be most interesting to discuss their imperfect consultations as well as they see this as a learning opportunity. The option to select the videos they want to show reassures some GPs.

I: Euhm, they will be good consultations, no? Or will it be parts to show how you don’t have to do it? Interviewer: Would it make a difference? I: Yes it would make a difference... I wouldn’t like it. (Pre 09, female, 35–39 years)

No problem. If it are good consultations, then it is ok (laughs). Interviewer: And what if it were consultations where something went wrong, could we use those? I: Yes, actually, yes (laughs). You can learn a lot from bad fragments, you know. (Pre 10, female, 60–64 years)

Some GPs have no problems to share their video, but others were more comfortable with only using a verbatim transcript in continuous training. GPs had two opposite ideas on receiving feedback. Most of them would like to discuss their consultations or receive written feedback. Others would participate to help science but do not see the need for feedback.

I don’t see myself in a conversation further analyzing my consultation or anything. (Pre 06, male, 60–64 years)

Among the ones who would like to receive feedback, some GPs would prefer to do that individually. Others were open to the idea of discussing it with peers and could see the added value of this. But the general feeling was that it should all happen in a safe environment, for example, with colleagues they know and trust.

You know, it all depends on the safety, if you’re sitting in a group where everyone is ok,... I wouldn’t mind. If you know that there is no one that will judge you, and we all know of each other, everyone is bungling sometimes, it is not that we are all so fantastic all the time, so...” (Pre 08, female, 40–44 years)

We chose to organize elicitation interviews after the video observations with a self-selected video, with only the main researcher present and not to use them for (peer)education. Participants in the video recordings looked back positively on their experience and described it as educational.

I’m curious for the results. It was certainly educational to be conscious of your way of consulting. (Post 17, female, 35–39 years)

**Discussion**

Exploring the views on video recordings in OOH primary care and the conditions that must be met in order for GPs to participate was the main focus of this study. We used the BAbAR...
study to illustrate how to apply these views and conditions to set up a video observation study and describe the advantages and disadvantages of choices made and formulate some guidance for future research. Generally, GPs are willing to record their own consultations, although they report that they will have to cross certain “mental” barriers as it makes them vulnerable. Therefore, certain conditions have to be met before GPs agree to participate. These conditions mostly relate to feeling safe, protecting the patient and handling the data carefully. They acknowledge that it can be educational, but they are not willing to put extra time or energy into the recordings. GPs participating in the postobservation interviews looked back positive on the recordings. Furthermore, GPs felt this was a helpful reflective learning tool. From a researcher’s point of view, some choices made based on the GPs’ preobservation interviews resulted in some disadvantages such as no patients on camera to analyze patients’ nonverbal reactions and no use of the material for teaching.

There are studies that discuss the views or experiences of certain stakeholders on video recording in settings other than the OOH primary care setting. For example, this was studied in palliative care consultations, in a hospice, in HIV/sexual health settings, in different hospital settings, and for routine primary care consultations (Bradshaw, Cohen, Day, Mandala, & Theobald, 2013; Hargreaves & Peppiatt, 2001; Pino et al., 2017; Ram et al., 1999; Rushmer et al., 2011). The conclusion of these studies is that the use of video recording is acceptable and valuable, taking into account some safeguards depending on the specific situation. Confidentiality concerns for patients and physicians, like in our study, were a recurring theme in all the different settings mentioned above, as well as safe data storage and data use.

Parry et al. (2016) suggest to undertake in-depth discussions with stakeholders when designing video-based research in health care. In accordance with this review, our study demonstrates that discussing context-specific barriers for participation with the relevant stakeholders beforehand can lead to successful data collection. Specific for the OOH context is the high workload and the specific role GPs feel they have as a GP on call (Colliers, Coenen, Remmen, Philips, & Anthierens, 2018). There is time pressure in these consultations, they have to be quick and efficient. So organizing a video observation study in this context should be minimally disruptive. We accomplished this by using a logistical person to set up the camera, inform and ask informed consent of the patients, technical support, and so on.

GPs identify strongly with their profession, and it is exactly this what makes them feel vulnerable when video recording their consultations. They “expose” themselves in showing who they are as a GP and possibly exposing themselves to critique. The study was featured as part of a learning environment, and we communicated to the GPs that their consultations would never be judged against a standardized communication or consultation style. The trustful relationship with the researcher, the nonjudgmental approach, but also the practical and logistical support were strong assets to convince GPs to participate.

Research on the influence of video recording on consulting behavior is limited (Coleman, 2000). There is the possibility that participating GPs will alter their behavior because of their awareness of the camera also known as the Hawthorne effect (Yanes et al., 2016). Although studies suggest that GPs’ behavior is influenced minimally while being video recorded (Pringle & Stewartevans, 1990; Themessl-Huber et al., 2008), awareness of the camera is an important concern from a researcher’s point of view. The goal is to record and analyze “natural occurring” behavior during consultations. We learned in the postobservation interviews that although GPs were aware of the camera, they said they did not change their habits and natural way of consulting. And there was no fear in showing their “difficult” consultations, the ones where they struggled or did not know exactly what to do. However, in the case behavior was altered, it can still inform research on good practices, show specificities in patient–doctor communications in the OOH care setting, show how communication is done on prescribing, and so on.

**Strengths and Weaknesses**

As far as we know, there are no studies that describe the video recording of consultations in OOH care to study prescribing behavior of antibiotics nor of other topics. Nor are there studies that discuss feasibility or acceptability of setting up such research. Infections are the number one reason to consult in OOH care and subsequently antibiotics are prescribed often (Colliers et al., 2019; Smits et al., 2019). GPs feel the threshold to prescribe antibiotics in OOH is lower in comparison to office hours, they feel a difference in their professional identity (they define their task differently, they feel more isolated, insecure, have the need to please, etc.), they see a different type of patients (unknown patients, vulnerable patients, other ethnicities, demanding patients, etc.), they feel time pressured, and there is a lack of diagnostic tools or follow-up (Colliers et al., 2018; S. J. Williams et al., 2018). Video observations could help us to explore patterns of behavior and communication between GPs and patients and to create awareness of doctor–patient interaction, guide changes in attitudes, practices, and interventions beneficial for improving antibiotic prescribing quality.

We explicitly stated the researchers’ background and position because of the effect it will have on the research (reflexivity; Malterud, 2001). The interviews were done by a former colleague of the GPs who worked in that specific GPC until 2015. This helped to build a relationship of trust and to engage GPs in participating in the research. The strength of this approach is that they might feel or expect a sense of recognizability on the subject because the researcher is a GP as well and she knows the sensitivities. The main researcher takes both an insider and an outsider role and takes advantage of both angles (McNiff & Whitehead, 2011). In this study, it leads to the necessary trustful relationship GPs needed to agree for participation.
There is the possibility that GPs who were willing to participate in this type of study are more prone to participate in research and maybe more progressive and open minded to new evolutions in their profession. They might have a more positive attitude toward video recording than the average GP. Consenting to recording of one’s consultations might also mean that they have different attitudes in clinical practice and consulting behavior (Coleman, 2000). We noticed a higher participation level of GPs working in group practices in the video recordings. Often they have a GP trainee working in this type of practices and they are used to working with video recordings as a learning tool and to receive feedback. But we think it was due to our convenience sample that less solo GPs participated.

We did not address the views of patients in our study. Previous studies show that the majority of patients are willing to participate in this type of study (Jepson et al., 2017; Krug et al., 2018; Themessl-Huber et al., 2008). In our study, 73% of patients consented to participate.

Conclusion

GPs support the idea of video recording their consultations in OOH care, taking into account some vulnerabilities and conditions including issues of data security, minimal impact on workload, and patient and doctor confidentiality. Addressing these individual and context-dependent concerns of the GPs when organizing a video observation study, as we did in a PAR study on treatment of infectious diseases, led to successful data collection. Video recording consultations gives the opportunity to gain insight into GPs’ habits in a real-world setting and it provides a unique learning opportunity for the GPs themselves.

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ORCID iD

Annelies Colliers https://orcid.org/0000-0003-4960-2355
Samuel Coenen https://orcid.org/0000-0002-1238-8052
Sibyl Anthierens https://orcid.org/0000-0003-4762-1907

Supplemental Material

Supplemental material for this article is available online.

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