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TELEMEDICINE AT THE THRESHOLD OF NEW RELATIONALITIES AND OLD RESIDUES: A CASE STUDY

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Abstract

The evolution and adoption of information and communication technologies have brought about significant changes in the way we perceive and relate to the world around us. These technologies have facilitated instant communication across distances and stretched our perceptual frontiers well beyond the constraints of physical space. In this study, we are exploring the influence of one of these technologies, telemedicine, on the human experience, a technology that has become particularly relevant amid the COVID-19 outbreak. Specifically, our study centers on patient-physician interactions through telemedicine during the pandemic in Turkey, with a sample of 30 patients who received consultations from the same pulmonologist. Our research highlights the need to consider the social and technical elements that construct technology to fully understand the impact of technological transformations on the human experience. Through our case study on telemedicine, we argue that this technology leads to a reframing of patients' perception of space, which in turn shapes a different mode of being for them in patient-physician interactions mediated by this very artifact. Furthermore, our emphasis on the relational aspect of technology underscores the idea that technology not only constructs new modes of relationships but also embodies the context in which it operates. In particular, our case study on telemedicine during the COVID-19 pandemic in Turkey highlights how this technology embodies a neoliberal socio-political framework from its inception and how, in turn, this leads to the construction of various forms of neoliberal participation, such as access to and use of this technology in the relations it facilitates. Consequently, our research highlights the interconnectedness of technology by examining the impact of telemedicine on patient-physician interaction in a given context.

Keywords: Telemedicine, patient-physician interaction, sociotechnical arrangements, COVID-19, mediation theory.

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ESKİ TORTULARIN VE YENİ İLİŞKİSELLİKLERİN EŞİĞİNDE TELETIP: BİR VAKA ÇALIŞMASI

Öz

Bilgi ve iletişim teknolojilerinin gelişmesi ve benimsenmesi, çevremizdeki dünyayı algılama ve onunla ilişki kurma biçimimizde önemli değişiklikler meydana getirmiştir. Bu teknolojiler, uzak mesafeler arasında anlık iletişim kurmamızı sağlamış ve algısal sınırlarımızı fiziksel mekân kısıtlamalarının ötesine taşımıştır. Bu çalışmada, COVID-19 salgını sırasında giderek daha önemli hale gelen bir bilgi ve iletişim teknolojisi olan tele-tıbbın insan deneyimi üzerindeki etkisi araştırılmaktadır. Çalışma, COVID-19 sırasında aynı göğüs hastalıkları uzmanından konsültasyon alan 30 hastadan oluşan bir örneklem ile Türkiye'de pandemi sırasında tele-tıp aracılığındaki hasta-hekim etkileşimlerine odaklanmaktadır. Araştırmada, teknolojik dönüşümlerin insan deneyimi üzerindeki etkisini tam olarak anlamak için teknolojiyi ve bağlamını oluşturan toplumsal unsurları birlikte dikkate alma ihtiyacı vurgulanmaktadır. Tele-tıp üzerine gerçekleştirilen saha çalışmasına dayanarak, bu teknolojinin hastaların mekân algısında bir dönüşüme yol açtığı ve bunun da hasta-hekim etkileşiminde farklı bir varoluş biçimini şekillendirdiği öne sürülmektedir. Teknolojinin ilişkisel yönüne yapılan vurgu, teknolojinin yalnızca yeni ilişkileri teşvik etmekle kalmayıp aynı zamanda içinde faaliyet gösterdiği bağlamı da cisimleştirdiği fikrinin altını çizmektedir. Tele-tıp üzerine yapılan vaka çalışması özelinde, bu teknolojinin Türkiye'de neoliberal bir sosyo-politik çerçevenin izdüşümü olduğu gösterilerek, yine bu teknolojinin kurguladığı ilişkilerde de bu neoliberal mantığın görünür olduğu savunulmaktadır. Bunun ise özellikle bu teknolojiye erişim ve teknolojinin kullanımı gibi çeşitli katılım biçimleri söz konusu olduğunda somutlaştığı vurgulanmıştır. Sonuç olarak araştırma, tele-tıbbın belirli bir bağlamdaki hasta-hekim etkileşimi üzerindeki etkisini inceleyerek teknolojinin ilişkisel varoluşunun altını çizmektedir.

Anahtar kelimeler: Tele-tıp, hasta-hekim etkileşimi, sosyo-teknik düzenlemeler, COVID-19, dolayım teorisi.

INTRODUCTION

The telecommunication revolution was dated to the 1990s in an article that used Craincross's quotation as an epigram: "The death of distance, should be welcomed and enjoyed" (Cartwright, 2000). The notion of the 'death of distance' indeed evokes profound philosophical and sociological contemplations about the fundamental nature of space and its intricate relation with human experience since, in its simplest terms, space is essential to understand *one's place* in the world, and it shapes one's *experience of reality* in profound ways. One can say that any human experience is necessarily conditioned by space. Today, technologies, especially Information and Communications Technologies (ICT), intervene in the definition of space by altering the meaning of *physical distance* and transforming it into a *relational distance* (Pols, 2012). Therefore, one can say that technology is not only a mere part of this space; instead, it has become one of the fundamental elements that constitute the space, and therefore human existence itself, transforming it into a more relational entity rather than a once-given, immutable being conditioned by a physical space. In this new, relational mode of existence through technology, virtual and physical existences merge. Furthermore, this 'new' relational space constructed by technologies manifests divergent interpretations of the concept of distance -and therefore, proximity. In one respect, it presents a new dimension of 'being there' or 'being close' that extends beyond the physical realm, thereby engendering ontological closeness. Of course, this ontological rapprochement is a self-contradictory closeness that brings with it different ways of 'being distant' such as the loss of physical proximity and face-to-face interaction.

In the forthcoming section of this article, we will discuss in detail the first implication of *distance*, which is closely linked to the intricate interplay of virtual and physical existences in telemedicine. We will firstly argue that despite the potential loss of certain aspects in the patient-physician interaction, *a sense of proximity*, which blurs the boundaries between the physical and the virtual existences, can still persist in this new form of interaction constituted by telemedicine. So, it may really mean a form of 'death of distance.' However, conversely, while physical distance is partly -ontologically- eliminated through telemedicine, we will argue that it also makes us confront a different gap, one shaped by the sociopolitical relations that contour this artifact with a neoliberal framework. Unsurprisingly, telemedicine's adoption in Turkey was accelerated during the COVID-19 pandemic, and our case study examines one of these recent adaptations. The arrival of COVID-19 in a context where the health system has long been in crisis (Yenimahalleli Yaşar, Birler & Göksel, 2017), coupled with the pandemic's crisis, has crystallized Turkey's health system's neoliberal ethos (Ergur, 2020). This neoliberal rationale is also evident in the telemedicine application that makes our case, which serves not as a systematic, but as an individual response to the crisis. We will discuss these individual strategies in more detail in the second part of the forthcoming section.

Through this case study, we want to demonstrate that no artifact emerges from or operates in a vacuum. Although technology enables new relationships, forms of engagement, modes of action, and modes of existence, as Verbeek contends, these "mediations are always context-dependent" (2005, p.11). Therefore, we must bear in mind that any technology always exists within a socio-technical arrangement, where social and technical elements mutually -and constantly- construct each other. Our case study of telemedicine will exemplify this interconnected existence of technology. We will expound on how technology presents a productive and relationship-building character while concurrently exhibiting context-specific features that reflect and embody the intricate relations in the given context. The article will illuminate this interconnectedness between technology and its context and shed light on this relationship by zooming in on a specific node of (undoubtedly a much larger) web of relations formed by the telemedicine artifact. Our case will cover 30 patients who used telemedicine for the first time to receive consultation from the same pulmonologist during COVID-19.

THE BACKGROUND AND METHODOLOGY

Background

The telemedicine case we explore was put into practice in one [anonymized] public hospital in Turkey in the first year of COVID-19. In the context of the COVID-19 pandemic where physical contact posed a risk, the acceleration of adaptation of telemedicine technologies was no coincidence. Although the integration of telemedicine into the medical field was already underway before the pandemic worldwide, the COVID-19 outbreak accelerated this process by bringing to light its potential benefits. Turkey created a case where this situational acceleration can be observed. In the first three months of the pandemic, most of the physicians in Turkey were referred to solely treating patients with COVID-19 in specialized wards while other in-patients and out-patient clinics were closed. Meanwhile, the follow-ups and treatments of many non-COVID patients were disrupted due to the lack of systematic preparedness within the Turkish healthcare system (Ergur, 2020). The acceleration of the adaptation of telemedicine technologies was an outcome of such a context. Although the Ministry of Health has officially authorized the launch of the telemedicine service, due to the insufficient reimbursement and regulatory framework, this proposal could not be adopted by many physicians. At the given time, there was yet to be any kind of infrastructure of the national health system to be utilized for in-distance consultations or treatments. The adaptation of telemedicine technologies in question was left to personal initiatives. The subject of this case study is an example of one of these personal initiatives where solely a single pulmonologist, one of the co-authors of this article, had adopted this telemedicine technology in the [X] Research Hospital, who does not receive any reimbursement as a result of their practice. Since they weren't a systematic interface to be utilized, in our case, Skype (Skype™, version 6.4, Microsoft, Redmond, WA, USA) was adapted as an interface for the application of telemedicine. For the sake of patient confidentiality, the name of the hospital was anonymized.

The complete delegation of such a practice to personal initiatives cannot be considered a singular and isolated example. On the contrary, it points to a much more entrenched crisis in the Turkish healthcare system, whose roots date back to the early '80s. During this era, New Public Management plans which were grounded in market-related public policies arose. With the endorsement of the World Trade Organisation's General Agreement on Trade in Services (GATS) and various other regional treaties, the ethos of healthcare systems throughout the globe has shifted into a neoliberal conceptualization (Ağarthan, 2007). Neoliberalization within the medical context has three leading indicators: adaptation of free market and deregulation conditions, decentralization, and individualism. An indication of the individualization of the medical field towards the neoliberal orientation is that individuals are left to address the difficulties they encounter in accessing health care through their initiatives (McGregor, 2001). With the economization of the political fostered by neoliberal rationality, not only do market principles are being applied to non-market spheres, but also subjects and principles are transformed into economic entities. This economization of the political is precisely relevant to our inquiry as it refers to the displacement of the mandates of the welfare state in favor of individualized responses (Brown, 2015). Thus, the term individualization, as used throughout the paper, indicates embedding the quality or access to the health care system within the framework of individual agency rather than as a matter of the state.

Historically, this individualism in the Turkish Health Care system started to manifest itself through the Health Transformation Program of 2003 where the Ministry of Health "has been gradually withdrawing from the provision dimension through the purchaser-provider split and organization of public hospitals into autonomous units" (Ağartan, 2012). These transformational steps in healthcare were institutionalized with different policies beginning in 2003 and this neoliberal trend is traceable through many different aspects of the health system in Turkey (Üstündağ & Yoltar, 2007; Ünlütürk Ulutaş, 2011; Pala, 2017; Vural, 2017). The fact that the implementation of telemedicine technologies is left to the ability, will, and initiative of hospitals or individuals during COVID-19 cannot be separated from these neoliberalized conceptualizations of the healthcare system that is rooted deeply in individualization. Through this neoliberal individualization, as in the case of telemedicine, physicians

are encouraged to altruistically undertake duties despite the inadequate infrastructure and the lack of compensation, while patients are guided to engage in these limited services only in accordance with their individual abilities. It should be noted that although the Ministry of Health sent official invitations to public health facilities to organize telemedicine services during the pandemic, the Ministry did not systematically publicize this to patients and did not offer reimbursement rights to physicians in line with the performance system. This abandonment of patients, physicians, and hospitals to their fate indeed, signifies a greater neoliberal question itself, however, this case study of a singular telemedicine adaptation also signals the levels of individualization within the field.

Methodology

The study was conducted as a case study because it aimed to explore the experiences of patients who use telemedicine services in-depth and to gain an understanding of the complex factors that influence their experiences. Case studies are particularly useful when the phenomenon being studied is complex, and when there is a great need to understand the contextual factors that shape it. In this study, the perceptions of the patients who use telemedicine services in the given hospital are conditioned by a variety of contextual factors such as health and technology literacy, age, socioeconomic status, and access to healthcare services. By conducting a case study, the researchers were able to gain a detailed and nuanced understanding of these factors and their influences on patients' experiences. There were a total of 30 participants comprised of varying demographic backgrounds whose detailed characteristics have been shown in Table 1. The mean age was 51 years (range: 21 to 73) whereas the female/male ratio was 17/13. This sample size was deemed sufficient to achieve data saturation, which is a point where the data collected is enough to capture the range and depth of experiences of the population being studied. In qualitative research, the sample size is not fixed and is determined by the research question and the nature of the data being collected. In this study, 30 participants were considered an appropriate sample size as it was expected that it would provide a rich and diverse range of experiences and perspectives on the use of telemedicine services.

Case studies make an important part of the investigation of the practices in a contextualized way (Smith-Doerr, 2017). Since semi-structured interviews are a reliable method of data collection when it comes to contextualizing and deeply engaging with the practices, ideas, and perceptions of the patients, it was used in the study to collect the data. Using this method, the interviews were conducted via various online meeting platforms (Skype, Zoom, WhatsApp call) based on the participants' preferences. Due to ethical concerns, the pulmonologist was not involved in any of the interviews. The interviews were audio-recorded with the consent of the interviewees and transcribed verbatim. The thematic analysis approach was used to analyze the qualitative data. The analysis process involved familiarization with the data, identifying codes, grouping these codes into themes, and analyzing the frequently used themes that are *the ways of being aware of the service and getting technical support*, *the comparison of healthcare services in pre-Pandemic and post-Pandemic periods*, *the experiences through the procedure*, and *the perception of the future of telemedicine.* This qualitative study was approved by the Institutional Review Board (IRB) of [Anonymous] University (Decision no: E-60116787-020-15395; Date: 02.02.2021). Informed consent was obtained from all participants before the interview. Participants were assured of confidentiality and anonymity, and they were given the right to withdraw from the study at any point without any consequence.

RESULTS AND DISCUSSION

Telemedicine can be considered an artifact that opens a whole different *space* for the patients and physicians to be present and interact, a space where virtual and physical reality is intertwined. In this context, we argue how distance, once perceived as physical, has become relative and related to sociopolitical context and interpersonal relations. Telemedicine creates a hybrid space during the

consultation that is neither entirely physical nor entirely virtual, but rather a combination of the two. In this *hybrid space*, interaction takes place through an interface. The doctor interacts with the patient through an interface, and the consultation occurs in a completely virtual environment. Within this intertwining that is *physically here but virtually there* (or virtually here and physically there) patients become *mediated*. This indicates a radical perceptional shift within the patient-physician interaction and introduces a new form of existence condition by this new meaning of space, that is, 'being remotely present' or simply *'telepresence'* (Steuer, 1992) to reconstruct this very interaction altogether. What stands out in this reconstruction is *the intertwining of human and non-human* in both perception and existence and this entanglement occurs through the mediation of technology. The very process of the physician diagnosing the patient's representation in a virtual examination room implies a new set of connotations within this virtual spatiality. This is a vastly distinct medical field from the one in which the healer engages with the patient's corporeality by touching and actively listening to the patient's body.

As it was discussed at the beginning of this article, if any human existence and experience is conditioned by space, one can say that this new space constructed through telemedicine conditions a new mode of existence for the patient. This existence is a hybrid existence mediated by technology, and because of its 'hybrid-being' it is an existence freed from the constraints of physical space, at least on the perceptual plane. This transformation at the perceptual level, in turn, marks a radical transformation in experience, because the very human-world relation and the 'existence' itself are constructed through perceptions (Merleau-Ponty, 1976). Through this perception, subject and object positionings are formed meaning that there are no such positions before the perception and these positions exist *in relations*, that is, *while one is approaching, perceiving, and relating to the world that surrounds them* (Verbeek, 2001; 2005). Moving forward, it can be argued that one's access to the world is not direct, meaning that each single perception is mediated (Verbeek, 2001). Today, technology is one of the dominant forms of these mediations, that is to say, since technologies alter and are altered by human perception, they must be theorized as the "mediator of human experiences and practices" (Verbeek, 2016, p. 2). When it comes to these mediations, rather than the conceptualization of subject and object (or, in this case, humans and technologies) as two poles in a dualistic understanding, these very subject-object positionings can be considered the outcome of this very relation (Verbeek, 2015). Mediation, then, ought to be thought of as "the origin of entities, rather than a 'middle position' between them" (Verbeek, 2012). What this means for our case is that in the case of telemedicine, the reconstruction of subject-object positions leads to a reconsideration of the physician's therapeutic touch, the very existence of patients' and physicians' bodies, medical gaze, and so on. In this new interaction mediated by this technology, it is not merely the patient and the physician who interact through telemedicine, but also their representations. In other words, these representations interact as a proxy. This indicates that we need to think of reality, corporeality, and spatiality through this mediation through which the patient, the physician, and the interface fuse to form a new spatiality, relationality, and thus existence. Both the patient and the physician *interact with each other through their interaction with their computer*, that is, the nonhuman.

Based on these insights, following the *mediation theory,* we argue that it is very difficult to conceptualize technologies as *passive intermediaries* between pre-existing subject positions, enabling relations between those pre-given nodes. Things are not neutral and passive intermediaries, in contrast, they are active mediators between human beings and reality, actively constructing new realities and modes of existence with their values, social action patterns, forms of interaction, and ways of thinking (Verbeek, 2005). In the case of telemedicine, this mediation gives rise to new kinds of interactions between patient and physician and new kinds of existences that will interact with this artifact. This implies a new mode of interaction between the patient, who must express the nature of his or her condition's manifestation, and the doctor, who must remotely re-invent the physician's therapeutic touch, as well as the new ways of existence that this interaction itself entails. Yet it is not only the interaction but also the structure and character of the medical ethos that is simultaneously sculpted by technology and thus reshaped by it. In this regard, one can argue, these interfaces and

artifacts hold a *thing-power* that is a kind of force that is exercised by non-humans upon humans and the term emphasizes the interconnectedness between these two (Bennet, 2004). This generates "a range of relational connections, effective forces, and agential capacities" (Lupton, 2019) that signifies "the ways in which human beings and thinghood overlap" (Bennet, 2004). In the instance of telemedicine, the overlapping of these two becomes visible in a new form of interaction in which the virtual and physical existences of both the patient and the physician are entangled.

This new form of interaction introduces a new way of relating that is unique to this technology. Both the patient and the physician will need to adjust their practices to accommodate this new relationship, which we will explore further in the next subsection, along with our field findings. However, it's important to note that telemedicine doesn't solely produce new relationalities but also incorporates remnants of the past and we will discuss this in the second subsection. In other words, we will argue how telemedicine creates new relationships while embodying established sociopolitical relations from its context of origin. These newly formed relationships subsequently display the characteristics of the relations that are embodied in telemedicine. Therefore, in our case, we view telemedicine as a "threshold" - a technology that both introduces new forms of relating and reflects the entrenched sociopolitical relations of its environment.

Lost in translation: New relationalities opened up from telemedicine

Telemedicine can be considered as an artifact that brings about radical transformations in the diagnosis process and renders it a practice mediated through an interface, thus, transforming the very nature of patient-physician interaction, a human-to-human relation into an interaction based on the entanglement of human beings and machines. In so doing, it constructs different ways of existence for both the patient and the physician as a networked entity, that is, as a *relational being-in-assemblages.* Within this assemblage, through which the physical and the virtual intertwine, telemedicine means the partial disappearance of various limitations of physical reality and space, and its replacement by a more fluid, virtual; physically and spatially, even temporarily unrestricted reality. The patient's existence is also attuned to this reality. Presenting the physical existence of the body in a digital form in the virtual environment can be considered as the replacement of a single—rather physical—ontology for the subjective existence of the patient by multiple ontologies. There are now different sites (Law, 2004; 2017) of patient existence: *physically here* and *virtually there* or from the point of view of the physician, and vice versa: *physically there* and *virtually here*. Therefore, the state of being in the same examination room has changed into 'telepresence' which implies a different room for each individual, that is, 'I am at your place, and you are in mine' (Pols, 2010).

> *"We held our meeting at our own home, in our environment. In a more stress-free environment. We were incredibly nervous when we went to the hospital because everyone was afraid of everyone at this time. In case anything can happen at any moment we had double masks, and disinfectants in our hands all the time. The hospital environment is stressful. But we were comfortable at home because we were in our environment."* ***I9***

This new perception of the space and the patient's body and this new kind of interaction constructed by telemedicine necessitates for the physician to *translate* their conventional professional skillsets, which makes an example of how through technologies, the perception of medical expertise itself as well is ever-changing. Part of this translation is, of course, the one about the practice of *therapeutic touch*. Touching has been an integral part of medical practice since the very beginning of the profession since it was always one of the most essential parts of 'interpreting' the body. While its further integrations into the history of medicine in Western societies are the subject of another study, it is safe to say that along with telemedicine, the traditional practice of diagnosis has shifted towards a paradigm based on talk and trust (Rosen et al., 2020). The replacement of the physical presence of

the patient's body with a virtual presence and the patient's narrative not only challenges the customs and the values of the old medical settings but also isolates patients since telemedicine adaptation in Turkey is profoundly rooted in patients' ability to perceive and articulate their bodily complaints, their ease of navigating digital spheres, and, of course, their privilege to have initial exposure to such technologies. However, this state of isolation and neoliberal individualization does not only occur among patients; on quite the contrary, the fact that neoliberal systems abandon individuals to their own devices is the root cause of the physicians' initial engagement in this practice in the first place. In precisely this context, even though telemedicine technologies have emerged as an opposition to the extensive shortcomings of neoliberalism in Turkey, they are essentially neoliberal in the sense that the mending of system deficits has become a matter concerning individuals.

Even if the physician translated existing interaction sets into a virtual environment, some aspects were *lost in translation*. Even though webcam technologies brought the 'clinical gaze' into the home when those who are looking at each other through the webcam aren't familiar with each other, this clinical gaze in question was argued to be "superficial" (Pols, 2012). Because human contact is mediated by touching the patient, which is the way of expressing caring, empathy, and solidarity (Singh & Leder, 2012), irreversibly disappears in interaction through an interface. Therefore, telemedicine points to the loss of trust in the patient-physician interaction for some patients. However, the paradigm based on *narratives* can help physicians to acknowledge *the physiological body* that is inseparable from the imagined and lived body (Mattingly, 1998a). While clinical reasoning is often regarded as an applied natural science and the body is "made up of parts that break down" (Martin, 1994), the role of sharing stories has been underlined many times stating that creating narratives operates a "double vision of clinical work" (Mattingly, 1998b).

Although telemedicine affects the nature of patient-physician communication both in terms of technical and interpersonal relationships (Miller, 2003) and brought new conveniences in accessing health services, from the perspective of patients, the uncertainties and obscurity of telemedicine technology were observed to be a source of hesitation and fear. The fact that telemedicine is a technology that transforms and displaces the setting of the conventional and rather physical patient-physician interaction into a virtual space may cause various hesitations and feelings of insecurity among patients. However, due to the average age of our sample, 51, the importance of being predisposed to technological contexts ought to be accentuated here. Indeed, the aforementioned feelings of insecurity and reluctance are also associated with the digital capital of individuals (Ragnedda and Ruiu, 2020). Webcams tend to deepen the already existing social relationship characteristics of the users, encounters among those who are strangers carry disquieting characteristics (Pols, 2010). The anxiety felt by interviewees, especially during their first meeting with physicians was frequently observed. At this point, it can be argued that tests and controls carried out at the hospital were indicators of trust and reliability according to the patients. Interviewees generally did not believe in the effectiveness of telemedicine alone unless they were called to the hospital by the physician and stated that if the doctor did not call for a test, they would evaluate the physician differently and would not even use the medicine prescribed. Thus, the residues of an already established relation, whether that is trust or discomfort, become an adhesive component of the new, spatiotemporally ruptured relation constructed through telemedicine. Hence, the patient's lack of knowledge about telemedicine, unfamiliarity with communication technology, fear of the unknown (Almathami et al., 2020, p.14), and mistrust of not being able to meet the doctor face to face (Chien-Hsing et al., 2020, p.177) were and still are questionable factors about telemedicine. Nevertheless, one must underline that in an environment where physical contact posed a risk of contamination, as telemedicine isolated patients from the hospital environment, crowds, and other patients, it served a particular function, especially throughout the pandemic.

> *"To tell the truth, it's not like a physical face-to-face examination. Frankly, during the conversation, there is a requirement for reassurance. It's our first online consultation experience, and at first, we had a bit of trouble." I25*

"Though you express yourself on Skype, I am not convinced that the doctor could understand properly. Probably because it is not real face-to-face communication." ***I****24*

"'You must come here for tests, she [the physician] said. That's why we went, but if we only had the online meeting, if there was no further appointment, would I have used the medicine given? I think I would not have used it." ***I****16*

"I didn't know how the first meeting would be. Because you don't know how it is, what it is, will she understand me or not, will it happen or not… You are used to meeting face-to-face all the time. That's what I said at first, then after the first meeting, you feel more relieved. But still, you can tell the difference." ***I****10*

"Of course, it would have been a mistrust if the doctor hadn't called us because we had concerns about how she would treat us via screen call. It would have raised a question such as if she were going to look at our radiologic images, this or that. But thankfully our doctor called us and did all of our tests." ***I****13*

Moving forward, as we observed in our fieldwork, this transformation in the relationship with the physician is one of the reasons why telemedicine is met with various uncertainties and insecurities despite its benefits. However, these insecurities and uncertainties are not limited to this. We observed that patients may also have various concerns when it comes to accessing and using this technology. Part of the reasons for these concerns includes but are not limited to, the lack of infrastructure, inadequate access to the internet and technological tools and equipment, and technological illiteracy. The extent to which individuals are abandoned in seeking access to healthcare services within the framework of the neoliberal system bears re-emphasizing here. Interviewees who only had access to the necessary technological infrastructure through their relatives experienced more distress than those who were already accustomed to technological equipment. Especially during the pandemic, when citizens aged 65 and over were prohibited from leaving their homes, the Ministry of Health did not provide widespread use of devices that could access the applications in question or did not issue explanatory texts, visuals, or videos on how to use these interfaces, further supporting this argument of neo-liberalization. The fact that both the implementation of telemedicine practice by the patient/physician depends on individual initiatives and the fact that the access to this service depends on various types of capital of patients adapts this technology, in our case, individual. That is not to say that this technology is intrinsically neoliberal, but rather it has acquired a neoliberal appearance in the context within which it is embedded, correlated with the socio-political milieu.

An embodiment of a neoliberal logic: Old relationalities that have become residues in telemedicine

Thus far, it has been illustrated how technologies are capable of not only creating but also shaping new forms of human engagements and ways of existing, intricately woven into a complex web of relations between humans and nonhumans. Moving forward, drawing on empirical findings gathered in the field, it will be discussed how a certain technology can present a different context-specific appearance and how telemedicine embodies a distinctly neoliberal appearance within the specific milieu of Turkey. Historically, a new public model for the health system called Socialization of Health Care was introduced in the 1960s, which aimed to provide health services continuously and comprehensively to meet the needs of all people. It proposed to bring all health facilities under one roof and address systematic inequalities (Günal, 2018). However, due to the reluctance of doctors, geographical gaps, and lack of funding, the SHS was never able to deliver on its promises. In the 1980s, with the adaptation of the New Public Management plans, market-oriented public policies made their entrance into the healthcare system on a global scale and Turkey was no exception (Ağartan, 2007).

After the ratification of the General Agreement on Trade in Services of the World Trade Organization and other regional agreements, the global commercialization of the services in question became traceable (Yılmaz, 2013). In 2003, the AKP government, referring to these new plans for public administration, proposed a program to transform the healthcare system. Although this system claimed to be universalistic and egalitarian, it has been criticized for creating new unequal positions based not on professional status but on income (Yılmaz, 2013). In this regard, we must underline that public services can be commodified through various strategies that are: by turning the services into purchasable entities, by convincing people to pay for something they used to be able to access for free, by turning the workforce that provides health care into a for-profit team while the state bears the risks (Leys, 2007). Thus, the HTP has not only contributed to the commercialization of health itself but also changed the origin of income inequality, as hospitals and physicians now function as autonomous for-profit entities. (Yılmaz, 2013).

Health and health services are deeply political in the sense that like all of the resources located within the neoliberal regime, some social groups have more or less than others (Bambra, 2005). The limitations to the routinization of telemedicine include a lack of available technological resources in certain parts of the country, issues with the security of patient data, and challenges in performing the traditional patient examination (Kichloo et al., 2020). The technology literacy level of the population can also be seen as an obstacle to the provision of online health services (Bali, 2018). In this regard, certain capitals come into play. In the course of the study, we have stressed the extent to which neoliberal logic relegates the health system to the discretion, ability, and will of individuals. Accordingly, it is significant to acknowledge the centrality of the various capitals that influence the quality of people's experiences with telemedicine, and indeed whether or not they can even engage in telemedicine in the first instance. The availability of devices such as telephones and computers sufficient to provide access to telemedicine services, and the existence of an internet infrastructure to maintain the consultation are profoundly linked to the economic capital of individuals, indicating the neoliberal quality of the adoption of telemedicine in the Turkish context. Yet it is not solely the economic capital that molds the practice of telemedicine. The capability to narrativize, which influences the trajectory of the medical diagnostic process, is correlated with cultural capital, while digital literacy correlates with digital capital (Ragnedda and Ruiu, 2020). Our study has demonstrated that the overall quality of the medical experience crucially relates to the form and amount of capital an individual possesses. So much so that people with higher levels of education were more rewarded due to their increased self-expression capacity, and interviewees who felt more at ease in virtual mediums proportionally claimed to be less distressed during the consultations.

> *"I am familiar with the internet environment, but possibly people who aren't used to using such technology might have difficulty."* ***I5***

> *"Although I am a mess around the technology, willy nilly. But during the Pandemic, everybody already uses it somehow, with social media at least. Downloading Skype or online conversation didn't cause any trouble for me I am very satisfied. Thanks to my doctor for her sensitivity and kindness all the time."* ***I16***

> *"Even though I have followed my doctor from her YouTube videos, I am not good with smartphones. I asked my son to help me reach that doctor."* ***I2***

Moreover, our study makes an example of how having access to these telemedicine technologies is heavily related to having prior contact with the physicians or the hospital as well, that is the social capital of the individuals. Even in instances where there is no prior reconnaissance, people get familiar with this service through research based on their credentials and can only access the necessary people by their own capacities and social links. That is to say, both the access to and use of telemedicine in our case was inextricably interconnected with the existing capitals of the patients, whether it be social, cultural, or economic, that is, their baggage and strategies. We have underlined how individualization is an inseparable part of neoliberalization of healthcare services. We have

already shown how the context in which the practice of telemedicine in our case emerges was itself neoliberal. Let us here mention once again that the technology itself does not have a neoliberal nature. Quite the contrary, the inherent structural flaws of the neoliberal, individualized healthcare system into which telemedicine technology was born are rendered even more visible with telemedicine technologies. Although the practice of telemedicine, which is implemented by a sole physician on personal initiatives without any compensation, emerged to ameliorate the symptoms of the aforementioned systemic problems, it is a legacy of the neoliberal milieu that renders healthcare access an individual matter. Moving forward, the fact that patients' access to telemedicine and their use of it emphasizes individual strategies also shows that this technology, as it is woven with neoliberal logic, gives rise to neoliberal forms of relation. Therefore, we advocate that technologies must be analyzed in the "wider ensemble within which it is inserted" (Bousquet, 2014, p. 3) and not as a "thing on its own" (May, 2009, p. 147) since the ethos of both technologies and medicine is heavily rotted in and cannot be separated from the sociopolitical context in which they are embedded.

> *"I know a doctor as a neighbor who works in the same hospital. I told him that my mom was afraid to go to the hospital with the anxiety of being hospitalized even though she was her doctor during the pre-pandemic period. Thus, I learned that my mom's doctor has started seeing patients online via video conversation. This is how we were aware of the system."* ***I1***

> *"Of course, this is an advantage for me, but there are also technical accessibility issues among different parts of society, especially for some age groups. For example, my mother is a pharmacist, but it is difficult for her to talk remotely via Skype. I must tutor her for hours. She must experience it with me. I mean, there are also handicaps like this."* ***I3***

> In addition to the many economic, social, and political factors affecting access to health care, the geographical dimension remains a great challenge as our case study shows. The fact that the least frequent users of these digital communication technologies in question were older men in rural areas with low education emphasizes how "technology reinforces existing systemic inequities based on age, gender, race, income, education, and geographic location" (West & Miller, 2009, p. 1).

Accordingly, our study, despite extending its reach beyond 628 kilometers, is not without its limitations: as the sample of the study is composed solely of telemedicine beneficiaries, the perspectives of those who do not possess access to this technology remain underrepresented. At this point, while telemedicine aims to reduce regional inequalities due to geographical reasons by enabling remote patient-physician consultation and medical counseling through communication and medical technologies (Durupt et al., 2016), one must acknowledge its shortcomings as well. Patients may get informed about this system, only if they 'come across' this application on social media or if they are already a patient of the relevant physician since there is yet to be any government initiative to announce and democratize telemedicine nationwide. Thus, this new form of interaction with the healthcare system signifies a 'by chance encounter', rather than a customary and systematic engagement. Therefore, reaching the system is itself a matter of social capital. In this new form of interaction, not the government actors, but individuals, who contextualize this system to the patients play a critical role when it comes to the announcement of the system, its operation, and most importantly, the attitudes of the citizens towards this newly introduced application since their encounter with the system occurs through their relationship with the physician. However, it is at this instance that one thing deserves attention: these systemic deficits in question are not just mere poorly implemented welfare regime policies but rather, a set of neoliberal policies whose shortcomings are systematically and willingly left to individuals to solve. The very same neoliberal agenda, one that is remarked by cost-cutting policies and regressing the welfare state through establishing health care as

a private good, a commodity, canalizes those who have the least amount of capital to come up with their remedy to their difficulties in accessing healthcare, by making it an individual responsibility (McGregor, 2001). As our field study has shown, the discursive but not financial directing of the physicians to this system by the Ministry, the lack of information or assistance to patients over 65 prohibited from going outside during the pandemic whose limited chances of accessing health care systems are through telemedicine, the very relation of the capitals of such individuals and the quality or even access of the care, these all signal the neoliberal character of the field. Although these individual strategies have been introduced to compensate for the wider systemic weaknesses engendered by neoliberal individualization and the lack of government responses, these strategies nevertheless have to be situated in a neoliberal context as it is up primarily to individuals to mend the system's deficits. Both with doctors executing the program at the compromise of their reimbursements and patients being left to adapt without any assistance in terms of introduction, information, education, or means of access to the system, telemedicine is an indicator of how telemedicine inevitably gained a neoliberal appearance in the context of Turkey.

CONCLUSION

We initiated this article with the provoking epigram, "The death of distance, should be welcomed and enjoyed," which strikingly encapsulates the gradual transformation of a matrix of relations over the last few decades. Telemedicine, indeed, rearticulates distance in a new conceptualization as it generates and reconstructs different ways of being and spatiality. This new form of existence requires a sophisticated understanding of what is *social*. Consequently, throughout this article, by resisting the ideas that deem technology a pure means, we aimed to underline how technologies are active mediators of how humans perceive reality. In our case, through the mediation of telemedicine technologies, the conventional modes of interaction between the patient and physician had undergone a dramatic transformation that altered the way the patient engages with the physician and vice versa. A key marker of this new form of engagement is that physical distance is replaced by a relational perception of distance. This not only entails the patient a new form of being (i.e. being virtually here, physically there, or physically here, virtually there) but also demands that the physician adapt their conventional skill sets in various ways to this new state of being, challenging the established notions of expertise, medical gaze or touch.

Furthermore, the relational distance established in the context of this new relationality gains a neoliberal appearance by the context in which technology is embedded. Through this appearance, the patient's connection to the physician depends on personal initiatives, possibilities, acquaintances, and capacities, thus the various forms of capital. Therefore, the very engagement with this technology itself is interconnected with neoliberal strategies that are remarked by extensive individualization within the system that deems health care a personal matter. Nor is this surprising because the manifestation of the telemedicine example we employed, in this case, is also a projection of a prolonged neoliberalization. Therefore, even though we can refer to the death of distance in a particular sense with telemedicine, technologies bring those who have access to these various capitals closer, while at the same time pushing others further away by reinforcing the inequalities that already exist. And therein lies the appearance that technology acquires in the context in which it is embedded. In other words, throughout the article, we have tried to show both how a technology, telemedicine, comes and constructs new forms of relations between patients and physicians, that is, its productive character, and how, in constructing these relations, it embodies certain sociopolitical patterns in the context in which it emerges. Yet again, this would not necessarily imply that the very essence of telemedicine technologies is neoliberal, but rather emphasizes that telemedicine embodies the particularities of the conjuncture in which it unfolds. In conclusion, in our case, the practice of telemedicine, which is conducted by a sole physician on their initiative without receiving any compensation, appears as an isolated individual resistance to ease the symptoms that are caused by the ever-neoliberalizing health system in Turkey. However, the initial necessity of such a personal intervention and involvement, and the fact that telemedicine is not implemented by the Ministry or

government actors, but by individuals on their initiative, is also framed within this neoliberal context. For one should not neglect that the very presence of resistance is conditioned by the existence of the resisted entity. So much so that the reason why this resistance remains an isolated phenomenon is the very neoliberalism itself, with its emphasis on individualization. Namely, telemedicine practices were not endorsed by institutional actors, the essential infrastructure was not established and no compensation was granted to the practitioner. Furthermore, patients were not briefed about the practice, their technological competencies or means were not assessed, and they were not encouraged to engage in the practice. This study demonstrates the extent to which individuals' participation in telemedicine is determined by their social capital, the extent to which the ability to narrativize illness, which is related to cultural capital, transforms the quality of the examination, the extent to which technological literacy reduces patients' stress due to digital capital, and the extent to which initial access to devices and the internet is associated with economic capital. Telemedicine itself, like all technologies, is not inherently a neoliberal technology. But technologies only exist in conjunction with the context they are embedded in.

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Annex 1: Participants

I#	Age	Sex	Distance (km)	Profession	Disease	First meeting	In-person	Follow-ups
1	72	F	0	housewife	Non-COVID	online	yes	both
2	45	F	236	farmer	Non-COVID	online	yes	online
3	45	M	28	textile employee	COVID-19	inpatient	none	online
4	38	F	28	housewife	Non-COVID	online	none	online
5	34	F	0	teacher	Non-COVID	online	yes	online
6	52	M	0	retired office worker	COVID-19	online	yes	online
7	73	F	0	housewife	COVID-19	inpatient	none	online

8	53	M	0	trader	COVID-19	online	to be hospitalized	both
9	63	M	0	farmer	Non-COVID	online	yes	both
10	36	F	96	housewife	Non-COVID	online	yes	both
11	66	F	240	retired office worker	Non-COVID	online	yes	both
12	56	F	129	housewife	Non-COVID	online	to be hospitalized	online
13	54	F	179	farmer	Non-COVID	online	yes	both
14	67	M	90	farmer	Non-COVID	online	yes	online

15	49	M	0	accountant	COVID-19	online	yes	both
16	27	F	0	accountant	Non-COVID	online	yes	both
17	38	F	221	belly dancer	Non-COVID	online	none	not necessitate
18	53	M	23	police	COVID-19	online	yes	online
19	50	M	0	retired office worker	COVID-19	online	yes	both
20	59	M	0	soldier	COVID-19	online	yes	both
21	21	F	80	farmer	Non-COVID	online	yes	both
22	61	M	88	farmer	Non-COVID	online	yes	both

23	64	F	0	housewife	COVID-19	inpatient	none	online
24	53	F	0	retired office worker	Non-COVID	online	yes	both
25	57	M	0	retired carpenter	COVID-19	inpatient	yes	both
26	45	F	0	nurse	COVID-19	online	yes	both
27	46	F	96	farmer	Non-COVID	online	yes	both
28	39	M	628	teacher	Non-COVID	online	none	not necessitate
29	41	M	206	office worker	COVID-19	online	none	online

30	69	M	0	textile employer	COVID-19	inpatient	yes	both

F: Female, M: Male

Non-COVID: any disease other than COVID-19

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