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Patient Perception, Preference and Participation

"They just say everything's a virus"—Parent's judgment of the credibility of clinician communication in primary care consultations for respiratory tract infections in children: A qualitative study

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ABSTRACT

Objective: To investigate parents' experiences and views of clinician communication during primary care consultations for respiratory tract infections (RTIs) in children under 12.
Methods: Semi-structured interviews with 30 parents who had recently consulted for RTI in their child. Purposive sampling was used to interview parents from a range of socio-economic areas.
Results: Parents critically assess the credibility of primary care clinician diagnosis and treatment recommendations based on their perception of the medical evaluation and how well their concerns and expectations have been addressed. A "viral" diagnosis could be perceived as trivializing, particularly when contradicting the parent's perception of severity. Parents expected advice on symptomatic treatment and felt frustrated by 'no treatment' recommendations. Parents commonly reported safety netting advice which was too vague to be useful.
Conclusion: Parents' perception of the credibility of the diagnosis and treatment recommendations is influenced both by their expectations and the effectiveness of clinician communication. Opportunities are being missed to inform parents about symptomatic care and when to consult for children with RTIs.
Practice implications: Clinicians should tailor diagnostic explanations to parental expectations and concerns and address the symptoms of significance to parents. Clinicians should provide advice about symptom relief and more precise safety netting advice.

1. Introduction

Acute respiratory tract infection (RTI) in children is the most common reason why parents consult primary care in the UK [1]. Communication within these consultations is often fraught with misunderstanding that can contribute to unnecessary repeat consultations and the over-prescription of antibiotics [2,3]. Inappropriate prescribing of antibiotics in the pediatric population is a serious problem [4]. Primary care practitioners are responsible for 80% of all antibiotics prescriptions, about half for RTI [5]. Despite evidence of limited or marginal effectiveness [6] they continue to be widely prescribed, contributing to increasing bacterial resistance to antibiotics [7], a problem now at the top of the public health agenda [8]. However, a recent systematic review of consultation interactions suggests that such misunderstandings are under-studied and parents' perceptions are seldom considered [9].

Communication in pediatric consultations can be complex due to the triadic interaction [10]. Parents commonly speak for their child and the needs and anxieties of the parent can take priority [11,12]. Parents can find it difficult to understand acute illness in their child and feel disempowered by inadequate information sharing by doctors [13]. In particular, parents report receiving insufficient information and being left with uncertainty after consultations for RTI [14].

Effective communication in medical consultations is associated with greater patient satisfaction [15] and improved health outcomes [16]. Communication skills training has been shown to reduce antibiotic prescribing significantly for RTI in adults [17,18] and the use of an interactive booklet to aid communication was shown to reduce antibiotic prescribing for children with RTIs without reducing parent satisfaction [19]. However, a recent review found that patients' views on doctor–patient communication in primary care are relatively under researched [20]. Studies have found that pediatricians use only a limited range of communication techniques in consultations [21] and that

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communication varies considerably between clinicians [21] and between consultations for different types of medical problems [22,23]. A recent study focused on parents' acceptance of antibiotic prescribing decisions for children with RTI and found that trust, open communication and continuity of care played a key role [24]. The study reported here aimed to improve our understanding of parents' experiences and views of clinician communication at all stages of the primary care consultation for a child with a RTI.

2. Methods

Semi-structured interviews were conducted with parents who had recently consulted primary care because their child had an RTI. Six GP practices were purposively selected to obtain practices with populations from a range of socio-economic situations (SES) and from both rural and urban areas. Practices were assigned to 1 of 5 SES categories using the practice level indices of multiple deprivation (IMD) scores [25] so that practices with an IMD score which put them in the most deprived quintile were in category 1 and practices in the most affluent quintile were in category 5. Two practices were recruited from SES category 1 and one practice each from the other categories. Eligible parents for the interviews were identified through a search of patient records for recent child consultations for RTI. Letters were sent out to 60 parents from each practice. Where more than 60 eligible children were identified, an additional search was conducted to find the number of consultations for that child in the past year and 30 of the most frequent consulters and 30 of the least frequent consulters were selected. The SES of participating parents was categorized using the IMD score for their home postcode to assign each to the corresponding SES category. Parents from the lowest SES category were under-represented in the sample recruited through practices and to increase the socio-economic diversity of participants additional parents were recruited through local parent groups.

Interviews were conducted with 30 parents between February and August 2011; the majority took place at the participant's home, with others in non-clinical settings. All participants provided written informed consent. Interviews were conducted by one researcher (CC) and lasted between 30 and 90 min. The interview topic guides (Box 1) were used to explore parents' views and experiences and revised in light of emerging findings. This study was approved by the NHS Ethics Committee South West 4 (ref. 10/H0102/55).

Data collection and analysis were conducted in parallel and interviews continued until data saturation was reached and no new themes were arising from the data [26]. Interviews were audio-recorded, fully transcribed, anonymized, checked for accuracy and then imported into the software package NVivo8. Thematic analysis, following the process described by Braun and Clarke [27] was used to scrutinize the data to identify and analyze patterns across the dataset. First the transcripts were read and interesting features of the data coded systematically across all the transcripts in NVivo8 by CC. A subset of 3 transcripts was independently analyzed by JH to contribute to the generation and refinement of codes and thematic categories to maximize rigor. Discrepancies were discussed within the research team (CC, JH & JI) and a consensus process was used to agree the final conceptual codes.

Box 1. Interview topic guide

Consultation experience

What was your experience of consulting your GP for your child(s) cough or chest infection?
- positive/negative features

What prompted you to consult your GP?
What were you expecting from the consultation?
- Were these expectations met?

Have you had other consultation experiences over the past 12 months for your child(s) having a cough or chest infection?
- How were they?

Information

Did your GP/nurse given you advice or information regarding your child's cough or chest infection?
- If so what?

What do you think about that advice?
- Did you act on that advice?
- Do you think it is important?

Would you like more or different advice?
- If yes, why? what? from whom? (GP/nurse/media) in what format?
- If no, why not?

3. Results

3.1. Sample description

Twenty-one mothers and two fathers were recruited through practices and seven mothers through parent groups and included a range of parents in terms of SES, education levels, age of parent, and number and age of children (Table 1). Most parents were of white British ethnicity. Consulting rates ranged from 1 to 24 per year (for the youngest child).

Four major themes were generated from the data. The first related to the role of communication in parents' perception of whether or not a credible medical evaluation had taken place; the other three to specific elements of communication during the consultation: diagnosis, treatment and safety-netting. There was a high level of agreement across parents' accounts, despite their diverse backgrounds, as illustrated by the quotes which are drawn from parents with a range of SES. Differences in experiences between parents of different backgrounds are described within the major themes below.

In the transcript extracts provided, '. . .' is used to denote a pause, '[. . .]' indicates that words from the original quote have been omitted (digressions or unclear speech), and a word in square brackets (e.g. '[he]') indicates words have been replaced to preserve anonymity.

3.2. "He didn't even listen": parents' views of the credibility of the medical evaluation

A predominant theme from all parent interviews was the parents' judgment regarding the credibility of the medical evaluation within consultations being dependent on the nature of the communication. If a parent felt the clinician was uninterested or dismissive, the diagnosis and treatment advice was less credible, compared to when they felt the clinician had taken them, and their child's condition, seriously and performed a thorough medical evaluation, even when the diagnosis and treatment advice were similar. Parents also reported they were more likely to re-consult (repeat consultation for the same illness episode) when they felt a credible medical evaluation had not taken place, both when they had received a 'viral' diagnosis and when they had received an antibiotic prescription.

> *"He spent quite a long time with her, kind of looking at her [. . .] that was the second time I'd been to the doctor's, and the first time I think I felt like I hadn't really been, you know, thoroughly . . . she hadn't been thoroughly checked over."* (Mother #21, 35 yrs, SES 4, 1 child: 1 yr)