



“It's safer to ...” parent consulting and clinician antibiotic prescribing decisions for children with respiratory tract infections: An analysis across four qualitative studies



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ARTICLE INFO

Article history:

Available online 16 May 2015

Keywords:

United Kingdom
Child health
Primary care
Consulting
Prescribing
Antibiotics
Health behaviours
Social norms

ABSTRACT

This paper reports a cross-study analysis of four studies, aiming to understand the drivers of parental consulting and clinician prescribing behaviour when children under 12 years consult primary care with acute respiratory tract infections (RTI). Qualitative data were obtained from three primary studies and one systematic review. Purposeful samples were obtained for (i) a focus group study of parents' information needs and help seeking; (ii) an interview study of parents' experiences of primary health care (60 parents in total); and (iii) an interview study of clinicians' experiences of RTI consultations for children (28 clinicians). The systematic review synthesised parent and clinician views of prescribing for children with acute illness. Reoccurring themes and common patterns across the whole data set were noted. Through an iterative approach involving re-examination of the primary data, translation of common themes across all the studies and re-organisation of these themes into conceptual groups, four overarching themes were identified. These were: the perceived vulnerability of children; seeking safety in the face of uncertainty; seeking safety from social disapproval; and experience and perception of safety. The social construction of children as vulnerable and normative beliefs about the roles of parents and clinicians were reflected in parents' and clinicians' beliefs and decision making when a child had an RTI. Consulting and prescribing antibiotics were both perceived as the safer course of action. Therefore perception of a threat or uncertainty about that threat tended to lead to parental consulting and clinician antibiotic prescribing. Clinician and parent experience could influence the perception of safety in either direction, depending on whether previous action had resulted in perceived increases or decreases in safety. Future interventions aimed at reducing unnecessary consulting or antibiotic prescribing need to consider how to make the desired action fit with social norms and feel safer for parents and clinicians. Crown Copyright © 2015 Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

1. Introduction

Acute respiratory tract infections (RTI) are common in children and the main cause of primary health care service use by parents in the UK (Hay et al., 2005). Although mainly self-limiting, they are a significant cause of concern for parents because of impacts on the child and family, and concerns about serious illness (Cornford et al., 1993; Kai, 1996a,b). Parents' decision to consult is influenced by perceived threat severity (Wyke et al., 1990; Cornford et al., 1993;

Kai, 1996a; Neill, 2000; Ingram et al., 2013), the perceived benefits of consulting, and an expectation of assessment, information, advice or treatment (Kai, 1996a; Neill, 2000; Ingram et al., 2013). Parents are uncertain how to assess illness severity (Kai, 1996a; Francis et al., 2008; Neill, 2010; Ingram et al., 2013) and when to consult (Neill and Carter, 2012; Ingram et al., 2013).

Inappropriate prescribing of antibiotics is now at the top of the public health agenda (Davies, 2013) and a serious problem in the paediatric population (Finkelstein et al., 2000). Primary Care practitioners are responsible for 80% of all antibiotic prescriptions in the UK, about half of which are for RTI (SMAC, 1998). Despite evidence of limited or marginal effectiveness (Butler et al., 2009) antibiotics continue to be widely prescribed, leading to bacterial resistance to antibiotics (Costelloe et al., 2010). One of the strongest

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predictors of antibiotic prescribing is perceived clinical need (Little et al., 2004; Fischer et al., 2005), but antibiotic prescribing is also influenced by patient/parent pressure for antibiotics as perceived by clinicians (Mangione-Smith et al., 1999; Little et al., 2004), perceived need (or lack of need) to reduce prescription of antibiotics (Tonkin-Crine et al., 2011a), clinical uncertainty (Tonkin-Crine et al., 2011a; Whaley et al., 2013), and the desire to maintain a good relationship with the patient (or parent) (Petursson, 2005; Tonkin-Crine et al., 2011a).

This paper draws on the results of qualitative research conducted as part of the NIHR funded ‘TARGET’ programme for applied research, which was designed to understand and improve the clinical response to children presenting to primary care with RTIs (Redmond et al., 2013). It explores some of the drivers for parental consulting and clinician antibiotic prescribing for children with RTIs.

2. Theoretical background

There are multiple models for understanding health behaviour, but no clear basis for selecting one over another (Michie et al., 2005). Comparisons reveal considerable commonality between the theoretical constructs of different theories (Michie et al., 2005) and similar predictive power (Redding et al., 2000). Previous studies investigating drivers of consulting and prescribing have tended to focus on individual parent beliefs about the health threat (Wyke et al., 1990; Cornford et al., 1993; Kai, 1996b), consultation benefits (Kai, 1996a; Neill, 2010) or clinician beliefs about clinical or social need for antibiotics (Little et al., 2004; Tonkin-Crine et al., 2011a). However, very little research into consulting and prescribing for acute childhood illness has explicitly used theoretical models or constructs to interpret observations. This paper seeks to address this gap in the literature, linking the abstract concepts (e.g. social norms) to the concrete experiences and beliefs (e.g. children’s vulnerability).

2.1. Parental consulting and the health belief model

In previous work (Ingram et al., 2013) we found that the Health Belief Model (Rosenstock et al., 1994) was useful for understanding the parent beliefs which influenced their decision to consult. In particular, the constructs of perceived severity of the illness, perceived susceptibility to the illness, self-efficacy in relation to home management of the illness, perceived benefits of consulting, and cues to action (i.e. to consult) (Rosenstock, 1974; Rosenstock et al., 1988; Bandura, 1998). Parents place a lot of emphasis on perceived severity in accounts of their consulting decisions (Wyke et al., 1990; Cornford et al., 1993; Kai, 1996b; Neill, 2000; Ingram et al., 2013) and some children (younger or with underlying health problems) are identified as more susceptible (Ingram et al., 2013). Parental self-efficacy (their perceived confidence in managing an acute illness at home) tended to decrease as perceived severity increased (Kai, 1996b; Ingram et al., 2013) but was increased by experience of self-limiting acute illness (Ingram et al., 2013). The primary perceived benefit of consulting was access to a professional medical evaluation that (parents believe) will identify and remove any health threat through appropriate treatment (Ingram et al., 2013; Cabral et al., 2014). Cues to action (in this case to consult) could include particular symptoms (e.g. fever), sanctioning or pressure from a social network or advice from official sources (e.g. NHS direct) (Wyke et al., 1990; Cornford et al., 1993; Ingram et al., 2013).

2.2. Parental consulting, normative beliefs and subjective norms

Just as social constructions of gender roles influence health behaviours (Courtenay, 2000; Verdonk et al., 2010), the social

construction of childhood and parenting may influence parent health behaviours when caring for their children. Children are viewed as an inherently vulnerable group (Frankenberg et al., 2000) and the authority to define, manage and monitor health risk is increasingly seen as the responsibility of professional medical-scientific authorities (Faircloth, 2010; Knaak, 2010), thus placing parents in a more powerless role (Macvarish, 2010). Parents who do not adhere to ‘best’ parenting practices are represented as a risk to their children (Faircloth, 2010; Lee et al., 2010). Thus parents making decisions about their child’s health take into account not only the health risks to their child but also the risk of appearing to others to be a bad parent (Casiday, 2007). It’s likely that normative beliefs do influence parent help seeking behaviour when their child is unwell but as yet this is little understood.

2.3. Clinician prescribing and normative beliefs and subjective norms

The social construction of children as vulnerable may also influence clinicians’ subjective norms when making decisions about whether or not to prescribe antibiotics for an acutely unwell child. The Theory of Planned Behaviour has been used to predict clinician prescribing behaviour for acutely unwell adults (Walker et al., 2001; Hrisos et al., 2008; Eccles et al., 2012; Yardley et al., 2013) but little attention has been given to what influences the normative beliefs that engender the relevant subjective norms. In hospital settings, clinician prescribing adheres to perceived prescribing norms, which are oriented towards immediate risk reduction and deference to the medical hierarchy within that setting (Lewis and Tully, 2009; Broom et al., 2014). Similarly in a primary care setting, GPs place great weight on professional norms and value interventions which give them insight into the antibiotic prescribing behaviour of their peers (Tonkin-Crine et al., 2011b). When dealing with a group which is perceived to be vulnerable, clinicians may feel extra pressure to prescribe antibiotics, but there has been little work looking at how normative beliefs in relation to specific groups may influence prescribing behaviour.

In this paper we present new evidence of how the social construction of children as vulnerable influences consulting and prescribing decisions for children.

3. Study methods

Analysis of qualitative data from three primary studies and one systematic review conducted for the ‘TARGET’ Programme are presented. These were originally conceived as linked but independent pieces of research to inform the development of an intervention. However, as analyses progressed, patterns were observed suggesting unifying themes. The process was facilitated by the fact that the studies were conducted in parallel with overlapping research teams: with CC and JH working on both primary studies and the systematic review. An integrated analysis, drawing on the whole programme qualitative data, was developed in parallel to individual analyses. This study was approved by the NHS Ethics Committee South West 4 (ref. 10/H0102/55). All participants gave informed consent to their participation in this research and to reporting of anonymised quotes in publications.

The methods and sample characteristics of the sixty parents contributing to individual studies have been published elsewhere (Horwood et al., 2012; Ingram et al., 2013; Cabral et al., 2014; Lucas et al., 2015). Three primary studies were conducted in an urban and rural area in South-west England during 2010 and 2011. The focus groups took place in private rooms in community locations where parents already met, most interviews took place in participants’

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