



## Wasting the doctor's time? A video-elicitation interview study with patients in primary care



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### ABSTRACT

Reaching a decision about whether and when to visit the doctor can be a difficult process for the patient. An early visit may cause the doctor to wonder why the patient chose to consult when the disease was self-limiting and symptoms would have settled without medical input. A late visit may cause the doctor to express dismay that the patient waited so long before consulting. In the UK primary care context of constrained resources and government calls for cautious healthcare spending, there is all the more pressure on both doctor and patient to meet only when necessary. A tendency on the part of health professionals to judge patients' decisions to consult as appropriate or not is already described. What is less well explored is the patient's experience of such judgment. Drawing on data from 52 video-elicitation interviews conducted in the English primary care setting, the present paper examines how patients seek to legitimise their decision to consult, and their struggles in doing so. The concern over wasting the doctor's time is expressed repeatedly through patients' narratives. Referring to the sociological literature, the history of 'trivia' in defining the role of general practice is discussed, and current public discourses seeking to assist the patient in developing appropriate consulting behaviour are considered and problematised. Whilst the patient is expected to have sufficient insight to inform timely consulting behaviour, it becomes clear that any attempt on the part of doctor or patient to define legitimate help-seeking is in fact elusive. Despite this, a significant moral dimension to what is deemed appropriate consulting by doctors and patients remains. The notion of candidacy is suggested as a suitable framework and way forward for encompassing these struggles to negotiate eligibility for medical time.

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### 1. Introduction

The timing of the first consultation between the primary care doctor and the patient marks the beginning of the patient's journey through the healthcare system, and determines if and when a diagnosis occurs, and whether treatments or referrals ensue (Morgan, 2003). If patients present early in the natural course of the disease, symptoms may be vague and mild, and the recommendation offered to the patient is often to watch and wait. If the illness is thought to be self-limiting, the recommendation is patience, with advice on self-care. If symptoms are established and clinical signs

elicited by the doctor, medical action might be taken in the form of medication, investigation or referral. Finally, if the symptoms have a long history or are interpreted by the doctor as suggesting underlying serious disease, a fast-track referral may be made. In the context of UK primary care, general practitioners (GPs) hold a gatekeeping role to triage and select those few patients who require further investigation and referral, amongst a majority for whom it is appropriate to offer advice, reassurance, watchful waiting or treat in primary care. This gatekeeping role is key to ensuring overall efficiency of the system and avoiding unnecessary medical interventions (Starfield et al., 2005).

Rationing is an inherent component of the British healthcare service (Mechanic, 1995), and general practitioners in particular are aware of the financial constraints within which they must operate (Jones et al., 2004). Increasing demand resulting from shifting demographics and advancing technology contributes to added

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pressure on the health service to control cost.

Central to this pressure for efficiency is ensuring that time is optimally used (Williams, 1998). With time experienced as a scarce commodity requiring thoughtful allocation (Horobin and McIntosh, 1983), patients with unexplained or self-limiting symptoms are at risk of being viewed by healthcare providers as drawing resources away from those patients more in need. Consultations for what were labelled 'trivial conditions' were already reported in 1964 as the greatest source of frustration in a UK-wide survey of GPs (Cartwright, 1967). More recent evidence suggests this frustration persists (Morris et al., 2001; Majid, 2015). Faced with this frustration, doctors may intuitively assign moral value to patients' reasons for help-seeking. Moral labelling, according to the sociologist Phil Strong, does not typically occur publicly: "A fundamental premise of normal doctor patient interaction is that, at least overtly, the patient is assumed to possess considerable moral character and competence" (Strong, 1979a). In his study of paediatric clinics, Strong describes a bureaucratic form where a semblance of moral neutrality dominates the clinic, and the patient (or in this case the parent) is idealised (Strong, 1979b). However, alongside this polite format, he observes what he calls a 'charitable' form in which moral judgments of parents are cast readily by doctors. Such judgments have been documented in the emergency department (Hillman, 2014; Jeffery, 1979; Roth, 1972) and in general practice (Charles-Jones et al., 2003; May et al., 2004). This moral labelling of patients by doctors takes many forms. It may relate to the patient's social deservedness (whether the patient is deemed responsible for the ailments), to the legitimacy of the patient's symptoms (whether the symptoms are deemed by the doctor to be organic or imagined) (Roth, 1972), or to a moral judgment on the appropriateness of health service use (Jeffery, 1979). It is the moral dimension of help-seeking which we focus on here. Most researchers report the phenomenon based on interviews with doctors (Charles-Jones et al., 2003; May et al., 2004), and on observations of consultations (Roth, 1972; Jeffery, 1979; Strong, 1979b).

If the prevailing moral labelling is sufficiently overt to be perceived by researchers, to what extent is it apparent to patients? How does this judgment influence patients' decisions to consult? Although it is said that, for a long while, patients were sheltered from the economic dimension of healthcare provision, pressures on resources have gradually become more explicit (Hughes and Griffiths, 1997; Russell et al., 2011). Public campaigns ask patients to refrain from using services unnecessarily (Choose well this winter, 2013). So how do patients experience this pressure to 'choose well'? Worries about wasting the doctor's time are frequently touched on in studies examining barriers to help-seeking, in particular amongst parents consulting with children (Cabral et al., 2015; Usher-Smith et al., 2015), and amongst patients with possible symptoms of cancer (Walter et al., 2014; Low et al., 2015). Only very recently has it become a subject of study in its own right (Cromme et al., 2016).

This paper devotes itself to investigating the patient's account of negotiating service use, and in particular the voiced notion of 'wasting the doctor's time' in UK general practice. The subject arose from interviews conducted with patients exploring their experience of a recent primary care consultation. The 'wasting doctors' time' theme lay beyond the primary aims of the original research and was not purposely explored during the interviews. However it arose sufficiently forcefully during data collection and preliminary analyses of early interviews to afford study in its own right. The purpose here is to investigate this moral component voiced in patients' accounts of help-seeking, situating it within the current social and political climate. Owing to the surface moral neutrality of medicine which Strong describes, the moral dimension of help-seeking has been broadly overlooked in biomedicine, and it

remains absent from many psychological models. We suggest that the theoretical notion of candidacy can be applied in conceptualising the moral component of help-seeking. Candidacy is a staged model of healthcare access which traces the patient journey from first noticing a need to consult, to the concluding encounters between patient and health service (Dixon-Woods et al., 2006). In recognising the adjudication by health professionals to which patients are exposed, and emphasising the process of negotiating entitlement to care, candidacy acknowledges the patient's worry about timewasting, and offers a framework accessible across disciplinary boundaries. It thus provides opportunity for insight into important components of the consultation which should be of interest to social scientists and clinicians alike. Accordingly, we aim to give attention to the concerns among patients about wasting doctors' time, and understand the contributing factors to such concerns. Studying these concerns is a crucial aspect of the endeavour to overcome barriers to healthcare.

## 2. Methods

### 2.1. Sampling and recruitment

This study is part of a wider programme of research investigating the role of patient experience surveys in primary care. The data presented are derived from video-elicitation interviews which were conducted with the aim of exploring patients' experiences of a recent consultation in primary care, with a particular focus on how these experiences related to their completion of a questionnaire on doctors' communication skills.

GP practices were sampled purposively to reflect a spread of practice characteristics, including size and geographical location, and a mix of ethnicity and deprivation levels. Sampling also took account of practice-level scoring on the doctor-patient communication items of the national GP Patient Survey. Patient experience scores in the national survey are typically high. To optimise access to a wider range of communication scores in line with the primary aims of the research programme (Roland et al., *In Press*) we intentionally only included practices scoring in the bottom 25% nationally. Following consent from doctors and patients, consultations were video-recorded. Immediately after the consultation, patients filled out a short survey (box 1) on their experience of the doctor's communication skills. Patients who expressed interest in taking part in an interview were subsequently contacted by a researcher by telephone or email. Patients were selected for invitation to interview according to a maximum variation sampling approach, to reflect a mix of patient characteristics and patient experience scores reported following the consultation.

### 2.2. Interview procedure

Interviews took place between August 2012 and July 2014, within four weeks of the consultation with the GP. 44 interviews were conducted in the participant's home, six at the GP surgery, one on university premises, and one at the participant's place of work. Interviews were semi-structured and focussed on the patient's recently recorded consultation with their GP. The interview was conducted using video-elicitation methods (Henry and Fetters, 2012). The technique involves playing the video of the patient's consultation with their GP during the interview (box 2). The video becomes a central feature in guiding the interview, and points of discussion arise whilst watching the interactions between doctor and patient. Participants are encouraged to pause the recording when the viewing triggers a thought or comment. The aim is to facilitate recall of the consultation and reflection on events, through re-living of the consultation (Henry and Fetters, 2012). In

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