



Patient Decision Making

A qualitative study of patient choices in using emergency health care for long-term conditions: The importance of candidacy and recursivity[☆]



Cheryl Hunter^{a,*}, Carolyn Chew-Graham^{b,d,1}, Susanne Langer^{c,2}, Alexandra Stenhoff^{c,3},
Jessica Drinkwater^d, Elspeth Guthrie^{e,4}, Peter Salmon^{f,5}

^a Nuffield Department of Population Health, University of Oxford, Oxford, UK

^b Research Institute, Primary Care and Health Sciences, Keele University, Keele, UK

^c Department of Mental and Behavioural Health Sciences, University of Liverpool, Liverpool, UK

^d Centre for Primary Care, Institute of Population Health, University of Manchester, Manchester, UK

^e Manchester Royal Infirmary, Manchester, UK

^f Division of Clinical Psychology, University of Liverpool, Liverpool, UK

ARTICLE INFO

Article history:

Received 14 January 2013

Received in revised form 27 May 2013

Accepted 7 June 2013

Keywords:

Healthcare utilisation
Primary health care
Patient experiences
Qualitative research
Longterm conditions
Unscheduled care
Emergency healthcare
Chronic obstructive pulmonary disease
Asthma
Diabetes
Coronary heart disease
Theory
Candidacy
Recursivity
Patient decision-making

ABSTRACT

Objective: We aimed to explore how patients with long-term conditions choose between available healthcare options during a health crisis.

Methods: Patients in North-West England with one or more of four long-term conditions were invited to take part in a questionnaire cohort study of healthcare use. Semi-structured interviews were conducted with a sub-sample of fifty consenting patients. Data were analysed qualitatively, using a framework approach.

Results: Patients described using emergency care only in response to perceived urgent need. Their judgements about urgency of need, and their choices about what services to use were guided by previous experiences of care, particularly how accessible services were and the perceived expertise of practitioners.

Conclusion: Recursivity and candidacy provide a framework for understanding patient decision-making around emergency care use. Patients were knowledgeable and discriminating users of services, drawing on experiential knowledge of healthcare to choose between services. Their sense of 'candidacy' for specific emergency care services, was recursively shaped by previous experiences.

Practice implications: Strategies that emphasise the need to educate patients about healthcare services use alone are unlikely to change care-seeking behaviour. Practitioners need to modify care experiences that recursively shape patients' judgements of candidacy and their perceptions of accessible expertise in alternative services.

© 2013 The Authors. Published by Elsevier Ireland Ltd. All rights reserved.

[☆] This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike License, which permits non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

* Corresponding author at: Health Services Research Unit, Nuffield Department of Population Health, Rosemary Rue Building, University of Oxford, Oxford, OX3 7LF, UK. Tel.: +44 01865 289393.

E-mail addresses: cheryl.hunter@dph.ox.ac.uk (C. Hunter), c.a.chew-graham@keele.ac.uk (C. Chew-Graham), s.langer@liv.ac.uk (S. Langer), Alexandra.Stenhoff@liverpool.ac.uk (A. Stenhoff), jdrinkwater@doctors.org.uk (J. Drinkwater), Elspeth.a.guthrie@manchester.ac.uk (E. Guthrie), psalmon@liv.ac.uk (P. Salmon).

¹ Tel.: +44 0178 273 3922; fax: +44 0178 273 3911.

² Tel.: +44 0151 794 4034; fax: +44 0151 794 5537.

³ Tel.: +44 0161 276 5326; fax: +44 0161 273 2135.

⁴ Tel.: +44 0161 276 5391/5331; fax: +44 0161 273 2135.

⁵ Tel.: +44 0151 794 5531; fax: +44 0151 794 5537.

1. Introduction

Health services in developed countries provide a range of options for healthcare in response to perceived urgent need [1,2]. Alongside a proliferation of care choices, health policy in many countries seeks to constrain and shape patients' care decisions in order to ensure that the service accessed reflects the level of medical need. Specifically, policies seek to reduce use of hospital emergency department care, mainly because of its high cost compared to alternative healthcare options [2–5].

Patients with long-term conditions (LTCs) are particularly frequent users of health care, and account for a large proportion of emergency care (EC) use [6–8]. In the UK and USA, policies have explicitly targeted people with LTCs in the attempt to constrain use of EC [2,8]. In addition to services available for acute illness, many patients with LTCs now have access to

additional types of practitioner, including specialist healthcare practitioners based in primary care or hospital clinics [9,10]. On the assumption that patients lack the knowledge to choose between services [11], or to manage their health needs effectively within the community [12], health policies emphasise shaping patient use of EC through education to address this purported knowledge gap [7].

Health policy thereby implicitly adopts a 'deficit' model of patients, as it asserts that patients require education in order to make effective choices, but this assumption has not been based on clear evidence about how patients with LTCs choose from available healthcare options in response to a health crisis. A recent review of qualitative studies of healthcare use in patients with LTCs found that patients' use of EC was influenced by their previous experiences of healthcare services, and reflected the values patients attributed to the different services [13]. For socially or economically marginalised patients, EC in particular offered access to care that might otherwise be unavailable to them [13]. This review suggests that, by focusing on patient education, policy may oversimplify how patients choose between healthcare services. However, a limitation of this review was that few papers addressed EC use directly. Moreover, none asked about instances where patients chose to avoid EC. In the present study, we aimed to elaborate on the processes by which patients with LTCs choose between available options for care in response to a health crisis, to inform the development of future policy and guidance on modifying EC use. Crucially, we explored, with patients, instances of EC use and instances of avoiding EC use.

2. Methods

The study was approved by NHS Research Ethics Committee 09/H1013/81.

2.1. Health system context

This study was based in North-West England. The UK National Health Service (NHS) is a public healthcare system that is free at the point of delivery to all patients [14]. Each patient has the right to choose a primary care practice and to express a preference to see a named general practitioner, and primary care is seen as the main healthcare provider for patients, with a key role in referring patients to other services [2]. However, patients can also access alternate healthcare services, such as emergency departments (EDs), out-of-hours primary care providers, and walk-in centres, without incurring financial cost.

2.2. Sampling and recruitment

The target population was patients, aged over 18, with one or more of four LTCs: chronic obstructive pulmonary disease (COPD); coronary heart disease (CHD); asthma; and diabetes. Patients were identified from Quality and Outcomes Framework (QOF) registers of general practices and invited to take part in the CHOICE cohort study (Choosing Health Options in Chronic Care Emergencies, <http://choice.mhsc.nhs.uk/home.aspx>). The QOF remunerates practices for providing evidence-based care in line with a series of clinical indicators [14]. Of 939 patients at six general practices within the cohort study, 474 (50%) consented to be contacted further. Out of those, we purposively sampled 212 people to invite for interview, aiming to achieve variation in age, gender, type and number of LTCs, and different levels of self-reported use of routine primary care and EC. Out of this purposive sample, 67 agreed to be interviewed, and a final sample of 50 people participated in semi-structured interviews.

2.3. Data collection and analysis

Semi-structured interviews (conducted by CH and SL) in participants' homes (30–90 min duration, mean 46 min) began with discussion of the participant's health and social circumstances, then explored attitudes to, and expectations and specific experiences of, EC, primary care, and other healthcare and community services. During interviews, patients were guided to reflect on specific instances of using EC, the circumstances surrounding these and the factors which influenced these decisions. In addition, respondents were also asked to reflect on times when they did not use EC, and on what influenced decisions not to use EC services. Interviews were audio-recorded with the participant's consent, anonymised and transcribed verbatim.

Analysis used the framework approach [15]. Analysis was an inductive and iterative process, developing through discussions within a multidisciplinary team (with backgrounds in primary care, psychology, social anthropology, and psychiatry). We compared instances of using EC with instances when EC was not used, both across and within cases. A thematic framework was developed and honed through constant comparison of data between and within cases. Each transcript was coded in-depth in QSR NVivo8, using this process to refine and test the thematic framework across the entire data-set. Data collection continued until theoretical saturation was reached, determined through periodic discussion within the research team whose members also read the transcripts [16].

3. Results

3.1. Sample characteristics

Fifty patients took part in a semi-structured interview. All patients were registered with a general practitioner, and most were White British ($n = 42$); 34 were retired or unable to work due to ill-health. Asthma was the most common condition ($n = 10$), followed by diabetes ($n = 9$), but almost half ($n = 24$) reported more than one of the four LTCs of interest. Most patients reported other co-morbidities, such as arthritis ($n = 28$) and high blood pressure ($n = 28$). Age ranged from 39 to 86 years (mean 63.6). Thirty-six patients had used EC in the past year. Table 1 summarises participants' socio-demographic characteristics, as well as information on use of EC during the year.

3.2. Findings

Patients described a variety of symptoms prompting them to consider using EC, particularly breathlessness, pain, dizziness, and unusual sensations. They described the use of EC as unavoidable because of the inherent urgency of their need. However, analysis showed that the judgement that need was urgent, and choice of EC provider, were influenced by previous experiences of care. We present illustrative data to characterise these findings, below. The ellipsis in parentheses (...) signifies omitted text. Square brackets denote explanatory text.

3.2.1. Patients framed instances of EC as unavoidable

When patients were asked about EC services, they consistently described reluctance to use them. This reluctance was expressed as a desire not to feel like a "burden" on services:

I'd prefer not to be a nuisance, you know, and I'll phone them [hospital staff] up and take advice, but I'd sooner not go round and bother people (P23, female, 53 yrs, asthma)

Download English Version:

<https://daneshyari.com/en/article/6152306>

Download Persian Version:

<https://daneshyari.com/article/6152306>

[Daneshyari.com](https://daneshyari.com)