



Following the patient's orders? Recommending vs. offering choice in neurology outpatient consultations



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ABSTRACT

The UK's Royal College of Surgeons (2016) has argued that health professionals must replace a 'paternalistic' approach to consent with 'informed choice'. We engage with these guidelines through analysis of neurology consultations in two UK-based neuroscience centres, where informed choice has been advocated for over a decade. Based on 223 recorded consultations and related questionnaire data (collected in 2012), we used conversation analysis (CA) to identify two practices for offering choice: patient view elicitors (PVEs) and option-lists. This paper reports further, mixed-methods analyses, combining CA with statistical techniques to compare the 'choice' practices with recommendations. Recommendations were overwhelmingly more common. There was little evidence that patient demographics determined whether choice was offered. Instead, decisional practices were associated with a range of clinical considerations. There was also evidence that individual neurologists tended to have a 'style', making it partly a matter of chance which decisional practice(s) patients encountered. This variability matters for the *perception* of choice: neurologists and patients were more likely to agree a choice had been offered if a PVE or option-list was used. It also matters for the outcome of the decision-making process: while recommendations nearly always ended in agreement to undertake the proffered course of action, option-lists and PVEs did so only about two-thirds of the time. While the direction of causality is unknown, this may indicate that patients are better enabled to refuse things they don't want when neurologists avoid recommending. We argue that our findings imply that neurologists tend to view choice as risky – in that the patient might make the 'wrong' choice – but that the inter-individual variation indicates that greater use of the more participatory practices is possible.

1. Introduction

Widely-publicized Royal College of Surgeons' (RCS, 2016) guidelines on consent specify that the aim "is to give the patient the information they need to make a decision about what treatment or procedure (if any) they want" (p. 4). The guidelines are responsive to the 2015 Supreme Court case of *Montgomery vs. Lanarkshire Health Board* in which a woman was awarded damages because her obstetrician had not fully explained the risk of vaginal birth in her circumstances (small pelvis, large baby). Her baby – starved of oxygen for 12 minutes – was born with cerebral palsy. This case, according to the RCS, marks a radical shift in how the consent process is conceptualized:

From one in which the surgeon would explain the procedure to the patient and obtain their consent to proceed, to one in which the surgeon sets out the treatment options and allows the patient to

decide (p. 15).

While recognizing that the UK's General Medical Council has "consistently supported patient autonomy", the RCS argues that "established clinical practice – and a large body of case law – [has typically] followed a more paternalistic approach" (p. 3). The *Montgomery* case thus necessitates "a change in attitude from surgeons in discussions about consent" (p. 3). Moreover, the RCS guidance is offered to "other healthcare professionals" (p. 4), implying that similar changes may be needed in other specialties.

In this paper, we engage with these guidelines through our investigation of decision-making in neurology – a specialty where the RCS guidance should already be embedded, given that The National Service Framework (NSF) for long-term conditions (Department of Health, 2005), in place for over a decade, specifies that patients should "receive appropriate information before starting medication to enable informed

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choice” (p. 27). Although the NSF allows for more leeway than the RCS guidelines – acknowledging that “not everyone with a long term neurological condition will want to participate actively in their own care” (p. 21) – the documents share an emphasis on providing information about treatment *options*. Neurology offers an excellent site, therefore, for investigating how (and to what extent) health professionals are already acting in accordance with the consent process proposed by the RCS.

Our wider project – funded by the UK’s National Institute for Health Research – sought to explicate interactional practices used by neurologists to initiate decision-making with patients. Here, we compare three such practices: recommending, option-listing and patient view elicitors (PVEs). We argue that, relative to recommending, the latter two invite patients to take a more active role in decision-making, and align more with the RCS guidelines. It is striking, therefore, that recommendations were overwhelmingly more common, even in neurology.

2. What we already know about real-time decision-making in the clinic

Our project builds on previous research on real-time decision-making in the clinic. Much of this has focused on the treatment recommendation. Although recommendations may be designed in various ways, it is well-established that clinicians and patients understand recommendations to be proposals: they are subject to the patient’s acceptance, and may be resisted (Costello and Roberts, 2001; Koenig, 2011; Stivers, 2005). Nevertheless, there is evidence showing how clinicians may persuade patients to accept the course of action they think is best (Quirk et al., 2012). Hudak et al. (2011) show how surgeons may build their recommendations to try to ward off resistance. Stivers (2005) found that parents were less likely to resist a non-antibiotic treatment recommendation for their child if this was framed as a positive recommendation (for a specific alternative), rather than as a recommendation against antibiotics. Opel et al. (2013) showed that significantly fewer parents resisted vaccine recommendations for their children when the provider used a “presumptive initiation format” (i.e. containing a linguistic presupposition of vaccination) as opposed to a “participatory” one (i.e. providing parents with more decisional latitude). This distinction maps closely onto the focus of our paper.

Collins et al. (2005) drew a related distinction, demonstrating a continuum of approaches to decision-making, ranging from ‘unilateral’ (or clinician-determined) to ‘bilateral’ (or shared). Illustrating the ‘bilateral’ approach, they showed how clinicians sometimes replace the treatment recommendation with efforts to include patients actively by, for example, “signposting options in advance of naming them; eliciting displays of understanding and statements of preference from the patient” (p. 2625).

Extending this research, our primary study used conversation analysis (CA) to identify two key practices whereby clinicians might invite patients to contribute, actively, to decision-making about treatment, investigation or referral options. We call these ‘option-lists’ and ‘patient view elicitors’ (PVEs) (Reuber et al., 2015). In brief, option-listing – illustrated below – consists of an explicit listing of alternatives (lines 2–3, 5–6) from which the patient may choose. This includes an initial announcement that there is a decision to be made (line 1).

Example of option-listing (G018; Multiple Sclerosis)

- 01 Neu: And **there’s two ways of dealing with this. If you don’t feel that**
 02 things are absolutely back to normal... then **I can give you some**
 03 **steroid treatment** for a short while.
 04 Pat: Mm hm. ...
 05 Neu: **Alternatively I could arrange for you to be seen by one of our**
 06 **MS specialists.**
 07 Pat: Uh huh.
 08 Neu: ... see if they think that the inflammation...would benefit from some
 09 other forms of treatment

The identifiers in this paper show where the recording was made (Glasgow or Sheffield) and the recording number (numbered consecutively at each site from 001). For ease of reading we have not used Jeffersonian transcription notation here, given our primary focus on the quantitative analysis.

The term ‘patient view elicitor’ incorporates a range of turn designs, which invite the patient to express:

- A preference; e.g. *Do you want to try a new drug?* (G075)
- How they “feel” about an option; e.g. *What are your own feelings?* (G092)
- Their “thoughts” on a proposed course of action; e.g. *What do you think about drugs like interferon?* (S084)
- And other variants on this theme; e.g. *Is that bad enough that you’d want to change drugs?* (S060).

All three practices may be designed in varying ways with implications for what sort of response is relevant next. The crucial contrast, for our purposes here, is the way in which option-lists and PVEs orient to the decision as lying in the patient’s domain. Both seek the patient’s active voicing of their position with respect to the option(s), while recommendations designedly make explicit which option the neurologist thinks is best, only seeking the patient’s acceptance thereof (see Toerien et al., 2013).

The following examples, together with the option-listing example, above, illustrate this contrast by showing the same decision type (whether to take steroids) handled using each practice. We have seen steroids listed as one option among two alternatives. In the following turn, the neurologist also constructs steroid use as optional, this time using a PVE, which foregrounds the patient’s wishes:

D’you want to try some steroids? (S080)

In our final example, the neurologist, having provided some diagnostic information about the patient’s symptoms (not shown), builds on this to justify steroids as his recommended course of action, thereby foregrounding his opinion.

And that’s why **I want to** get the trial of steroids... It kind of depends on how things go, but I think five days of steroid tablets, you know, a short sharp course... should give us enough information to see whether or not we need to do anything else with it (G042).

We understand these three practices as alternative approaches to the same activity: initiating – and, for later decision-points, pursuing – a decision about some possible treatment, investigation or referral, introduced by the neurologist.

As we have argued previously, although option-lists and PVEs seldom set up an entirely open (or neutral) decision, they can be said to offer the patient more of a say in the decision-making than recommendations (Reuber et al., 2015). This is for two, interrelated reasons. First, recommendations seek acceptance of a conclusion

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