

Delivering patient choice in clinical practice: a conversation analytic study of communication practices used in neurology clinics to involve patients in decision-making

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Scientific summary

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Background

The National Health Service (NHS) is committed to offering patients more choice. Yet 'patient choice' is a contested concept, taken to mean different things, even within the NHS. For instance, the *NHS 2013/14 Choice Framework* lays out a set of legal 'rights to choose' accorded to all patients. But a broader notion of patient choice is also evident within NHS policy, which documents an ambition to transform the service from a 'paternalistic' one into a 'partnership' between doctor and patient (Department of Health. *NHS 2013/14 Choice Framework*. London: The Stationery Office; 2013). We focus on this broader conceptualisation, addressing the fact that, although clinicians are directed to increase patient involvement in decision-making, there is little detailed guidance on *how* to do so.

Objectives

In broad terms, the study addresses the following key research questions:

- What communication practices are clinicians using to give patients choice in decision-making processes?
- How do patients respond to the different practices used by clinicians?

More specifically, in answering these questions, the study aims to meet three objectives, namely:

1. to contribute to the evidence base about whether or not, and how, patient choice is implemented
2. to identify the most effective communication practices for facilitating patient choice
3. to disseminate these findings to clinicians and patients in order to help translate into practice the policy directives to increase patient choice (where appropriate).

It is worth noting that there are situations in medicine when patients are physically unable to contribute directly to decision-making processes (for instance when they are unconscious or lack competence). Our study focuses on the many other situations in which decisions about tests or treatments can reasonably be discussed between clinician and patient.

Design

This study uses conversation analysis (CA) to identify and evaluate the practices whereby neurologists offer patients choice. CA is a qualitative, microanalytic, systematic method for studying real-life interaction. It is widely recognised as the leading methodology for investigating how doctor–patient communication operates in practice. It uses audio- and video-recordings of interactions to enable direct observation and fine-grained analysis, focusing not only on what is said but *how* it is said (e.g. the exact words used and evidence of hesitation, emphasis, interruptions, laughter or misunderstanding). Its key advantages are that it does not rely on recall – which can often be incomplete or inaccurate – and it investigates how people behave at a level of detail they could not be expected to articulate (e.g. in a research interview). Our main data set consists of over 200 audio- and video-recorded consultations.

Patients also completed pre- and post-consultation questionnaires and neurologists completed the latter, which we analysed quantitatively. In addition to clinical, demographic and patient satisfaction data (using the Medical Interview Satisfaction Scale 21) this gave a measure of participants' *perceptions* of choice. On the basis of the questionnaire data we were able to compare neurologists' perceptions with those of patients, as well as the self-report data with what demonstrably occurred in the consultations.

Setting and participants

The study was conducted in neurology outpatient clinics in Glasgow and Sheffield. The eligible sample population was all neurologists (20 in Sheffield and 23 in Glasgow) at the two sites and all patients (aged ≥ 16 years) attending the participating neurologists' clinics over a 6-month period, provided they were able to give informed consent in English. Fourteen neurologists, 223 patients and 120 accompanying others took part (with a patient response rate of 66%). Neurology is an ideal setting for addressing the study aims because a person-centred service is a quality requirement for neurological practice, and two neurological conditions (epilepsy and multiple sclerosis) have been identified by the UK's Department of Health as particularly suited to shared decision-making (SDM).

More broadly, because our focus is on communication strategies that occur in real clinical practice, our findings should not be assumed to be limited to neurology. Although the *content* of a choice may be condition-specific, *practices* for making choice available in interaction with patients are not. The findings from this study should therefore be of relevance to clinicians working in a range of settings.

Key findings

From the self-report data

Patients stated that choice had been offered after 71.8%, and neurologists stated that they had offered choice after 67.9% of appointments. Patients and clinicians agreed that choice had featured after 53.6% of encounters. There was disagreement about the presence of choice after 32.1% of consultations, with either patient or neurologist stating that choice was offered when the other did not. Both parties agreed about the absence of choice after 14.3% of clinic interactions. Choice was perceived less often by patients without post-school qualifications. Choice was more commonly offered in general than specialist clinics and when clinicians were more certain of their diagnoses. However, quantitative analyses of all available clinical and demographic factors did not really explain in which consultations choice was offered or perceived. The presence of perceived choice was not associated with higher levels of patient satisfaction with the medical interview.

From the no-choice subset (n = 28)

For the purpose of our qualitative analysis, the corpus was divided into four subsets: (1) patient and clinician agree that choice was present; (2) patient and clinician agree that choice was absent; (3) patient 'yes', clinician 'no'; and (4) patient 'no', clinician 'yes'.

Seeking to link these self-report findings with what happened in the recordings, we examined the full data set for any patterns in how decision-making was conducted. We found a distinction between those cases for which neurologist and patient agreed that choice was absent as opposed to present. In the former – but not the latter – the neurologist constructed what was to happen next, not as a matter to be decided, but as a logical consequence of the diagnostic conclusions reached (thus far). We found that this no-choice subset was largely characterised by five types of logical consequence (see *Chapter 5*). In short, the key finding from the no-choice cases was that, when the main conclusion of the consultation was that nothing (or nothing new) could be done from a neurological perspective, then the neurologist and patient typically both reported that no choice was offered.

From the choice subset (n = 105)

Comparison of all four subsets of recordings (i.e. agreement there was a choice, agreement there was not, neurologist reported there was a choice but patient did not and vice versa) produced a second, striking finding: that option-listing – which we first identified in our pilot data set as a practice for giving patients choice – was present *only* (with one exception, which, as we show, proves the rule) in those consultations for which neurologist and patient *agreed that a choice had been offered to the patient*. It appears, then, to be a practice that is not only analysable as creating a slot for patient choice, but also one that neurologists and patients perceive as doing so when they reflect on their interactions. This was also the *only* practice demonstrably oriented to offering patients choice that we could identify as being unique to this subset. We therefore subjected all instances of this practice to extensive analysis using CA.

Analysis of option-listing

We show that option-listing in its full form is a multicomponent package, consisting of:

- an announcement by the neurologist that there is a decision to be made
- the formulation of a list of options
- an invitation to the patient to announce their views with respect to the options or to select an option from the list [the patient view elicitor (PVE)].

Focusing on the design of each of these components (see *Chapter 6, Component 1: constructing the decision as yet to be made, Component 2: constructing more than one option as a reasonable course of action* and *Component 3: producing a slot for the patient to announce a view on, or selection from, the listed options*), we show how they can be produced in ways that, incrementally, construct the decision as the patient's. Examining patients' responses to option-listing, we also show how each of three response types – those that *align* with the action performed by the neurologist's turn, those that *defer* the production of a relevant response, and those that *counter* the action of the neurologist's turn – all demonstrate patients' orientations to option-listing as a practice for handing the decision to them.

Focusing next on our second study objective – to identify the most effective practices for facilitating patient choice – we argue that this practice works in one sense (i.e. it readily generates the perception of choice; see *Chapter 7*). With respect to whether or not patients actually go on to make a choice following option-listing, however, it clearly only works some of the time. We considered the possibility that this could be explained by the design of the third component of option-listing, the PVE. Thus far, however, we have been unable to show a link between outcome (whether or not the patient makes a choice) and the specific wording of the PVE. Rather, the crucial factor seems to be whether or not (and if so, when) the neurologist announces his/her view. If the PVE is either replaced with, or displaced by, a recommendation from the neurologist, the slot for the patient response to option-listing can be significantly altered. Moreover, we show that, depending on when and how the machinery of option-listing is used, it can have the opposite effect to that shown in *Chapter 6*: instead of promoting patient choice, it may curtail it.

Analysis of patient view elicitors

In our final analytic chapter (*Chapter 8*), we examine an additional practice that was common in (but not exclusive to) the subset of consultations for which neurologists and patients agreed that a choice had been offered (i.e. PVEs used independently of option-listing). Decisions initiated with PVEs are not constructed as a matter of selecting from a menu of alternatives. Rather, they involve making a decision for or against one possible course of action. Our collection of these single-option PVEs divides into two groups: those where the course of action was introduced prior to the PVE and those where it was introduced through its use. We show that:

- PVEs with prior information provision function to cast that informing as a matter of laying out *an option*, as opposed to telling the patient what to do
- PVEs without prior information provision function to avoid constructing a recommendation to the patient altogether, foregrounding, instead, the patient's wishes.

Thus, both forms of PVE – like option-listing – place the decision in the patient's domain. However, we suggest that each raises a potential difficulty for patient choice; that is, PVEs produced after the neurologist has informed the patient about a possible course of action run the risk of being treated by patients as *recommendations* (and not a matter of choice) because the information may be heard as an indication of what the neurologist thinks ought to happen next (rather than as a neutral informing). By leaving out the prior information, neurologists may avoid this risk. However, they may, instead, leave the patient ill-equipped to respond to the PVE. On hearing a stand-alone PVE, then, patients may recognise they have a choice, but be unable to exercise it.

Discussion

Doctors typically occupy a position of greater epistemic (knowledge-based) and deontic authority (having the right to determine another's actions) with respect to test and treatment decisions than patients. We argue, however, that option-listing – relative to the alternative practice of recommending – provides one way of tempering clinicians' exercise of authority. This is because option-listing may be used in such a way as to claim only knowledge of *what is on offer*, rather than a view on what the patient *ought* to do. Option-listing represents, then, one kind of response to the critique of a paternalist approach to medicine.

Our analysis of PVEs used for single-option decisions indicates, however, that there can be a trade-off between epistemic and deontic authority. Because, as we show, information provided about a single option may be susceptible to being heard as a *recommendation* for that option, as the *epistemic* gradient is *reduced* (by informing the patient) so the *deontic* force may be *increased* (by virtue of the informing being hearable as an indication of what the neurologist thinks is best). But if the neurologist decreases the deontic force without also decreasing the epistemic gradient (by handing the decision to the patient without prior information), the patient may be unable to act on his or her increased right to decide (owing to a lack of resources). We show some ways in which this may be addressed and propose that the success of option-listing with respect to participants' *perception* of choice may lie partly in its ability to resolve this dilemma.

We suggest, also, two main implications of our findings for medical sociology. First, that the standard CA account of the treatment phase – which takes the recommendation sequence as given – needs revision. Widening the focus beyond recommending will allow more extensive investigation both of the ways in which clinicians are orienting to policy directives to give patients 'more choice', and of their impact on the consultation. Second, this study not only adds substantive detail to models of SDM – based on actual practices evident in doctor–patient interaction, rather than summary coding or reports thereof – but it also shows how, in the absence of more detailed analysis, guidance that has obvious face validity may not function as expected when acted upon in the moment-by-moment reality of interaction.

Conclusions

Choice featured in the majority of our recorded consultations. Whether doctors offer, or patients perceive, choice is not readily explained by clinical or demographic variables. Whether or not offering choice is the best way to initiate decision-making is contingent on clinical, ethical and practical considerations. If doctors want to ensure a patient knows she or he has a choice, option-listing is most likely to be identified by the patient as an invitation to choose. However, an important lesson from this study is that simply asking doctors to adopt a practice (like option-listing) will not automatically lead to a patient-centred approach. Our study shows that precisely *how* a practice is implemented is crucial, and should encourage doctors to focus more on the micro-level of talk if they want to interact most effectively. An immediate next step for the research team is to use our findings to develop a leaflet and workshops to disseminate our findings to health professionals in ways that may be readily used in practice.

Future work

Future research directions include follow-up studies to investigate (1) links between the practices identified here and relevant outcome measures (like adherence); (2) if being given a choice is better or worse for patients than receiving a doctor's recommendation, taking account of clinical and demographic factors; and (3) if our approach could be fruitfully applied in other settings.

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