**Nurse-patient consultations in primary care – do patients disclose their concerns?**

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**Abstract.**

**Background:** Person centred care and shared decision making are important for the management of long term conditions. Interventions to improve them have been inconclusive which may reflect variable disclosure by patients of their concerns.

**Aim:** To quantify the extent to which patients disclose concerns to community nurses during wound care consultations.

**Methods:** Using unstructured interviews, the issues which impacted on the quality of life of nine patient participants with chronic venous leg ulceration were elicited. The interviews were audiotaped, transcribed and, using thematic analysis, the themes and subthemes were identified and an ‘observation checklist’ constructed. This was completed during four observed wound care consultations with five of the interview participants and their district nurse.

**Results:** Four themes and 28 subthemes were identified. During the 20 observed consultations, the patient participants had 160 opportunities to raise previously identified pain, exudate and odour symptoms yet did not on 64 (40%) of occasions. They had 28, 32 and 84 opportunities to raise emotional, wound care and daily living issues but did not on 16 (57%), 3 (9%) and 32 (38%) of occasions. On a further 8% of occasions issues were raised by patients but either not picked up or disregarded by their nurse.

**Conclusion:** Overall patients did not raise 38% of their concerns. If these data are representative, this has profound implications for person centred care and shared decision making models of care which are predicated on patients articulating their needs and for the development of health carers communication and consulting skills.

**Key words:** Chronic venous leg ulcers. Community nursing. Consultations. Person-centred care. Observation. Interviews.

**Introduction.**

Patient centred care (PCC) seeks to expand the focus of the clinical encounter to include the psychological and social context of the patient’s presentation.1 PCC embraces shared decision making (SDM), where healthcare decisions are made jointly by the practitioner and patient.2 Stewart 3 suggested a mechanism (Figure 1) as to how the consultation results in improved health outcomes largely through its impact on patient behaviour. PCC and SDM should result in greater agreement and consequently increased concordance with a management plan, resulting in enhanced behaviour change and improved health outcomes increasing the likelihood of improvements in patients’ functional status, self-care and satisfaction.4 Thus PCC is recognised as an indicator the of quality of health care.5-7

**Figure 1: The effects of patient centred care.**



Although this appears a relatively simple process, both medical and nursing practitioners often fail to elicit patients’ concerns or negotiate treatment options during the consultation.8–10 In a series of general practice consultations, 54% of patient problems and 45% of patient concerns were subsequently unknown to the doctor;11 in another series of observed consultations the general practitioner made an active effort to elicit the patients’ view about the significance of their diagnosis in only 6%12 and in another series, physicians and patients failed to agree on the presenting problem in 50% of consultations.13 Nurses, on occasion, also fail to communicate well with a tendency to approach patients to deal with either administrative and functional issues14,15 and patients often feel intimidated and reluctant to express their needs,16 a problem compounded by poor clinical communication.15,10

Chronic venous leg ulceration (CVLU) is common, intractable and often recurs.17,18 Care of such patients is often focused on healing the ulcer 19,20 and frequently neglects to address issues of pain, odour, depression, anxiety and social isolation.21 The impact on the patient and their quality of life (QoL) is consistently underestimated.22,17 CVLU therefore offers a rich context in which to investigate PCC and its impact on patient outcomes.

**Methods.**

**Design.**

This was a two phase study. In phase 1 we systematically identified the factors of importance to people with CVLU; these are also briefly described in Figure 2 below. 23 In phase 2 (reported here) we observed the five of the same people’s wound care consultations using a checklist – which was based on the phase 1 findings. This enabled us to identify which factors were raised by patients and the extent to which they were addressed by experienced nurses. This was preparatory work for a pilot study of an intervention to increase PCC in CVLU care.

**Figure 2 – Themes and subthemes identified from phase 1 interviews.**23

**Sample.**

***Nurse participants:*** Nurse participants were recruited by advertisement to community nurse teams in two primary care trusts. The inclusion criteria were the nurse had worked in primary care for at least six months, had people with CVLU on their caseload and would consent to the recruitment of their patients to the study and subsequent peer observation of their consultations.

***Patient participants:*** Patient participants were recruited from the caseload of the nurse participants by nurse participants giving potentially eligible patients a letter of invitation, a participant information leaflet, consent form and an addressed freepost envelope. Potential participants contacted JG who formally consented eligible people for the study. The patient participant inclusion criteria were CVLU for in excess of 6 weeks and competent to provide informed consent.

Thirteen community nurses were recruited to the study. All were women and had worked in primary care for a median of 5 years (range 6 months–20 years). Nine patients (4 male; 44%) were recruited for the phase 1 interviews (median age 76 years, range 39–99 years). Five (3 male; 60%) patient participants were involved in phase 2 of the study (median age 76 years, range 39-86 years); the ulcers of two had healed, one was in hospital following a fall and one had been discharged.

***Ethics approval:*** The study was approved by the Mid Staffordshire Local Research Ethics Committee.

**Data Collection.**

Having identified the themes and subthemes from the phase 1 interviews24,23 ( Figure 2), JG and AP independently developed checklist items from these themes and sub-themes. They then agreed a checklist of 28 items which was verified in discussion with RJ. This formed a predetermined observation schedule25 (Table 1).

**Table 1: Consultation checklist items.**

|  |  |
| --- | --- |
| **Symptoms**: | **Wound Management**: |
|  Presence of pain. |  Update on the wound. |
|  Cause of pain. |  Wound measurement. |
|  Type of pain. |  Nurse advice. |
|  Timing and duration. |  Patient understanding of dressings. |
|  Use and effectiveness of analgesia. | **Effects on daily life**: |
|  Advice on pain management. |  Sleep. |
|  Comfort of dressing. |  Personal hygiene. |
|  Discomfort during dressing. |  Legs washed. |
|  Exudate. |  Mobility. |
|  Odour. |  Clothes and shoes. |
|  Depression. |  Opportunities for work and leisure. |
|  Fears and concerns. |  Isolation. |
|  Self-image. |  Relationships. |
|  Fear of people’s reactions. |  Financial issues. |
|  Fear of recurrence. |  |

For ease of completion, tick, comment and ‘scoring’ boxes were included in the checklist, thus minimising distraction for the researcher when recording whether an issue was raised by the patient or the nurse participant and the depth to which it was explored. A ‘scoring’ scale, based on those used in similar studies, 26 facilitated rapid assessment and recording of the depth of exploration of each theme (Table 2).

**Table 2 - Scores for checklist themes.**

|  |  |
| --- | --- |
| **Score** | **Criterion** |
| 0 | Theme not raised by nurse or patient. |
| 1 | Nurse did not identify cue from patient. |
| 2 | Nurse picked up cue only. |
| 3 | Nurse identified patient cue and asked about the issue. |
| 4 | Nurse picked up cue and partially dealt with it. |
| 5 | Nurse picked up cue and dealt with it fully. |

**Procedure.**

JG observed four successive consultations between patient and nurse participants, either in the patients’ home or a clinic, to determine the extent to which the themes / subthemes patient participants had disclosed in phase 1 were explored during the subsequent consultations with their community nursing team. JG took the role of non-participant observer completing the consultation checklist during the consultation and field notes on the context of the consultation and the nature of interactions immediately afterwards. Each observation lasted between twenty and thirty minutes.

Data collection on both phases was undertaken between Jan 2010 and December 2011. The analysis was concurrent and cumulative and shows the proportion of occasions patients who had raised a theme during the interview raised it with the participating nurse and the extent to which the nurse dealt with it.

**Results.**

The five patient participants consulted with 13 nurse participants during the 20 observed consultations. Results for the themes and subthemes are displayed in Table 3 below. Overall, 38% of concerns were not raised by patient participants and of the 62% which were raised, 8% were either missed or ignored by nurse participants. 30% were discussed but not managed leaving 24% which were at least partially managed. There are statistically significant differences in the results (Chi2 =55.0, df = 20, P<0.0001). Wound management concerns may be more likely to be acknowledged and managed while emotional effects of the ulcer are less likely acknowledged and managed.

**Table 3 –Observation results.**

|  |  |
| --- | --- |
| **Issue (total number of potential occurrences of each issue)** | **Number (%) of known issues were raised by patients to****and responded to by nurses.** |
| **Not raised (score = 0)** | **Cue not identified (score = 1)** | **Cue blocked (score = 2)** | **Discussed (score = 3)** | **Partially dealt with (score = 4)** | **Fully dealt with (score = 5)** |
| **Pain (132)** | 55 (42%) | 9 (7%) | 1 (1%) | 36 (27%) | 9 (7%) | 22 (16%) |
| **Exudate & odour (28)** | 9 (32%) | 1 (4%) | 1 (4%) | 5 (18%) | 1 (4%) | 11 (38%) |
| **Emotional effects (28)** | 16 (56%) | 2 (7%) | 1 (4%) | 8 (29%) | 0 (0%) | 1 (4%) |
| **Wound management (32)** | 3 (9%) | 0 (0%) | 1 (3%) | 9 (28%) | 4 (13%) | 15 (47%) |
| **Effects on daily life (84)** | 32 (38%) | 8 (10%) | 1 (1%) | 33 (39%) | 3 (4%) | 7 (8%) |
| **Total (304)** | 115 (38%) | 20 (7%) | 5 (1%) | 91 (30%) | 17 (6%) | 56 (18%) |

**Discussion.**

This small group of people whose concerns were known did not raise 38% of their concerns during four consecutive consultations with their nurses. Of the 62% of concerns that were raised, the nurse overlooked or ‘blocked’ 8% and discussed but did not act on 30%. Thus only ¼ (24%) of patients’ concerns were addressed to some degree during the consultation. For every concern not picked up by the nurse another was not raised by the patient.

**Figure 3 – Results flow chart.**



Figure 3 combines Stewart’s 3 earlier described mechanism to explain the link between consultations and improved patient outcomes (Figure1) with the results from this study: 38% of patients concerns were never raised and thus ‘lost’ to the consultation, a further 38% were either ignored by the nurse or discussed without any change in the care proposed or agreed and for only ¼ (24%) of the patients’ concerns is either a partial or complete solution proposed or agreed.

These results echo those of Stewart et al 11 who demonstrated that some 50% of patient problems and concerns were unknown to the doctor although the proportion of concerns that the patient failed to disclose was not identified. This study unpicks this data to reveal that many concerns may not have been raised by patients during their consultations. The effectiveness of the consultation relies on the SDM behaviours from both members of the patient-practitioner dyad 27 and the particular importance of this study is to show that effective interventions are likely to include enhancing patient disclosure as well as clinician training.

The strengths of this study are the single observer, the rigorous identification of the patient concerns through paired thematic analysis and development of the consultation checklist and the multiple observations which increased the likelihood of observing an issued being raised and reduced the Hawthorne effect 28 and also the careful field notes taken by JG. It also adds to previous work by demonstrating that amongst the large proportions of patient problems and concerns of which practitioners may be unaware11 half were not disclosed by patients whilst half were but were ignored or not acknowledged.

Weaknesses in this study are the potential for the observation to affect the interaction and that the issues identified at interview may have resolved between the interview and observation. We have also assumed that all issues identified in detailed interviews with patients were still current when their care was observed; both that the chronicity of the condition18 and JG’s field notes indicate that this was the case.

Recommendations to enhance PCC generally either focus on interventions that change practitioner behaviour, such as enhancing consultation style 29 or patient mediated interventions, such as decision aids.30, 31 This study offers a rich, unique albeit situated insight into the gap between the concerns people may have with respect to their condition and those which they share with their health professionals. A large proportion of patient need is not disclosed and that interventions to enable patient disclosure may result in substantial gains.32,33 This has important consequences for PCC.

Patient-practitioner communication has long been a subject of research34 and barriers to effective communication have been attributed to: ‘the asymmetry of the physician-patient relationship’ (p. 32); 35 poor communication; 36 organisational constraints; 37 delays in answering patient’s questions; 38 a focus on functional activities.15 Work has focused on practitioners with little attention being paid to why patients may not express their concerns. This paper quantifies these facets: for every issue raised by a patient and not dealt with by a nurse, another issue had not even been disclosed. The focus of research into patient-practitioner communication needs to be widened to include the patient.

**Conclusion.**

The findings of this study, albeit embedded in a local, clinical context provide an insight into the nature of information sharing during the consultation and an insight into the nature of PCC and SDM. The findings of the study have implications for the care of people with CVLU and those who provide their wound care; they also provide food for thought for all who seek to provide PCC and SDM. We may thoroughly address the expressed agenda of our patients but still miss over a third of the potential of the consultation.

Patient centred care is the product of effective collaboration between the patient and their health care professional. Unless patients are enabled to articulate their concerns, many will remain unacknowledged and, therefore unmanaged. Thus, urgent work is needed to determine how we, as healthcare practitioners, can enable our patients to share their concerns so that together we can address them and improve health outcomes.

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**Conflicts of interest**: the authors have no conflicts of interest to declare.

**Ethical approval**: Mid Staffordshire Local Research Ethics Committee approved this study.

**Overview.**

**What is already known on this subject:**

The clinical consultation is considered a central focus of patient centred care and, in order for this to be effective, patient concerns must be shared and decisions jointly made.

**What this study adds:**

As many as 38% of ‘known’ patient concerns were not revealed during sequential observed consultations. A further 30% of concerns are discussed and only a partial or complete solution offered on 24% of occasions. Incomplete disclosure of concerns by patients may be a significant barrier to optimal shared decision making.

**Further research:**

Studies which explore reasons non-disclosure. Development and evaluation of interventions to improve the consulting skills of health care professionals and activate the patient to express their concerns across a range of locations of care and conditions.