Communication about risk: diversity among primary care professionals

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Objective. We aimed to identify the important clinical topics and to report current practice of communication about risk in primary care.

Methods. We carried out a qualitative study using six semi-structured focus group discussions with primary care professionals. The subjects were 36 primary care professionals from general practice, practice nurse, district nurse, community psychiatric nurse and health visitor disciplines.

Results. All clinical topics were felt to raise issues of effective risk communication. Participants expressed concern about the lack of accessible up-to-date information and the problems of conveying information to patients. They described the circumstances and contexts in which communication varies and is difficult, and identified media and medico-legal influences and professional uncertainty as also contributing to the problems of risk communication. Specific training in risk communication was identified as an important need.

Conclusions. The complexity of risk communication and diversity of influences on it will require wide-ranging interventions in order to address them. Standardized communication may be a difficult goal to attain.

Keywords. Primary care, qualitative research, risk communication.

Introduction

Much of the work of primary care professionals addresses and makes attempts to reduce patients’ risks. Clinical areas include antenatal screening, cancer screening and primary prevention,1,2 and increasingly others such as genetic counselling.3 Recently there has been an ‘epidemic’ of risk literature in medical journals,4 and it is crucial that we convey this risk information effectively to patients if research findings are to be implemented in practice. Our understanding of how to present risks and benefits to patients is, however, still limited.5 The interpretation of risks by patients and doctors varies,6,7 and conflicting evidence exists regarding whether verbal or numerical representations of probability are preferred by patients.8 The extent of health promotion work in primary care9,10 and communication discourse have been studied,11 but we still require an understanding of current risk communication in order to identify the problems and modifying influences. Understanding the approaches used by different professional groups will identify where improvements may be possible, and we undertook a qualitative study to achieve this.

Subjects and methods

Method

We undertook a series of focus group discussions to explore the consistency or diversity of approaches used in risk communication by primary care professionals. The focus group methodology is useful in identifying group norms or a range of views,12 and capitalizes on the interaction within a group to elicit rich experiential data.13 Within- and between-group comparisons are then possible. When interpreting data, their timing in the discussion is important. Data from the latter parts of discussions may be given more weight as the group moves towards establishing its view of the topic matter.

Study sample

Thirty-six subjects participated in six separate groups. Each focus group involved a separate discipline:
practice nurses (7 nurses involved); district nurses (8); community psychiatric nurses (6); GPs (4 and 5 in two groups); and health visitors (6). The sample formation was designed to enable comparison of whether risk communication issues are consistent or vary for different professional and patient groups: participants were chosen to represent the range of disciplines, those working in different social class areas, those recently trained or otherwise and varying levels of educational or managerial commitment to others. One GP group comprised new principals in general practice, whilst the other more senior group comprised medical student tutors. The GP, health visitor and practice nurse groups were convened by invitation to local practices. The district nurse and community psychiatric nurse (CPN) groups were convened via in-service training courses. The health visitor group included one manager.

Focus group discussions
The invitations to participants included a questionnaire exploring the clinical topics for which risk communication is important, and difficulties that arise. This was an initial focus on the topic matter, from which to develop the discussions. AE facilitated each discussion and EM took contemporaneous notes. Where inconsistencies (of views but not of factual information) were apparent, these were noted, and then fed back for clarification. The discussions explored risk communication in general, asking participants to identify whether problems existed, and if so, in which clinical areas. Participants then discussed ‘routine’ practice in covering a specific topic relevant to their own patients, identified from the opening discussion. (They also commented on two standardized languages of risk proposed by Calman and Paling, and finally a pharmaceutical company’s (Schering) visual aid for risk communication, depicting the relative risks of the contraceptive pill compared with ‘everyday’ risks: these results are reported in the accompanying paper.

Data analysis
Each discussion, lasting approximately 1 hour, was audio-taped and transcribed. The transcripts were assessed for emerging themes by separate researchers (AE, EM and RP), which were then agreed by discussion. All data were then classified independently by three researchers (AE, EM and RP) according to these themes and agreement over classification again achieved by discussion. Data will be presented indicating their professional group (GP1, Tutor GPs; GP2, new principal GPs; HV, health visitors; CPN, community psychiatric nurses; PN, practice nurses; DN, district nurses) and page numbers from the transcripts for reference.

Results
The problem in general
Every clinical topic area encountered in practice was felt to present problems of risk communication. Different groups suggested different elements of the problem. These were classified under two broad headings: communication issues and availability of information.

Four groups (both GP groups, practice nurses and district nurses) felt that information and communication issues were both important. For example, one senior GP commented: “there are so many bits of information coming through . . . (the problem is) whether you have the time and the resources to actually look into the information and whether you can then communicate that back to your patients” (GP1, p3).

The CPN and Health Visitors groups felt that it was primarily a communication issue. The CPNs felt that they had the information to hand and that it was more a challenge of getting things across, with characteristic difficulties in their client group. The Health Visitors viewed their role and therefore communication challenges as qualitatively different from those of other disciplines. They were less concerned about information availability, regarding their main challenge as simply getting clients to acknowledge the reality of risks: “I would work in a much more qualitative way, trying to get them to understand that there was a risk” (HV p12).

Routine practice
Many different approaches were revealed in the separate group discussions. Both groups of GPs discussed risk communication about the oral contraceptive pill (OCP). They reported discussing ‘major’ and ‘minor’ problems associated with OCPs (GP2, p6), or “discussing the serious side effects, just saying that they don’t occur very often” (GP1, p9), or “in my clinical practice I’ve only seen one” (GP2, p6), rather than mentioning specific numerical risks. One exception to this was “at the time of the last scare (October 1995) where the press was bandying about this 15 per 100,000—they seemed able to identify with that and then they made their decisions” (GP1, p10). Another GP also found the “hundred woman years business helpful” (GP1, p11). The senior GPs reported usually using a standard communication method (which may change with time due to external influences such as the press), but the newer GPs reported tailoring communication to the patients’ perceived needs: “if you’ve got someone who is interested you tend to elaborate more” (GP2, p8); and “if they seem terribly interested in the risks . . . I tend to de-emphasise the risks and emphasise the benefits” (GP2, p8). Both groups of GPs described, however, that risk communication is often of lower priority than other aspects, such as how and when to take the pills, and what to do after missing pills. They would often “give the very minimum of information to start with.”
... and bring up other concerns at the next visit” (GP1, p10) owing to time constraints.

In order to prompt these concerns, and to convey the bulk of the advice, both groups supported the manufacturers’ patient leaflets. With other medication, however, they were less enthusiastic, viewing leaflets as often contributing to patient concerns and development of side-effects (GP2, p3). The OCP patient leaflets had more support as they have been used for some time, and are therefore familiar to patients (GP2, p6).

The practice nurses discussed their communication about inhalers for asthma. They too encountered difficulties arising from the patient leaflets, and would sometimes respond “just forget it, treat it; if you read that you would never take any medication” (PN, p2). In other situations, though, they were happy to have such leaflets available for their own security: “with the pneumovac I actually give them the sheet and discuss it... and then say ‘knowing all of this, are you happy to have it?’” (PN, p4). Generally practice nurses were inclined to “give a little information to some and more to others” (PN, p1), and to concentrate on ‘safe’ or positive words like “rescue” therapy rather than discussing specific risks.

The district nurses discussed dietary advice and how they “introduce things quietly at each time and don’t just go in there with dos and don’ts” (DN, p5). They would “take the lead from the patient, according to individual needs” (DN, p5) and would often be hampered by circumstances (“they’ve just come out of hospital... and are not feeling up to having long conversations and taking in information, so we may not be the best person for that particular health education” —DN, p6). They would restrict themselves to simple advice, and not usually engage in detailed discussion of risks.

The health visitors often adopted a similar approach (HV, p6). Regarding immunizations, one said “I try and be very brief about the research that’s been done... because the risk of having the vaccine is lower than not having it” (HV, p7). They would adopt a more “pictorial than factual approach... giving comments like ‘Have you ever seen a child with whooping cough?’” (HV, p7). The advice would be different for different groups of people, sometimes giving a parent “all the information, and at the end of the day it’s her choice, isn’t it?” (HV, p8). More generally, however, the health visitor’s approach to risk communication was more ‘categorical’, seeking to get people to acknowledge the reality of a risk: “this is potentially dangerous for your child” (HV, p6).

The CPN group discussed patients wishing to discontinue medication against medical advice. They reflected many of the same themes: “I try and channel their thoughts down actually looking at the risks they are running” (CPN, p4). They would usually alter their communication to accommodate the patient and the environment (CPN, p7). They would not routinely discuss figures for the relapse risks, but would sometimes feel this appropriate, such as with professional or well-educated clients, and they had encountered psychiatrists doing this (CPN, p6).

Modifiers of risk communication
Several specific themes emerged as important modifying influences and problems in risk communication.

Types of patients and diseases. The GPs, practice nurses and health visitors noted that there were difficulties with different ethnic groups of patients (mainly Indian or Chinese). Comments included:

“There is a cultural perception that’s different, and that’s difficult”. (GP1, p8)

“These women don’t think there is a risk—they are not ill so they are not at risk [of cervical cancer].” (HV, p1)

Participants also observed differences in communicating with patients who are ill or well: “we need to be aware of what you are treating and with what—the side-effects they are willing to take are different in family planning compared to asthma” (PN, p1). The “very anxious” also require a specific approach: “they seem to want immediate reassurance and want you to have everything at your fingertips” (GP1, p8).

Media. The media’s role in generating health issues was noted by many participants, especially the GPs. Regarding the meningitis cases at the University of Wales (October 1996), one observed:

“The first I knew about it was on the News of Wales bulletin. So I knew we were in for a hammering the following day. And likewise with the pill scare of just over a year ago, the first I heard of that was the 1 o’clock news, so it really took some time for the information that we were supposed to be giving our patients to get through to me. But in the meantime we had been inundated with queries from what were inevitably the more anxious members of the population who are the most difficult to deal with and that makes for two or three very, very difficult professional days.” (GP1, p1)

Practitioners were also concerned about perceived inaccuracies in press reports and the impact that this has on doctor–patient relationships: “if something is there in black and white in a newspaper, if that is slightly inaccurate even if you have an excellent relationship with your patients, they tend to believe the inaccurate report rather than yourself and it’s a big task then changing their views” (GP1, p2).

Legal issues. The GP groups were the only groups to raise medico-legal issues in risk communication. They
described it adversely affecting the relationship between
doctor and patient, with comments including "The
litigious sort of culture in our whole practice now is
such that people’s perception of adverse risks is much
greater because they get mentioned" (GP2, p2) and "if
patients ask for information regarding anything on the
side-effects of drugs—if they just happen to get one and
you didn’t warn, then you are leaving yourself open to
a law suit" (GP1, p7). Once the professional has
addressed key side-effects the GPs expected patients
to share responsibility: "That’s your risk, and the rest
is for them" (GP2, p6), though the earlier comments
may suggest that this expectation is not met.

Professional uncertainty. Many participants noted prob-
lems arising from relevant data not being available, and
if it was, not having confidence in the data. Comments
included:

"I’ve yet to see the sort of paper that helps me
to help my patients in such a way which really
is the information they want to know" (GP1, p4)

"I think part of the problem is that we deal with
people on an individual level . . . the consulta-
tion is one-to-one, doctor to patient, and yet we
try to help our patients based on population
studies" (GP1, p3)

"I feel the main problem is when the experts keep
moving the goalposts" (DN, p9)

The impact of uncertainty on patients was evident:
"they are bound to perceive that a risk is perhaps
greater if they are getting equivocal advice" (GP1,
p2).

Probabilistic information. Although several participants
discussed using numerical data in consultations, they
also noted that problems arise concerning professional
and patient understanding and the presentation of
figures. Comments included:

"Do you think ‘1 in 5’ would mean anything to
patients?" (PN, p6)

"Once you get to loads of noughts, it’s got beyond
me, I wouldn’t take it in so why should they?"
(DN, p7)

"It’s difficult for an individual to assess whether
they are 1 in a 1000 or 1 in 500—what I’ve come
across recently is with ante-natal screening . . .
I’ve had some patients who have been extremely
upset with having AFP scans for their risk of
Down’s—if they’ve got a 1 in 600 risk should they
be worried and if they’ve got a 1 in 300 risk, how
much more worried should they be? And it is
really difficult because it is their one pregnancy
and they are 1 in 600 or they may have 599
chances of being normal." (GP1, p4)

Training needs. GPs identified that "we need some sort
of training in the communication of risk in everyday
terms that is perceivable by patients" (GP1, p4).

Discussion

This qualitative study has identified that all the primary
care disciplines involved in these discussions recognize
problems in risk communication. The problems arise
in many clinical topics, which vary according to pro-
fessional roles, but with substantial overlap, especially
between GPs, practice nurses and district nurses.

The methodology used here capitalizes on the interac-
tion within a peer group to elicit data and to gauge
individuals’ views. The use of single discipline groups
enables the participants to relate to each others’ ex-
periences and to develop a collective view about cur-
cent practice and problems. Using a doctor as the
facilitator may have influenced the nurse discussions
to reflect a more ‘textbook’ version of events,
delineating professional boundaries more than in prac-
tice. The strength in numbers of the group should,
however, limit this effect and maintain an acceptable
level of validity in the data. Consistency within and
between groups is not generalizable from this sample,
but where differences are identified, this shows that pro-
fessionals in practice are not consistent. Differences are
thus interpretable as generalizable evidence of a range
of views and approaches in wider practice.

Most groups viewed risk communication problems
in two broad categories. The first concerned the
availability of up-to-date information. All groups ex-
cept the health visitors and CPNs regarded this as prob-
lematic, the latter groups viewing it as of less concern
generally, but easily available in some key topics such as
immunizations.

The second problem area relates to risk communica-
tion once the professional has the information. This con-
cerns how probabilistic information should be conveyed
and whether it is interpreted as intended. In routine prac-
tice, most professionals tailor advice according to the
perceived characteristics of the patient, deferring risk
communication and prioritizing ‘more important’ issues.
These might include establishing rapport or initial
emphasizing of treatment concordance.

Some professionals (especially the senior GPs)
reported often giving standard advice, and using
numerical representations of risks. Others held mixed
views about whether this would always be helpful or
the same message received. Most professionals reported
more flexibility in communication, following patient
responses and varying according to patient
characteristics: age, social class, intellectual ability,
linguistic ability and ethnic background. It is likely that
communication in practice reflects the well-known
variability of general practice and combines both
these standard and response-led approaches.
Whilst appreciating this issue of numerical risk communication for immunizations, the health visitors viewed their clinical objectives as qualitatively different and detailed discussion of quantified risk estimates as less relevant. In fact, many features of the communication by district nurses and CPNs showed similarities, which may result from their work taking place mostly in patients’ homes. This affects the dynamics of the interaction, perhaps making professionals less ‘powerful’, and the communication more suited to patients’ perceived needs than in other practice-based consultations.

Other identified themes reflected the range of everyday difficulties confronting clinicians communicating about risk. As well as the contextual variations with individual patients, there were the external media and medico-legal influences on practice, described particularly by the GPs. The GPs demonstrated a paradox in sometimes being influenced by medico-legal pressures to ensure ‘informed choice’, but in other situations deferring risk communication for more immediate concerns, which may be regarded as either humanitarian or unduly paternalistic in controlling the consultation.

This complexity in risk communication and diversity of influences on it make simple solutions unlikely. Solutions must address all aspects from communicating probabilistic information, to general communication discourse in the consultation, to making information available and accessible to professionals, and identifying what professionals have to discuss with patients to reduce the influence of defensive medicine. The issues identified in this research from the professional’s perspective can inform efforts to improve risk communication, and should clearly be complemented by similar data from patients.

Acknowledgements

We thank all the participating primary care professionals from general practice, practice nurse, district nurse, CPN and health visiting disciplines in Bro Taf Health Authority; Diana Thomas for transcribing and Claire Collins for processing data for analysis. This work was funded by the NHS Executive Research and Development Programme evaluating methods to promote the implementation of Research and Development.

References


Conclusion

All the primary care disciplines involved in this qualitative study recognized problems with risk communication. There are several elements of the communication process: individual characteristics of the patient or their morbidity; different interpretations of probabilistic information by professionals and patients; professional uncertainty; and external influences such as the media and medico-legal background. Research to improve risk communication must consider innovations in all these elements. In the context of this complexity standardized communication may be a difficult goal to attain.