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# British Journal of Nursing

## Advantages and disadvantages of encouraging consumerist notions of healthcare at two minor injury units: results of a multiple embedded case study --Manuscript Draft--

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**Advantages and disadvantages of encouraging consumerist notions of healthcare at two minor injury units: results of a multiple embedded case study**

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## **Advantages and disadvantages of encouraging consumerist notions of healthcare at two minor injury units: results of a multiple embedded case study**

### **Abstract**

Since the 1980's, successive UK Governments have encouraged an increasingly pro-market model of healthcare provision. This has resulted in a system where patients are not only encouraged, but expected, to take increasing responsibility for healthcare decision-making and the risks that it might entail. This paper investigate how and why patients make choices about their healthcare and how service providers help to facilitate this. Between October 2014 and May 2015, the researcher was embedded as an emergency nurse practitioner at two minor injury units in order to undertake direct and participant observation. During this time, 40 patients, 17 service providers and one senior manager also consented to semi-structured interview. The findings suggest that patients should continue to be encouraged to make decisions about their healthcare but only if they feel confident to do so. The challenge for service providers is to recognise when this is/not appropriate and tailor interaction accordingly.

**Key words:** patient choice, shared decision-making, consumers, customer service, minor injury unit

### **Introduction**

Since the 1980's, successive UK Governments have encouraged a competitive and pro-market model of healthcare service provision that has resulted in a system where choice and consumer participation have emerged as the defining characteristics of the patient's relationship with healthcare services (Clarke et al, 2007). Patients have been slowly reinvented as healthcare 'customers' or 'consumers', a development which shifts emphasis away from the duty of the state to

provide universal coverage and reinforces the rights of the individual to make choices about the services that they use (Mold, 2011, 2015). Encouraging choice and self-determination has resulted in benefits for patients by helping to situate them at the centre of their care. According to Leadbetter (2004) patients occupy a much stronger position to influence healthcare decisions and outcomes when they participate in the production, delivery and consumption of their healthcare. The empowered patient-consumer is often viewed, therefore, as an effective mechanism to counterbalance professional dominance and paternalism and to strengthen the ability of managers to squeeze greater value from the system on their behalf (Coulter, 2011; Clarke and Eales-Reynolds, 2015). However, there are also potential drawbacks and disadvantages associated with greater choice and increased participation. For example, there is a risk that extending patient choice not only produces competition between healthcare providers but also between patients themselves as they compete for resources in a financially restricted system (Oliver and Evans, 2008; Simmons et al, 2009). In addition, whilst some patients may benefit from participating in the decision-making process, and taking greater responsibility for their healthcare management, not all are able, or wish, to do so (Robinson and Thomson, 2001; Flynn et al, 2006). This is particularly relevant following the publication of *Consent: Supported Decision-Making* by the Royal College of Surgeons (RCS) in response to a judgment in the Supreme Court in 2016. The guidelines advocate a 'resolute move away from the more paternalistic traditional model of consent towards a patient-centred perspective' and recommend that surgeons no longer consider themselves 'the sole arbiter of determining what risks are material to their patients' (RCS, 2016). Whilst the new guidelines have been broadly welcomed, since they advocate greater partnership between doctor and patient, there is also concern that time and workload pressures may result in doctors (and other healthcare professionals) simply laying out available options in order to avoid the risk of litigation (Bodkin and Donnelly, 2015; Boseley, 2016). Similarly, there is an expectation that healthcare professionals will explain all available options to their patients, including those they would not recommend themselves, which may result in confusion and/or treatment that would not have previously been

considered necessary. This paper explores how and why patients make choices about their healthcare and how service providers help to facilitate this at two minor injury units (MIUs) in the south of England (UK). It also investigates how consumerist notions of choice have influenced this process and the advantages and disadvantages this offers.

## **Methods**

### **Design**

A qualitative design was chosen since the research explores patients and service providers' attitudes towards healthcare decision-making and co-production of care. Comparative case study design allows synthesis and analysis of the similarities, differences and patterns across two research settings that share a common focus or goal (Goodrick, 2014). It is also beneficial when the research relates to contemporary phenomena, within a real-life context, where the researcher has little control of the behaviours and events being investigated (Yin, 2009). The study was submitted for approval to the National Health Service (NHS) research ethics committee in May 2014. Favourable ethical opinion was provided in August 2014 (REC reference: 14/LO/0908).

### *Setting*

Two MIUs were selected as research sites since they serve large communities with multiple and diverse needs. The MIUs represent bounded social systems (cases) in which patients have an opportunity to make choices regarding the provision of healthcare and the treatment they receive. Case A provides a 24-hour, nurse-led MIU service, 7 days a week, 365 days a year (Table 1). At the time data collection took place, it was staffed by 14 emergency nurse practitioners (ENPs) and 7 technicians (nursing support staff). Case B also provides a nurse-led MIU service but does not provide 24-hour care. It is open between 09.00-19.00, Monday to Friday, and 10.00-18.00 at weekends/bank holidays (excluding Christmas and Boxing Day when it is closed). At the time data

collection took place, case B was staffed by 5 ENPs and 1 staff-nurse (no technician support). Both cases also provide a co-located primary care service staffed by 1 general practitioner (GP) respectively.

Table 1: Case A and B summary information.

	Opening times	Population served*	Total MIU staff	Co-located primary care service	Shifts worked by researcher as ENP/ participant observer	Interview participants
<b>Case A</b>	24 hours, 7 days a week, 365 days a year	Urban 54,880  District 151,200	14 ENPs  7 technicians (nursing support staff)  5 receptionists	Walk-in service (11.00-21.00 Mon-Fri, and 08.00-20.00 weekends)  Funded by NHS Hospital Trust	Oct.2014: 17, 24 Nov.2014: 7, 15, 21, 28 Dec.2014: 4, 5, 18, 19 Jan.2015: 9, 16, 23, 28, 31 Feb.2015: 7, 11, 19	Patients: 21 [15 female, 6 male]  Service providers: 10 [ENP = 7, GP = 1 Technician = 1, Receptionist = 1]
<b>Case B</b>	09.00-19.00, Mon-Fri, and 10.00-18.00 at weekends/bank holidays (excluding Christmas and Boxing Day when closed)	Urban 41,709  District 111,7000  * 2011 UK census	5 ENPs 1 staff nurse  No technician support  1 receptionist	Appointment only (11.00-21.00 Mon-Fri, and 08.00-20.00 weekends)  Funded by Prime Minister's GP Access Fund	Feb.2015: 26 Mar.2015: 4, 11, 18, 25 April 2015: 1, 7, 22, 27 May 2015: 4	Patients: 19 [6 female, 13 male]  Service providers: 7 [ENP = 5, GP = 1 Staff nurse = 1]  Senior manager: 1 (both sites)

### *Data collection*

Between October 2014 and May 2015, the researcher was embedded as an ENP at case A and B and undertook direct and participant observation to sample interactions between patients and service providers. Supernumerary status allowed the researcher to complete field notes (FNs) and undertake semi-structured interviews with patients and service providers in addition to working as an ENP. In order to minimise the incidence of leading behaviour, observer effect and bias, only unsolicited interactions that occurred between patients and other service providers (i.e. not the researcher) were eligible to be recorded as FN's. Similarly, patient interview participants were not treated by the researcher at any point in their care.

Twenty-one patients and 10 service providers were interviewed at case A, and 19 patients and 7 service providers were interviewed at case B (Table 1). One senior manager was also interviewed to provide further perspective since they had a role at both sites. Patient interview participants were selected from those who registered to see an ENP or GP at case A and B (no more than two per day). Those who consented, were interviewed in a private room once treatment had been completed. The interview lasted for between 30 and 40 minutes on average. All service providers received an individual written invitation to participate in the research before data collection commenced in order to ensure they were fully aware of/consented to the researcher's participant observer role. Interviews took place by appointment and lasted for between 40 and 50 minutes on average. Interviews were recorded and transcribed and all interview participants received a copy of the transcript for member checking.

As part of the ENP team, the researcher also received the weekly report from the short message survey Friends and Family Test (FFT) outlining patient satisfaction/dissatisfaction at each site (ranked numerically on a scale of 1-6 with qualitative comments). From April 2013, every NHS hospital has been required to ask patients accessing emergency care (and other clinical services) whether they would recommend the care and treatment they received to friends and family (NHS England, 2014). Consequently, data were collected using three different instruments: patient and service-provider interview, field notes derived from participant/direct observation and comments from the FFT survey.

### *Data analysis*

Case study inquiry relies on multiple sources of evidence with data needing to converge in a triangulating fashion (Yin, 2009). Consequently, the different data collection strands from each case were coded and analysed for recurrent or discrete issues and themes using qualitative data analysis computer software NVivo (version 10).



## Findings

### *Shared decision-making and co-production of care*

Most patient interview participants at case A and B (31/40) stated that they wanted to be involved in the decision-making process regarding their healthcare management. However, there was considerable variation at both cases regarding the level of participation considered necessary or desirable. Some patients demonstrated a high level of personal autonomy regarding their health and wanted to actively participate in the decision-making process regarding all aspects of their care and treatment. For example, when asked if they thought it was appropriate for patients to be involved in clinical decision-making, patient 13 at case B (P13B) replied:

*“Yes, absolutely. I would expect to have a hand in those decisions. Obviously they need to be informed decisions. But yes, I would expect to be able to make some of those decisions and have opinions myself without being told what was best for me necessarily...I think that people should have the confidence and freedom to feel they can ask and challenge rather than be told because professionals don’t always get it right.”* (retired engineer, male, 61).

Conversely, other patients felt that it was not always appropriate to be involved in the decision-making process either because they lacked knowledge and understanding (and felt that their contribution was unnecessary) or because they demonstrated a high level of trust and confidence in professional knowledge and experience. For example, when asked if they expected healthcare professionals to ask their opinion regarding care decisions, P12A answered:

*“Well I don’t know because you get to a situation sometimes where a doctor will say ‘what do you want me to do?’ and I feel like saying ‘I’ve come to you. You’re the doctor’”* (retired cook, female, 71).

However, those who did not wish to participate in the decision-making process still seemed to value explanation of their care and treatment since it helped them to understand why it was necessary,

increased confidence in professional recommendation, and made them feel valued. A number of patients also explained how the relationship between patients and service providers seemed to have improved for the better. For example, P2A remarked:

*“I grew up in an age when you were frightened of doctors. Doctors didn’t converse with you they told you what was happening. This is changing, their attitudes towards patients are changing and that’s much better because if you feel part of the process, and you feel that you have a say, you equally feel that you are being listened to”* (support worker, male, 50).

All service providers at case A and B expressed clear support for shared decision-making and co-production of care with patients. Service provider 1 from case B (SP1B) explained how it benefitted patients and service providers:

*“Once I’d read about ‘no decision about me without me’ I thought ‘oh yeah’...I think they should be involved and they should see what I’m seeing. And I write in front of them most of the time so they can see what I’m writing about them because it’s related to them...I think the only way forward for us is if we involve them and it’s safer for them and safer for us”* (ENP).

At the same time, SP3B remarked that it can be difficult to accommodate choice and decision-making when it contradicts clinical guidelines or evidence:

*“I think their clinical decision become difficult when we’ve got strict guidelines to follow...But I do think patients generally should have choice about their care”* (ENP).

At other times, service providers experienced difficulty assessing whether patients wanted to be actively involved in the decision-making process or whether it was appropriate at that time. For example, when asked if they encouraged patients to make decisions about their healthcare, SP10A replied:

*“Only if I detect that they want that as part of the partnership that I’m trying to develop. Some people, if you give them too many options, believe that you don’t know what you’re doing. What they’re articulating is that they’re not used to the idea of choice and therefore they want to be directed. So it is about reading the patient and it’s about saying...we need a partnership but it depends...whether there is an attitude from the patient. Some attitudes range from the positive to the not positive and therefore I have to read the patient and decide whether or not it is somebody who would engage in the idea of choice.” (ENP).*

### *Consumerist attitudes to healthcare*

Although very few patients from case A or B identified themselves as ‘customers’ or ‘consumers’ of healthcare (3/40), there was a strong sense that high standards of customer service were important and desirable. Patients and service providers from both cases identified how customer service skills were firmly embedded in most working environments and how this impacted on people’s expectations when accessing healthcare. For example, P14A saw little difference between the type of customer etiquette observed in a supermarket and that expected in a hospital. For them shopping and healthcare both involved rules and socialised modes of consumer behaviour:

*“All the way through my life dealing with the public and in my different jobs that I’ve had we’ve always spoken about the customer. You know, I’m the customer today or you’re the customer...It’s a bit like when you go shopping at the end of the week for your groceries, you don’t just go bowling in there and say ‘I want that, that, and that and that’ and jump the queue and things like that. Everything has a system so you have to stick to that system”*  
(retired stock manager, male, 60).

Similarly, P4A remarked:

*“...say you go into a restaurant to order food and your food is cold, you say something about it. I come here for healthcare and if I do not think my health has been taken care of then I’m going to complain. It’s exactly the same” (P4A, student, female, 22).*

Service providers also observed that choice and convenience are no longer confined to traditional consumer activities such as shopping and SP7A commented:

*“I think people do now view it [healthcare] maybe as more of a consumer experience. They’re used to going to the supermarkets and having an express service and I think that transition has come into healthcare to a certain extent.” (ENP).*

Similarly, SP10A noted that consumer attitudes and behaviour that are acceptable (and encouraged) in other transactional situations seem to be becoming more common in a healthcare context.

*“...if you’ve got a choice of 15 different providers for your internet there is a tendency to get quite argumentative and assertive with the provider because you are saying: ‘I’ve got choice, I can go elsewhere’. And I can understand it...I wouldn’t want them to skip into deference but, on the other hand, it goes too much the other way sometimes. What people do, in my view, is use the communication strategies that they use elsewhere...the same type of assertive behaviour that they’ll use in Curry’s or in KFC or when they go to Travel Lodge” (ENP).*

This phenomenon is encouraged at case A and B by the FFT survey that invites patients to rate the care they received and to ‘recommend’ it to others. The results and comments from the survey are often published and patients can read about positive experiences or how the organisation intends to remedy poor experiences. For example,

*“overall my experience at the unit was fast and i experienced good customer service” (case A: 11/2014).<sup>1</sup>*

*“didnt even get a xray. Didnt get a xray for ribs” (case B: 04/2015).*

Members of the public are increasingly familiar with consumer rating reports such as TripAdvisor and the customer focused language of the FFT does not identify or differentiate between ‘appropriate’ and ‘inappropriate’ attendance. This is important since one of the most consistent observations at cases A and B was that many patients presented for care even when they had received a more appropriate appointment elsewhere or had been advised to attend another facility. For example, a patient presented at case A requesting removal of sutures (FN: Jan.16, 2015). When asked why they had attended case A rather than their practice nurse, the patient stated that it was more convenient since it was closer to their place of work. This type of attendance is common and, although it is not encouraged, ENPs rarely decline to provide treatment once patients have waited to be seen. Another patient telephoned case B for advice following a traumatic injury two weeks earlier (FN: Mar.18, 2015). They were advised by an ENP that, in view of the history provided, it would be best to attend A&E at one of two local hospitals since it was likely they would require surgical opinion/intervention not available at case B. However, the patient stated that they would rather attend case B since it was closer and more convenient. Following examination, the patient was referred to A&E for surgical opinion as originally advised. The senior manager noted how patient expectation regarding when they are seen, and the type of care they expect to receive, has changed over time:

*“[Patients] expect to be able to do their day’s work and then come to MIU at their convenience. They pick up on certain things in the media and the television. The Prime Minister now obviously wants seven days a week, 24-hour healthcare available. They’ve*

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<sup>1</sup> Grammar, punctuation, spelling and syntax in all FFT quotations is reproduced as originally written.

*heard that headline...You have to say 'we try but...if we bring you back to clinic at half past 7 and I need a physio, they haven't gone 24-hours yet'. So it is not always that simple".*

However, she also explained how patient expectation can help to this improve service provision:

*"The main thing I've noticed over the course of my career is patient expectation is far greater. They expect far more. It can cause friction...[but]...I think it depends on the practitioner themselves...If a patient is expert in something that I know nothing about, I am extremely honest...And it does keep you on the ball. You have to, this sounds awful, be better than your patients, more knowledgeable, and it makes you think well actually you can't just know about that ankle, you do have to treat the whole person" (senior manager).*

## **Discussion**

In the UK, healthcare services have increasingly become subject to the same consumer drivers that can be identified elsewhere in society (Simmons et al, 2009; Mold, 2015). This has fostered a number of positive outcomes and patients from case A and B described how services have become less paternalistic and more customer focused as shared decision-making and co-production of care have been introduced and encouraged. Although very few patients from case A or B identified themselves as 'customers' or 'consumers' of healthcare, high levels of customer service were valued and expected. Both patients and service providers identified how customer service skills were firmly embedded in most working environments and how this influenced people's expectations when accessing healthcare. Almost all patients stated that they wanted to be involved in the decision-making process regarding their healthcare management. However, there was also considerable variation of opinion regarding the level of participation considered necessary or desirable. Some patients demonstrated high levels of personal autonomy regarding all aspects of their care, whilst

others were content to be guided and advised by healthcare professionals. This was recognised by service providers who broadly supported shared decision-making and co-production of care providing it did not contradict clinical guidelines or lead to harm. However, there is potential for conflict and confusion when patients are encouraged to review and recommend the service they have received to others (e.g. via the FFT survey) at the same time organisations are trying to signpost patients to the most appropriate provider or actively discouraging non-urgent consultation during the winter months.

### **Limitations**

The chief limitation of this study is generalisability since both cases are situated in the south of England. Although they are located in different geographical areas and contrast demographically, there is a high degree of ethnic homogeneity that may not be representative elsewhere in the UK/world. The sample size is appropriate for a comparative case study project of this nature but further research, at other locations, would help to confirm/disconfirm the findings. Another issue that should be acknowledged is the possibility of selection and sampling bias. Although the patient interview participants were selected throughout the data collection period, most were satisfied (to a greater or lesser extent) with the care they received at the point of delivery. This almost certainly reflects a degree of selection bias in that many of them were treated relatively quickly (a source of satisfaction) and therefore had the time and inclination to discuss their care, views etc.

### **Conclusion**

Few people would argue with the idea of empowering patients to make choices about their care but simply providing a menu of available options without appropriate explanation is not helpful. It is important for service providers to be aware, therefore, that whilst some patients are able and willing

to participate in the decision-making process in relation to their healthcare, others may require and/or benefit from a more supportive approach. The challenge for service providers is to recognise when this is/not the case and tailor their interaction accordingly. This is particularly important at a time when patients are not only encouraged, but expected, to take increasing responsibility for healthcare decision-making and the risks that it might entail. There is concern from both patients and service providers at case A and B that conceiving of patients simply as 'customers' or 'consumers' of healthcare places them at a safe distance rather than working collaboratively to achieve the best outcome. At the same time, it is important that the drive to encourage greater choice and self-determination does not reward those who actively participate in their healthcare with greater access to services than those who do not. It is also important that NHS organisations do not provide mixed-messages to patients regarding access to services. Whilst choice and convenience are important considerations, patients should be signposted to the most appropriate healthcare provider to avoid duplication of care.



### **Key points**

- In the UK, healthcare services have increasingly become subject to the same consumer drivers that can be identified elsewhere in society.
- This has fostered positive outcomes for patients since it helps to situate them at the centre of their care and provides a counterbalance to professional paternalism.
- However, there are also drawbacks and some patients require/desire a high level of professional guidance.
- Organizations may also encourage inappropriate attendance when they ask patients to review and recommend services to others based upon their personal experience.
- Patients and service providers at case A and B identified how customer service skills are firmly embedded in most working environments and how this impacts on people's expectations regarding healthcare.
- Although increasing patient expectation can prove challenging, it can also help to drive service improvement in some areas.

### **Reflective questions**

- How do you encourage patients to become more involved in their healthcare decision-making and management?
- What are the potential benefits and disadvantages of encouraging patients to take greater responsibility for their care and treatment management?
- What are the obstacles to providing greater personal autonomy for patients in your clinical area?
- Have you ever felt pressurized by a patient to provide care or treatment that you considered not to be in their best interest? If so, how did you respond and would you do anything differently if it happened again?
- How does patient feedback help to improve practice?

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**Table 1:** Case A and B summary information.

	<b>Opening times</b>	<b>Population served*</b>	<b>Total MIU staff</b>	<b>Co-located primary care service</b>	<b>Shifts worked by researcher as ENP/ participant observer</b>	<b>Interview participants</b>
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