Choosing to attend an asthma doctor: a qualitative study in adults attending emergency departments

J Douglass, D Goeman, R Aroni\textsuperscript{a}, F Thien, M Abramson\textsuperscript{b}, K Stewart\textsuperscript{c} and SM Sawyer\textsuperscript{d}


Background. Asthma treatment guidelines currently recommend a ‘therapeutic partnership’ to achieve best care. It is frequently assumed that individuals presenting to emergency departments with asthma do not have a good doctor–patient relationship. We asked what is the nature of patients’ relationships with their doctors in those presenting to hospital emergency departments for asthma care.

Methods. A qualitative study of all consenting individuals aged 18–70 years who presented to a hospital emergency department over 2 months was carried out. Sixty-two participants (19 male) engaged in in-depth interviews which were taped, transcribed and underwent thematic analysis. Questionnaire data were also collected and asthma severity determined.

Results. Nearly all patients (61/62) had a doctor whom they saw for their asthma. Patients made thoughtful choices on where they sought care according to their needs. Our findings identified that perceptions of doctors’ competence, listening to patients and time constraints were important influences on doctor–patient relationships. Participants had strong expectations that their personal disease experience would be acknowledged by their doctors.

Conclusion. This group of patients had doctors who cared for their asthma. The acceptability of medical care was determined as much by patient choice as by the quality of the doctor–patient relationship.

Keywords. Adherence, asthma, bodily experience, chronic illness, discourse, doctor–patient relationships.

Introduction

The evolution of internationally consistent guidelines for asthma treatment has led to specific challenges to clinicians.\textsuperscript{1} As a chronic illness, asthma requires adherence to long-term treatment hopefully to alter disease outcomes and minimize symptoms. In order to achieve this goal, ‘guided self-management’ has been recommended.\textsuperscript{1,2} Guided self-management is predicated by the ‘therapeutic partnership’ model of health care which urges health care providers to negotiate mutual goals in partnership with their patients to achieve best health outcomes. Achieving such a ‘partnership’ has a major influence on optimal health outcomes and patient satisfaction.\textsuperscript{3,4} However, institution of such care is not universally accepted as it may involve increased resources.\textsuperscript{4,5}

Paradoxically the ‘therapeutic partnership’ model is based on a medical paradigm, rather than seeking the views of patients on their care.

Individuals seeking emergency care for asthma provide a particular target for interventions to improve medical care, as inadequate primary care may be one of the causes of poorly controlled asthma.\textsuperscript{6} However, there
is little information regarding the perspective of patients who present to an emergency department with asthma on their medical care. We previously have reported the use of asthma action plans and perceptions of the costs of asthma in a qualitative study of patients attending emergency departments for asthma care. This paper looks at what these same individuals report about doctor–patient relationships. What do the individuals who seek emergency care for asthma look for in a doctor–patient relationship?

Methods

Participant recruitment
All individuals aged 18–70 years who attended an emergency department for asthma care over a defined 2-month period were contacted by letter. Emergency departments from a central city teaching hospital (The Alfred), a suburban hospital (Box Hill) and a rural hospital (Latrobe Valley) were chosen to ensure that the sample included groups from different socioeconomic and geographic backgrounds. Patients who did not register an unwillingness to participate were telephoned and an interview arranged. The study was approved by the ethics committee of each hospital and written informed consent was obtained from each participant.

Data collection
Information collected at interview included demographic data, a respiratory health questionnaire adapted from the European Community Respiratory Health Survey (ECRHSQ) and a validated asthma knowledge questionnaire. A semi-structured in-depth interview was conducted, with areas of enquiry including history of the individual’s asthma, previous health system experiences, medications, costs of treatment and the impact of asthma on an individual’s life. Previous contact with doctors was obtained from the ECRHSQ and confirmed and expanded during interview. Interviews were tape-recorded and transcribed, and transcripts were returned to participants for confirmation of accuracy.

The medical record was interrogated to determine asthma severity. Acute severity was determined by peak flow as a percentage of predicted immediately on index presentation to the emergency department. Chronic severity was measured according to the Australian Asthma Management Guidelines predominantly determined by medication use.

Data analysis
Data analysis has been described previously. Briefly, transcripts were initially read by the authors who met to discuss emergent themes, from which emerged the broad coding. Coding of the transcripts was performed independently by DG, RA and JD who met to compare interpretations and facilitate fine coding of the data. This process allowed for the incorporation of deviant cases into the emerging thematic constructs. For each broad theme, subsequent analysis was performed according to asthma severity so that any consistent differences could be noted.

Using the qualitative data, we categorized patients into those who reported a good relationship with the doctor they currently designated as providing asthma treatment, a bad relationship, or those who reported no regular doctor.

Demographic and questionnaire data were entered into the SPSS software package for analysis. Because of small numbers, statistical associations were assessed with exact tests.

Results

Patient group
Sixty-two informants completed the interviews, 37% (23) from a city hospital, 47% (29) from a metropolitan hospital and 16% (10) from a rural hospital. The participants consisted of 19 males and 43 females, average age 39 years (range 18–69 years). All respondents spoke English at home. Fifty-one participants (82%) had asthma for >10 years. Chronic asthma severity was assessed for all 62 individuals: 30 were severe, 20 moderate and 12 mild. Chronic asthma severity in 32 participants was severe, 14 moderate and 16 mild. Sixty-one participants had seen a doctor for their asthma prior to their presentation to an emergency department. Nearly two-thirds (64%, n = 40) of participants had seen a doctor within 4 weeks of presenting, and 40% (25) within 7 days.

Issues influencing doctor relationships
Relationships with doctors. Two-thirds (39) of participants reported a good relationship with their doctor although they also described previous unsatisfactory experiences. Twenty-two participants described a poor relationship with their doctor, or had no regular doctor. Participants with severe asthma were significantly more likely than those with mild asthma to report a good relationship (exact test, P = 0.016) (Table 1), A poor or no relationship was reported significantly more often by patients who smoked (exact test, P = 0.012) (Table 2), and participants in this group generally reported being told by their doctors not to smoke and acknowledged that it was harmful for them to continue to do so.

What makes a good doctor? Being knowledgeable was seen as a prerequisite for being a good doctor. Pro-active
questioning by the doctor was indicative of competence (Box 1). Participants appreciated doctors signalling to them the areas that they felt were important.

“the doctor sits there and says ‘take this seriously’.” (9: male 30s, chronic severe asthma)

Participants also stated that they appreciated a doctor who would “actually sit down and listen to you” (127: female, 40s, chronic severe asthma). They also valued long-standing doctor–patient relationships:

“Doctors are like barbers, you don’t change them.” (153: male, 40s, chronic mild asthma)

Patients were often critical of the medical care received, blaming their doctors for failing to prevent an asthma attack leading to hospital presentation, particularly when they felt their personal understanding of illness was not heard.

“I did in a way blame my doctor a little bit for my last attack. Because I did go and see him two weeks before, and I said to him I didn’t feel well. . . . I thought then I should have really got something like an antibiotic or something. He said to me no, you didn’t need it.” (3: female, 30s, chronic moderate asthma)

Time constraints. A common theme was an acute awareness of other patients in the doctor’s waiting room. Participants expressed feelings of being rushed or wishing that the doctor had time to sit and listen, together with dissatisfaction about what one described as a “retail medicine philosophy” (139: male, 50s, chronic severe asthma).

“. . . you always feel the waiting room [is] full of people, just get in and out. You don’t hold him up too long you know. Got a long day as it is.” (53: female, 40s, chronic moderate asthma)

Recognition of patient expertise. Participants spoke of being able to best recognize and care for their own disease:

“I’m my own best doctor because I can tell what my body is saying to me.” (134: female, 20s, chronic moderate asthma)

Hence, they expected a doctor to be respectful of their own knowledge and experience of disease.

“. . . As just an average person, he’s someone who looks after my health. And I’m arrogant enough to think that I have some idea of what’s going on with me now.” (102: male, 30s, chronic mild asthma)

### Table 1  
Asthma severity and relationship with doctor

<table>
<thead>
<tr>
<th>Asthma severity (chronic)</th>
<th>Relationship with doctor</th>
<th>Participants total, %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good</td>
<td>Poor/no regular doctor</td>
</tr>
<tr>
<td>Mild</td>
<td>7 (44%)</td>
<td>9 (56%)</td>
</tr>
<tr>
<td>Moderate</td>
<td>6 (46%)</td>
<td>7 (54%)</td>
</tr>
<tr>
<td>Severe</td>
<td>26 (81%)</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>22</td>
</tr>
</tbody>
</table>

*Missing data for one participant with severe chronic asthma.

### Table 2  
Smoking and the doctor–patient relationship

<table>
<thead>
<tr>
<th>Do you smoke?</th>
<th>Relationship with doctor</th>
<th>Participants total, %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good</td>
<td>Poor/no regular doctor</td>
</tr>
<tr>
<td>Daily</td>
<td>5 (31%)</td>
<td>11 (69%)</td>
</tr>
<tr>
<td>Weekly</td>
<td>1 (50%)</td>
<td>1 (50%)</td>
</tr>
<tr>
<td>Less than weekly</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
</tr>
<tr>
<td>Not at all</td>
<td>31 (78%)</td>
<td>9 (22%)</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>22</td>
</tr>
</tbody>
</table>

*Missing data for one participant.
Choosing to attend an asthma doctor

Perceptions that disease experience was dismissed were likely to adversely influence the doctor–patient relationship.

“Well she [the doctor] understands I also know all about my asthma... I’ve had it all my life and I understand my asthma better than anyone else. Someone that lives with it. So if they don’t answer me the way I know they should be I won’t go back.” (37: female, 19 years, chronic severe asthma)
Content of consultations. There appeared to be a development of relationships with doctors so that those with recently diagnosed asthma appreciated education about their illness.

“...I thought it was beneficial that they suggested I get the peak flow meter...I was very interested in that chart...When you're wheezing, this is your peak flow let's say it's 500. When it falls to 350 you up your medication and you double the dose or whatever...I can't remember but I've got it written down. And when it gets to this...you need to ring an ambulance...it kind of empowers me to look after my own health...So I feel really happy, I feel that I have my medication under control.” (6: female, 50s, chronic mild asthma)

Other patients with greater experience of asthma were able to be more directive in their relationships with their doctors (Box 1):

“...I have, especially these days, I have pretty strong opinions about what I will and won't do and what I'm prepared to do. I ask for what I want and my doctor's very good. Like we discuss a lot...and then I guess we sort of reach a bit of a compromise.” (102: male, 30s, chronic mild asthma)

An extension of this theme was that some individuals confined the role of a medical consultation to providing a prescription for medication, making a value judgement on whether the doctor can add to their asthma knowledge or understanding.

“It's a pain in the arse to get a script. Excuse my French,...Just I'm only in there to get a script. Know what I need and it's just a top up.” (148: male, 30s, chronic moderate asthma)

Choosing emergency care. Participants made thoughtful choices as to where to seek care based on their perceived needs, whether prescription, care for unstable asthma or emergency care. This was predominantly based on issues of: access to care, convenience, perceptions of quality, the time it would take and the cost of care (Box 1)

“I know my GP is terrible. He's only good for prescriptions....The only reason I go to him is for a prescription and I never go to him if I'm sick....We've got a group medical centre down the road from us. I'd go to them if I was sick.” (R2: female, 40s, chronic severe asthma)

Participants were discerning in their choice of emergency care, and cost was a factor in this. For example:

“I tend to find GP's are pretty useless in an emergency situation....Normally if I'm getting major attacks they come on so quickly that you know going to a GP's an unnecessary overhead. ...” (105: male, 50s, chronic moderate asthma)

Discussion

It is frequently assumed that individuals presenting to emergency departments with asthma do not have good doctor–patient relationships, or may not even have a doctor for asthma care. Our qualitative study provides contrary evidence, showing that most people who presented to an emergency department with asthma nominated a doctor whom they saw for asthma care and nearly two-thirds (64%) of participants had seen a doctor for asthma within a month of their emergency presentation. Patients made choices informed by their experiences about where to attend for asthma care. While most patients appreciated an inquiring approach by a doctor, this was not uniformly so, and a theme was that some patients chose to attend some doctors only for prescriptions. A further theme was that patients expected doctors to acknowledge their disease experience and expectations. Doctors who really listened and who provided a clear and pro-active approach were appreciated. Patients in our study were acutely aware of other people waiting outside the doctor's door and time constraints in a consultation. Our findings would indicate that satisfaction with a doctor–patient encounter is determined as much by the patient expectations of the consultation as by the doctor–patient relationship.

Australia has a universal health care scheme, ‘Medicare’, which legislates a schedule of fees for medical services. Doctors can choose to bill the government directly (‘bulk bill’) for services rendered and receive a direct rebate of 85% of the schedule fee. Alternatively, they may bill the patient, in which case the doctor can charge an amount in excess of the schedule fee and the patient must pay the ‘gap’ between the rebate and medical bill. Currently, increasing numbers of GPs are charging above the Medicare schedule fee. Specialist consultation is provided only following GP referral and is also subsidized by Medicare, although most specialists charge more than the rebate, leaving a ‘gap’ to be covered by the patient. Public hospitals are funded independently of Medicare and provide care that is free at the point of delivery, particularly emergency care, although waiting times for non-urgent conditions are lengthy.

Our sample was drawn from people who attended emergency departments for asthma care. Although this group of individuals had predominantly severe asthma, some also had mild asthma. Consequently, we believe...
our findings apply to a broad range of people with asthma. Furthermore, our recruitment strategy ensured that a broad range of socio-economic and geographic groups was included in our sample, reflecting the demographic of the regions we recruited from and the predominance of women, as occurs in emergency room presentations for asthma.

Our study uses qualitative methodology, seeking to ascertain the range of themes important to participants rather than their prevalence. These methods, therefore, do not assume a quantitatively representative sample, but do aim to represent comprehensively the range of attitudes and beliefs held.

One problem with the recruitment methods used for the study is that we have no information on those individuals who attended their doctor for emergency care, and where subsequent hospital presentation was prevented. As this group is not represented in these results, we do not know whether this group would have a different view of doctor–patient relationships. We did not manage to recruit any indigenous Australians, nor did we specifically target non-English-speaking groups.

Our study showed that patients carefully chose where to attend for medical care, matching the care they believed was available with their own needs at that particular time. Patients chose hospital emergency departments when they felt they had acute asthma requiring emergency treatment. Our previous work in this same patient group indicated that cost is a factor in determining doctor attendance. In Australia, medical consultation may be free at the point of delivery or involve a co-payment. Participants chose between these alternatives, selecting a doctor who may provide a no-cost prescription when this was their major need, or a longer consultation.

Our findings would strongly suggest that in order to influence where patients choose to seek care, such as attempting to divert asthma exacerbations from the emergency department, the availability of appropriate care would need to be known to patients who are making choices about where to seek care and that cost would be part of this determination.

Few studies have explored the patients’ perspectives of their relationships with doctors in an open-ended fashion. Barry and co-workers qualitatively studied the dialogue occurring during general practice consultations in all age groups to ascertain patients’ and doctors’ views of satisfaction with outcomes. In this study, patients with chronic illness had different expectations from those with acute illness. Further data from the same study, in a paper by Britten, proposed that unanswered concerns regarding medication use lead to suboptimal utilization of therapy. We agree with these results regarding the importance of the patient’s concerns of effective medical consultations, and our findings would further suggest that doctors need to explore and acknowledge their patients’ personal disease experience and opinions in order to address these concerns appropriately. Whilst patient knowledge and experience is being increasingly acknowledged in the planning and delivery of health services, such understanding is not currently prominent in instructions to doctors on how to form a patient partnership.

As has been reported in previous studies, our findings support that patients appreciate a ‘preventive’ or ‘pro-active’ approach to chronic illness. Although many of our participants appreciated the doctor being opportunistic in asking about asthma when this was not the primary reason for visiting the doctor, there was a group of patients who only sought medication from a particular encounter. In this group, attention to patient requests would probably fulfill the patient’s needs of the consultation without providing comprehensive medical care. Such conflict has been identified previously by Butler and co-workers who found that patients may request treatments that are not consistent with recommended guidelines and express dissatisfaction with such consultations.

Our findings provide a strategy for doctors when placed in such a predicament. Listening and acknowledging a patient’s perspective and concerns is likely to support a good relationship despite contrary initial patient expectations.

Our findings also emphasize how commonly patients are aware of a doctor’s workload and of the patients sitting outside the consulting room door. Such awareness would suggest that doctors can use this in explaining to patients the barriers to spending more time and seek alternative times or strategies, such as asthma nurse educators, to manage these demands.

Significantly more individuals who smoked were dissatisfied with their doctor. A clear explanation for this did not emerge in the course of the interviews. Possible reasons may be that doctors ‘blame’ such patients for their asthma, thereby inadvertently treating them less well. It is also possible that patients may feel judged or embarrassed about continuing to smoke despite personal and public warnings of its dangers.

In conclusion, in this group of patients, a ‘therapeutic partnership’ was only one of several factors in determining patients’ overall evaluations of their medical care. This finding is consistent with recent publications by Mead and co-workers, who showed that GP consultation style predicted neither patient satisfaction nor enablement. Our findings lead us to urge doctors to ascertain patient’s expectations of consultations and to respect a patients’ interpretations of their symptoms and disease experiences in order to achieve a therapeutic partnership. Our findings also indicate that patient satisfaction is unlikely to be wholly determined by the attainment of a ‘therapeutic partnership’ and that a patient’s preconceptions regarding consultations may be as influential on their overall satisfaction.
Acknowledgements

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