Consent rates for video-recording general practice consultations: effect of ethnicity and other factors

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Abstract

We sought consent for video-recording general practice consultations from 260 consecutive attenders in nine surgeries. Intensive fieldwork including language support, from both the researcher and professional interpreters, was undertaken. The overall consent rate was 77.3%. No significant differences in consent rates were found between white and south Asian patients, even after controlling for age, gender and self-reported understanding of English. No differences in consent rates were found with respect to age, gender and self-reported understanding of English.

Keywords. Consent, ethnicity, video-recording.

Introduction

There is a long tradition of consultation research based upon video-recorded consultations, both in the UK and abroad.\(^1\) Consent to video-recording varies across studies: younger patients\(^2,3\) and those with embarrassing\(^2\) or overt presentations of a psychological problem\(^3\) are less likely to agree to recording. It is unclear whether patients' ethnicity influences their propensity to consent because few studies have examined these factors and whether or not they influence consent.\(^1\) No previous studies have attempted specifically to recruit members of the UK south Asian population or patients whose first language is not English. One recent Dutch study has reported the recruitment to video-recording in general practice of 48 children and the parents from “ethnic minority groups,” defined as either the child or at least one of the parents being born in a “non-Western country,” with a 64% recruitment rate.\(^4\) There is some evidence to suggest that south Asians are excluded from research because of language difficulties.\(^5\) The aim of this paper is to explore whether ethnicity and other factors influence patients' consent to video-recording.

Methods

We undertook the study in nine general practices across West Yorkshire. Professional NHS interpreters were used in one practice that had significant numbers of patients speaking Pahari (Punjabi dialect). White and south Asian patients consecutively attending their GP were asked if they would participate. Patient information sheets and consent forms were available in the community languages. Biographical data were collected from all of those willing to speak with the non-clinical researcher who was fluent in Punjabi/Pahari and Urdu, who then sought consent. Self-reported data relating to understanding of ordinary everyday English (i.e. “fluency”) were sought on a 5-point scale ranging from “very good” to “very poor”. Responses of “very good,” “good” and “average” were grouped together, as were “poor” and “very poor” (full details from the authors). Chi-squared tests were used to compare consenters and non-consenters on categorical variables (sex and ethnic group), and *t*-tests were used for continuous variables (age). Logistic regression was used to control for potentially confounding variables (age, sex, ethnicity and fluency).

Results

Consent was sought from 260 patients from nine practices, consulting with 11 different GPs. A total of 201 (77.3%) patients provided consent for video-recording, and recordings were subsequently made for all but 18 of these (due to technical reasons). One hundred and ten
were of UK/Irish descent, two “other white Europeans,” 75 Pakistanis, eight Bangladeshis, two Kashmiri, one Indian, one “other” and two data missing. The factors associated with providing consent are shown in Table 1. This shows that none of the variables was distributed differently between those who provided consent and those who did not. There was no significant difference [chi-squared = 2.16, df(1), \( P = 0.142 \)] in the consent rate between males (83%) and females (75%). There was no significant difference (\( t = 0.770, \) df = 245, \( P = 0.442 \)) in age between those who consented, and those who did not. There was no significant difference [chi-squared = 2.89, df(1), \( P = 0.089 \)] in the consent rate between the white patients (82%) and the south Asians (74%), even after controlling for age and sex [odds ratio (OR) 0.68, 95% confidence interval (CI) 0.34–1.33, \( P = 0.255 \)]. Further controlling for understanding of English (fluency) showed no significant difference (\( P = 0.055, \) OR 0.273, 95% CI 0.73–1.21). After including all the variables in a logistic regression equation, none of the factors were significant in explaining consent.

Conclusions
This is the first paper to report consent rates for video-recording of consultations by ethnic group, and shows that in our sample ethnicity did not appear to influence consent rates. However, the combination of the finding that there was an 8% difference in consent rates between white and south Asian patients, and the relatively low power of the study, does suggest that a larger study is needed in order to be more definitive about the influence of ethnicity on consent rates for video-recording. In this study, intensive fieldwork with language support may have helped to promote consent rates in our recruitment, since the overall consent rate was high.\(^4\) We cannot comment on the potential confounding effect of clinical problems since we did not collect morbidity data. Our findings suggest that researchers should be encouraged to include south Asians in studies using video-recording of consultations, as should educators and learners recording consultations in general practice settings.

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References