

The value of choice: a qualitative study

Julie Barnett, Jane Ogden and Emma Daniells

ABSTRACT

Background

Providing choice in health care is part of an ongoing policy initiative.

Aim

To explore how people understand choice in healthcare provision.

Design of study

A qualitative study using semi-structured interviews.

Setting

South East England.

Method

Twenty-two people were interviewed about the issue of choice in general, and choice in healthcare in particular. Data were analysed using template analysis.

Results

Participants discussed choice in the NHS within the context of the GP consultation. Four main themes about choice were identified: positive aspects of choice; the appearance of choice; unwanted choice; and the role of information in choice. Participants valued choice in principle, and having choice was seen as positive. However, the provision of choice options was not always associated with the possibility of meaningful choice. Participants expressed that in some instances they were given the appearance rather than the substance of choice. Making — as opposed to having — choice was often unwanted and considered as indicative of erosion in trust in the GP. Information was seen as a necessary, but not sufficient, prerequisite of informed choice.

Conclusion

People value having choices rather than making choices but are concerned about choice provision for its own sake rather than choice that is available in a meaningful way. Health care policy that recommends an increase in choice per se may be met with scepticism which could ultimately undermine, rather than promote, the doctor–patient relationship.

Keywords

choice; primary healthcare; qualitative research.

INTRODUCTION

Extending consumer choice from the private to the public sector has been a key part of the government's modernising agenda.¹ In 2004 the Department of Health explicitly located choice as a mechanism for improving health.² Policies have been developed to embed patient choice across a number of areas of healthcare provision including the Choose and Book referral service,³ and patients are now given a choice of hospital.⁴ There is a commitment across political parties to extend the choice agenda,⁵ and the value of choice is largely considered as self-evident: 'Who could argue against the desirability of allowing patients more say in decisions concerning their health?'.⁶

Much research, particularly within the social sciences, emphasises the positive consequences of choice, such as enhancing enjoyment and task performance and producing more positive outcome evaluations (see Botti and Iyengar⁷ for an overview). Such benefits seem to occur even when choice is illusory.⁸ In contrast, Schwartz⁹ in *The Paradox of Choice* drew attention to some of the negative consequences of choice in everyday life and suggested, for example, that a proliferation of options can render consumers anxious and overwhelmed. Similarly, Iyengar and Lepper¹⁰ reported that many choices can result in decreased motivation to choose and lowered satisfaction. Research also indicates that the impact of choice may be especially negative when the psychological consequences of choosing are heightened,⁷ and that the benefits of choice may be culturally specific.¹¹

J Barnett, PhD, senior research fellow, J Ogden, PhD, professor in health psychology; E Daniells, MSc, research assistant, Department of Psychology, University of Surrey, Guildford.

Address for correspondence

Dr Julie Barnett, Department of Psychology, University of Surrey, Guildford, GU2 7XH.
E-mail: j.barnett@surrey.ac.uk

Submitted: 27 March 2008; **Editor's response:** 19 May 2008; **final acceptance:** 9 July 2008.

©British Journal of General Practice.

This article was originally online first. Cite this article as:
Br J Gen Pract 2008; **58**: 609–613. Advance online publication.
DOI: 10.3399/bjgp08X330717

How this fits in

Providing choice in health care is a key part of current policy initiatives. Research highlights the possible negative impacts and the benefits of choice. This qualitative study explores how people understand choice in healthcare provision. Overall, people are positive about having choice but only if the choices offered are meaningful. Participants were sceptical of patient choice as a political box-ticking exercise for GPs. They are less positive about making choices. Patients' trust in the choice provider may be undermined by provision of choices that are considered meaningless, and in instances when patients consider choice to be a burden.

In terms of choice in the context of health care, research remains limited. For example, one market-research study explored public preferences for choice in 'out of hospital care',¹² and emphasised the importance of tailoring choice-related policies to the needs of particular groups. More recently, a quantitative study explored the impact of choice on patient outcomes.¹³

Although choice remains central to the contemporary healthcare agenda, an understanding of how choice is perceived in the context of health care remains limited. The present research used a qualitative design to provide preliminary insights into the ways in which people understand choice in health care in the UK. This report forms the basis of the subsequent paper published in this journal which aimed to develop a new tool to assess patients' beliefs about the value of choice.¹⁴

METHOD

Participants

Following advertisements placed in and around the University of Surrey, 22 participants working in administrative, ancillary, and research jobs at the University took part in the study. They were selected to form a reasonably heterogeneous sample in terms of age, sex, and ethnicity. Fifteen were female and seven were male; 17 described themselves as 'white', three described themselves as 'mixed' ethnicity, and one as 'other'. The sample ranged in age from 18 to 63 years with a mean age of 39.9 years. Some participants had experienced a serious illness which

had resulted in them having more experience of healthcare services.

Design

The study used in-depth semi-structured interviews. All participants consented to the interviews being recorded. Full transcripts of each interview formed the basis of the analysis.

Interview schedule

Participants were initially asked about how they thought about choice in their everyday lives. They were then asked to consider choice in relation to health care, and were prompted to consider this in relation to their own experiences and those of friends and family. Prompts were used where necessary to encourage exploration of the main questions (Table 1). All interviews were anonymised and each participant was given a pseudonym.

Data analysis

Template analysis was used to analyse the interview data:¹⁵ this is a type of thematic analysis. The emerging template depicts relationships between the themes in a way that is meaningful and useful. The themes that are identified and the way in which these are aligned within a template are not simply 'uncovered'; they are partly a product of the preoccupations and perspectives of the researcher.

Initially, all transcripts were read without comment. On second reading, sections of text that seemed to have a bearing on the aims of the research were noted and the essence of these was logged. This was done for the first five interviews. At that point, a set of themes both within and between interviews was identified, and an early template depicting the way in which these themes related to each other was proposed. Analysis of the remaining interviews was aligned with this initial template and themes were added, deleted, subdivided, and reassigned as applicable. Nothing in the template was changed in response to the material provided by the final three interviews. Results from this analysis were used to inform the development of a new tool to measure people's beliefs about the value of choice.¹⁴

RESULTS

There was a clear awareness of the choice agenda in health care, although not all participants felt they had had occasion to exercise choice themselves. Choice was primarily discussed in the context of the consultation with the GP. Participants' discussion of choice of hospitals or consultants was discussed with regard to the primary care consultation environment and to experiences of diagnosis and treatment in this context.

Table 1. Interview questions.

- ▶ Do you feel that you have had choice in the area of health care?
- ▶ How does it feel to have choice/no choice in this area?
- ▶ Would you like more or fewer choices in this area? Why?
- ▶ Can you give me an example of choice-making in this area, and tell me what happened?

Four main themes were discussed in relation to choice in health care: positive aspects of choice; the appearance of choice; unwanted choice; and the role of information in choice. The distinction between having and making choices was applicable to these four themes which are outlined below.

Positive aspects of choice

Participants expressed that they considered the principle of choice to be important. This was primarily expressed as concern about the implications of choice being removed or unavailable:

'I think choice is always a positive thing, yes, I don't like not to have a choice'. (Fiona)

Choice was desired (that is, its erosion was resisted) primarily because choice allows the expression of autonomy and efficacy. This general theme was carried through into the domain of health care:

'You feel empowered if you've got a choice. So I think that's the most important thing. And I think if you're a reasonably intelligent person you should be given the facts and be able to make your choice'. (Victoria)

Participants perceived that the healthcare consultation was often structured by the GP in terms of providing choice; this was generally welcomed. People felt this indicated that the GP had been mindful of their perspectives and had acknowledged their validity. The provision of choice signalled the autonomy of the patient and implied that the patient was able to weigh up options and be active and capable in the management of treatment or illness:

'That's right, yes, because you, when you have a life-threatening disease, you kind of have lost a bit of control in your life and you, and people don't like not to be in control. Well I certainly don't, so it did give you a little bit of control back, at least you had some control, because you had no control over how ill you felt or anything and your life was really controlled by your treatments, and it's 6 months so it did give you some kind of choice, gave you a bit of control'. (Fiona)

Providing choice was also valued insofar as it gave the possibility of expressing preferences that were not strictly based on medical criteria; for example, being able to choose to see a specialist who has a 'warm demeanour' (this kind of information could be gleaned through other patients or support groups).

Across all interviews, choice was not considered to be simply the provision of options, but also people

wanted to be able to query GP judgements, express preferences and, if necessary, highlight factors that they felt should be taken into account. There was also some evidence that 'choice' was invoked as a desirable model for health care as a reaction to general dissatisfaction with the outcomes of previous encounters with the healthcare system.

The appearance of choice

Although people emphasised choice as positive, many also differentiated between the appearance, rather than the substance, of choice. There were two ways in which this theme was exemplified. First, it was clear that, to some extent, participants perceived the existence of choice from interpersonal cues provided in the GP consultation. For example, a willingness to answer questions, not to withhold information, and to indicate interest in the patient's perspective was, to a large extent, considered synonymous with the provision of choice. A good doctor-patient relationship was equated with a primary-care environment that facilitates choice. Similarly, offering choice was seen to signal promising qualities of the doctor-patient relationship:

'If he offered choice to me that is good. I don't care whether the choice [he] offers is good or not. He offered me a good sign [that] he is reliable'. (Adrian)

Second, the appearance of choice was emphasised with participants stating that the choice must be meaningful. For example, simply being presented with the option of a specialist appointment with different consultants is a meaningless choice if there is no relevant information about those consultants as a basis for that choice:

'Say if I was ill and there's a choice of three consultants, if they just said you can see this person, this person, or this person, then it wouldn't mean anything unless they said this person is a specialist in this and this person has worked for 10 years. Unless you got all the information then your choice isn't informed ... You might as well just be given anyone and had the choice made for you'. (Laura)

This theme of the appearance of choice is linked to a perception that the issue of choice is, to some extent, a politically driven box-ticking exercise, where offering options is the end rather than a means of facilitating meaningful and substantial choices. If such options were perceived as negligible, in terms of actual choice, this had the effect of undermining both the perceived mutuality of the preceding discussion

and confidence in the doctor–patient relationship.

Unwanted choices

The third theme focused on circumstances where choice was unwanted, which is surprising given current policy initiatives in this area. The healthcare consultation was often considered to be structured by the GP in terms of providing choice. The unwanted dimension of choice did not relate to having choice (that is, to discussing a range of options), but related to the suggestion that the patient should be active in making choices.

People primarily chose to illustrate this resistance to the exercise of choice in relation to decision making around serious conditions. Patient choice in these instances was seen as a way of potentially weakening or threatening patients' faith in the expertise of the doctor at a time when they were most reliant upon it:

'Well I have had a quite serious illness. I had breast cancer. And I had it a couple of times and it was, um, quite a serious situation at some stage. And I don't think I was actually looking for choices then. I think I was, I put myself in the hands of somebody that I thought I could trust. And I don't think I was, I don't think I wanted to make choices then. I wanted somebody else to make them for me, really ... I think when it reaches a serious situation, then the last thing on your mind is choices. You just want somebody else to make the decisions for you and tell you what they think is best for you.' (Sue)

One reason for avoiding a leading role in making choices was to avoid regret:

'I'd rather someone chose for me to be honest ... I think I'd rather blame someone else than blame me, so ... ' (Laura)

For some participants, the idea of being invited to make choices about treatment options seemed to underplay the importance of the decision. Given the magnitude of the problem, it was believed that GPs should lead the process of making choice in line with their expertise and experience.

Information and informed choice

The final theme related to the role of information in enabling choice. Acquiring information is vital for informed consideration and investigation of choices and options. However, many participants suggested that information provided by GPs was inadequate to inform consideration of their options. Information was considered to be inadequate, not necessarily because the information was unavailable, but

because there was too much information to process and to consider. Dissatisfaction with information provision also related to recognition that information (for example, in relation to particular hospitals) would be partial and self-serving:

' ... I can't imagine the X casualty department booklet looking like it does there. It won't. So booklets do lie and, it's just ... How do I know that another hospital's better? You see, I don't. So how can I possibly have the choice?' (Jenny)

DISCUSSION

Summary of main findings

Results from this study indicate that choice is valued in principle and is welcomed by most people. However, the way this works in practice was questioned on a number of levels. A key distinction was illustrated between the value of having choice and making choice. Generally, people valued having choice which was seen as central to their autonomy and were concerned about having their choices taken away. Participants were sceptical about the provision of choice for its own sake, rather than provision of choice in a meaningful way.

Participants were less positive about making choices. Several of them emphasised the need to consider the implications of choice for the trust placed in GPs and confidence in their expertise. Information, though necessary, was by no means sufficient for informed choice. In general people believed that having choice, as long as it is real, enhances a sense of autonomy and self efficacy. In contrast, they believed that primary responsibility for making of choices resides with the GP and that this does not detract from the autonomy gained from the provision of choice in the first place.

Strengths and limitations of the study

There are a number of limitations that need to be addressed. First, this study used a qualitative design and, therefore, had a small sample size. Although this limits the generalisability of the findings, it did enable an exploration of people's detailed and close reasoning around the provision of choice in health care. This is of particular importance given the limited research in this area and the need to explore how lay people operationalise choice. Second, participants in this study were not selected in relation to their health status. It would be useful to conduct further qualitative and quantitative research (ideally longitudinal); for example, examining patients diagnosed with what are likely to be long-term health conditions or those who are currently making choices about their health care. Third, the sample was somewhat skewed towards those who were white and working in a university

environment. Recent research indicates that beliefs about the value of choice are linked to measures of social class.^{13,14} Future research using a quantitative approach could assess the views about choice from a wider sample of the population.

Comparison with existing literature

The value placed on choice and the reluctance to have choice taken away reported in the present study is in line with both current policy initiatives that provide choice within the NHS¹⁻⁶ and research highlighting the benefits of choice.^{7,8} In contrast, the results also provide support for suggestions that choice can at times be unwanted.^{9,10} These contradictory findings may be due to the kind of choice being assessed, and the kind of choice may correspond with participants having and making choices as reported in the current study. Results indicate that, while having choice was valued (as long as it was meaningful), making choice was seen as the domain of the healthcare provider. This distinction between having and making choices supports recent discussions in the literature concerning the nature and value of choice.¹⁶ This distinction also provides a basis for the subsequent paper published in this issue which further develops the difference between having and making choice.¹⁴ However, this distinction is somewhat at variance with the policy initiatives in this area.¹⁻⁶

Implications for future practice and future research

The current results indicate that future studies are needed to address the value placed on choice within a wider population. Research should explore the beliefs and experiences of those who vary in terms of a number of relevant factors, such as healthcare experience, current and past health status, education, and ethnicity. Research could also assess the beliefs of those who are currently in the process of making choices and observe how these beliefs change as the decision-making process develops.

The current results also have implications for policy. In general, participants valued having choices but were concerned about choice provision for its own sake, rather than choice from a range of meaningful options. Therefore, healthcare policy should continue to offer choices; however, an increase in choice per se may be met with scepticism if it is perceived as a political box-ticking exercise for GPs. People were less concerned about making their own choices. Therefore, policy and healthcare practice that places responsibility for choice making onto patients may be giving them an unwanted extra burden at a time when they are at their most vulnerable.

The current results have implications for consultations. The current primary care climate has

two aims: to include patients in the decision-making process while maintaining trust in the medical profession. By creating scepticism through the 'pretence of choice' and placing the burden of choice onto the patient, the contemporary emphasis on patient choice may achieve the former aim while undermining the latter. If the choices offered are seen as meaningless or the act of making choice is unwanted, this may undermine the trust placed in the medical profession.

Funding body

ESRC RES-000-22-1658

Ethical approval

University of Surrey Ethics Committee (ES/2006/83/PSYCH)

Competing interests

The authors have stated that there are none

Acknowledgements

We would like to acknowledge the support of the interviewees who took part in this study.

Discuss this article

Contribute and read comments about this article on the Discussion Forum: <http://www.rcgp.org.uk/bjgp-discuss>

REFERENCES

1. Cabinet Office. *Modernising government*. London: The Stationery Office, 1999.
2. Department of Health. *Choosing health: making healthy choices easier*. Department of Health, 2004. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550 (accessed 24 Jul 2008).
3. Department of Health. *'Choose & book': patient's choice of hospital and booked appointment: policy framework for choice and booking at the point of referral*. London: Department of Health, 2004. <http://www.dh.gov.uk/assetRoot/04/08/83/52/04088352.pdf> (accessed 24 Jul 2008).
4. Department of Health. *Choice of hospital: guidance for PCTs, NHS trusts and SHAs on offering patients choice of where they are treated*. London: Department of Health, 2003. <http://www.dh.gov.uk/assetRoot/04/07/54/12/04075412.pdf> (accessed 24 Jul 2008).
5. Appleby J, Dixon J. Patient Choice in the NHS. *BMJ* 2004; **329**(7457): 61-62.
6. Appleby J, Harrison A, Devlin N. *What is the real cost of more patient choice?* London: The King's Fund, 2003.
7. Botti S, Iyengar SS. The psychological pleasure and pain of choosing: when people prefer choosing at the cost of subsequent outcome satisfaction. *J Pers Soc Psychol* 2004; **87**(3): 312-326.
8. Langer J. The illusion of control. *J Pers Soc Psychol* 1975; **32**(2): 311-328.
9. Schwartz B. *The paradox of choice: why more is less*. New York: HarperCollins, 2004.
10. Iyengar SS, Lepper MR. When choice is demotivating: can one desire too much of a good thing? *J Pers Soc Psychol* 2000; **79**(6): 995-1006.
11. Iyengar SS, Lepper MR. Rethinking the value of choice: a cultural perspective on intrinsic motivation. *J Pers Soc Psychol* 1999; **76**(3): 349-366.
12. Pfizer/MORI. Health choice index: public opinion on choice in out of hospital care. 2005. <http://www.ipsos-mori.com/content/polls-05/pfizermori-health-choice-index.ashx> (accessed 28 Jul 2008).
13. Ogden J, Barnett J, Daniells E. When is choice a good thing? An experimental study of the impact of choice on patient outcomes. *Psychol Health Med* 2008. In press.
14. Ogden J, Daniells E, Barnett J. The value of choice: development of a new measurement tool. *Br J Gen Pract* 2008; **58**(554): 614-618.
15. King N. Template analysis. In: Symon G, Cassell C (eds). *Qualitative methods and analysis in organizational research: a practical guide*. London: Sage Publications, 1998.
16. Bryant LD, Bown N, Bekker HL, House A. The lure of 'patient choice'. *Br J Gen Pract* 2007; **57**(543): 822-826.