



## NHS Direct: Patient Empowerment or Dependency

E·S·R·C  
ECONOMIC  
& SOCIAL  
RESEARCH  
COUNCIL

# RESEARCH FINDINGS

### KEY FINDINGS

NHS Direct was established in the late 1990s and designed to provide patients with both easy access to medical advice and to empower them via self-learning. There was also an expectation it would be cost-effective and reduce demand on other parts of the NHS.

This project sought

To understand how it is both used by and meet the needs of different social groups?

To develop an analysis of when people use the service and when or how the advice, information and reassurance they receive is used.

To ascertain whom callers see as accountable for the advice given and action taken, how this impacts on trust and confidence in the service its implications for patient empowerment?

- **Joint Production of Health:** The service provided by NHS Direct is based on shared understandings and is jointly produced between the caller and professional. Hence the need to establish trust and develop shared understandings is paramount. Our work shows that at least three types of misunderstandings may arise (1), the character of the service (2), patients' symptoms, and (3), the advice that nurses' offer.
- **Nursing versus Computer Expertise:** A key innovation within NHS Direct is the use of computerised decision support software known as CAS. CAS is used differently to how its use is envisaged by designers. This is a response to the joint production of the service which encourages the departing from organisational routines.
- **Quality, Quantity and Users:** A conflict exists between answering as many calls as possible and spending time with callers. Caller interviews suggest the same individuals expect to use the service in different ways thus there is no simple search for empowerment or the simple creation of dependency. Again, time, shared understandings and trust are key.
- **'Unusual' Users:** Young parents and men use the service more than one would perhaps expect.
- **The assumptions made about individuals within Reflexive Modernity/Risk Society debates appear flawed.**

#### RESEARCH TEAM

Professor Gerard Hanlon, University of Leicester

Jackie Goode and Professor David Greatbatch, University of Nottingham

Dr Donna Luff and Alicia O'Cathain, University of Sheffield

Dr Tim Strangleman, London Metropolitan University

In collaboration with  
and co-sponsored by



## Shared Understandings and Joint Production

Areas of Misunderstandings:

### 1. NHS Direct Service

Callers' expectations may be at odds with what is officially on offer and/or the expectations of particular nurses. For example, callers may expect a diagnosis, whereas nurses restrict themselves to triage (although there is often a fine line between allocation/triage and diagnosis/consultation). Or callers may contact NHS Direct with a range of aims that may not be immediately apparent to nurses: e.g. double-checking the explanations/actions of other medical professionals, etc.

### 2. Symptoms

Problems may arise regarding the character, location or effects of patients' symptoms. For example, nurses and patients may experience difficulties achieving mutual understanding with respect to the sensations patients say they are experiencing. Such misunderstandings may arise because the descriptors people use for their symptoms do not have fixed meanings. Additionally, callers' understandings of human anatomy may differ from those of nurses, and may vary from one caller to another.

The possibility of misunderstandings between nurses and callers arising is perhaps increased in the context of telephone triage due to the fact that the nurses cannot see or touch patients. In face-to-face interaction medical professionals rely heavily on sight, touch and gesture. On telephone professionals work on the basis of what they are told and, in some cases, paralinguistic phenomena such as tone of voice, breathing patterns, etc.

Nurses must also evaluate the patients' descriptions and understandings of their conditions e.g. does a patient exaggerate

their level of pain or are they characterising it incorrectly. (Note also that people may use the same descriptors - e.g. burning, sharp, stinging and the like - to describe different sensations.)

### 3. Advice/Information

When nurses offer/relay advice or information the question arises as to whether patients understand the advice/information and its implications. In some cases patients respond in ways that display their understandings of advice/information. In others, however, their responses merely assert that they understand. Such assertions of understanding can mask interpretations of advice/information that may be problematic when viewed from the nurses/NHS Direct's perspective.

## Nurse Versus Computer Expertise

As stated in the bullet point findings, sometimes the nurses diverge from the technological and organisational procedures. This leads highlights a number of issues e.g. trust, professional autonomy, individualised services, standardisation, etc which are central to the service. At the heart of these is a contradiction. The government has called for greater individualised health services and yet in this new area of healthcare there is a policy of using CAS to standardise provision. At the core of this standardisation is the assumption that the protocols in CAS can account for every eventuality. However, as numerous studies on the social application of technology have demonstrated, such an outcome is simply not possible. This is especially true in an area such as healthcare where a caller may be asking an elderly relative or child to interpret what is happening to their body and then interpreting this interpretation for a nurse, who then has to interpret (again) the meaning. If a shared understanding (and thus trust and possible empowerment) is to emerge, the nurse has to retain greater

flexibility than the system currently allows. It is only by doing so that the system can function. This innovation enables nurses to provide an individualised, tailored service and to deal with the variety of calls that come in from people with a diverse set of backgrounds, knowledge and understandings of their own bodies and healthcare requirements. In short (from the nurses' view) it allows them to better meet caller needs.

Such flexibility runs into conflict with the government desire to control and manage risk. This desire drives the urge to standardise the service. Given media scares about the 'risks and inconsistencies' within NHS Direct, this desire is perhaps understandable if debilitating. The service needs to balance its trust in nurses to make independent decisions and the need to minimise risk. Indeed, perhaps the two are not in conflict trusting nurses may be a way of minimising risk.

### **A Complex Engagement with Health and the Ahistorical Nature of Reflexive Modernity**

The project has produced evidence to query the central claims of the risk society/reflexive modernisation thesis. The key questionable claim is not that people are reflexive or that they are active agents. Rather, it is how new all of this is? Our research suggests it is not new and some of the key novel elements e.g. the questioning of expertise and undermining of experts, are more complicated than suggested in the thesis. What the research seems to show is that people engage with their health a key part of the reflexive project in a complex manner. They are 'traditional' in their dealings with expertise, they treat health expertise not as something objective or alien to them but as something they can comment on, assess and make useful to themselves in ways that Beck and others do not allow for. Added to this, they are sceptical of and active in their engagement

with the NHS they have views on its pressures, they perceive that its experts work in a constrained environment, etc. and this shapes their treatment of expertise expertise is assessed subjectively to some extent, it is not 'out there' or alienated. In short, they locate expertise in a social context rather than see it as something objective.

There is historical research to suggest people have always behaved this way. Individuals have always been active in terms of their health. To seek or not to seek medical advice is itself sometimes an active decision, to be passive or not within a consultation can often be interpreted as a reflexive and active decision. Our work suggests people use a number of strategies in their engagement with the health service and that these are often reflexive. However, this is not 'radical doubt', nor the questioning of expertise. Rather, it is an understanding of the environments health professionals work in, a building of shared understandings and trust and an active pursuit of strategies that will result (or not) in the healthcare sought after. This is not to say that all are equal in this pursuit clearly they are not. Some groups appear to be more active and empowered in their use of NHS Direct than others e.g. parents use it more than the elderly, middle class professionals appear to use it more than others, etc. What our work suggests is that reflexive modernity is not operating in the way some would suggest, nor is it new. However, we are not saying that nothing has changed, rather we are arguing that things may have altered but not in the ways theorised thus far. One of our tasks is to develop these theories over the next year.

An interesting feature of our methods was the way reflexivity emerges. Our CA largely demonstrates a 'traditional' passive role within the professional-caller interaction, whilst our interviews highlight a more active 'memory' of the call and the placing of the

call within a 'strategic' engagement with the NHS. It seems the different data highlight different ways of engaging. On the one hand people appear passive even though they may be questioning the advice of a professional they met previously - whilst, on the other hand, the interviewees talk about an active negotiation with the NHS. Thus reflexivity in health appears not to be the active questioning of experts but rather a mix of active/passive, questioning/acceptance and of placing health in a social and subjective context.

## About the Project

This project examines how people use NHS Direct's provision of professional medical advice. It is hoped this service will encourage self-learning and allow individuals to take greater responsibility for their health. Such a process may be fraught with complications because research indicates that individuals use the welfare state in very traditional ways and often expect it (and not them) to take responsibility for their problems. Such views may colour how people engage with NHS Direct. At the very least, individuals will bring with them attitudes and perceptions of the service, themselves, medical professionals and so on which will help to shape the service.

To repeat, our central questions were

- How is NHS Direct used by, and how does it meet the needs of different social groups?
- How do people use the advice, information and reassurance provided by NHS Direct and does this coincide with what NHS Direct anticipates?
- To discover who callers feel is accountable for the advice given and action taken and how these views impact on trust and confidence in the service.

Research suggests callers help to shape the service provided through their understanding of their own bodies, their education, their ability to challenge or reaffirm professional authority, etc. This knowledge helps to structure the nature of advice given, people's satisfaction with the service, and their ability to engage in self-learning. It seems that the shaping of the service plus people's understanding of themselves and their ability to demand information and advice and to take responsibility for their own well being are ongoing and reflexive processes. For example, as people become more knowledgeable or sceptical about the service they modify their interaction with it, hence reshaping the nature of the service. In short, people's experience structures their interaction with NHS Direct thereby moulding it. This in turn colours their experience of it in an ongoing process.

Our research aims to examine how people engage with NHS Direct through the use of conversational analysis (CA) and semi-structured interviews. We analysed transcripts of 120 calls. Using CA techniques we mapped how people use the service, if they challenge or reaffirm professional authority, demonstrate understanding or merely assert it and so on. Our interviews also allowed us to analyse how much responsibility they are prepared to take for their well-being, how they reflect on the consultation process and NHS Direct, whether or not they feel they have learned from the process, whether they feel empowered or disempowered, and when they would and would not use NHS Direct. Analysing both data sets paint a picture about how callers use NHS Direct, what they use it for, whether or not they learn from it and how they actively help to jointly produce the service.

**For further information contact:**

**Professor Andrew Webster, IHT Programme Director**

**Department of Sociology, University of York, Heslington, York YO10 5DD**

**Tel: +44 1904 43 3064/4740 ♦ Fax: +44 1904 43 4702/3043 ♦ E-mail: [iht@york.ac.uk](mailto:iht@york.ac.uk)**

**Web site: <http://www.york.ac.uk/res/iht/>**