SCIENTIFIC LETTER

Audiotaping the heart surgery consultation: qualitative study of patients' experiences

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Opinion as to whether to offer patients an audiotape of their health care consultation is sharply divided. Following the Bristol Inquiry, the Kennedy report¹ recommended that tape recording facilities should be provided by the National Health Service. The Department of Health² rejected this on the basis that “it could undermine the relationship of trust between patient and health care professional”. The Society of Cardiothoracic Surgeons thought the proposal was of “doubtful practicability”.³

We found no evidence base within cardiology or cardiac surgery to support the use or otherwise of audiotapes. Existing research examining the effects of audiotaping is almost exclusively within oncology, and suggests that the use of recordings is probably helpful to most people with cancer, but not all. The evidence for its effectiveness, however, is currently weak, uncertain, and limited to a small number of studies.⁴

We report the findings from the qualitative component of a pre-protocol pilot for a randomised controlled trial, to evaluate whether there are benefits to prospective heart surgery patients in providing a recording of their heart surgery consultation. In contrast to previous research, where findings on use of audiotaping have come only from intervention groups in trials, we included the perspectives of those without access to a recording.

METHODS

Fifty four consecutive patients, newly referred to GC, were sent information inviting them to join the study (May to November 2002); of these, 22 replied. JD saw patients before their surgical consultation and obtained written consent and demographic information. We aimed to recruit 20 patients. One patient was excluded because they could not read or write English. Of the remaining patients, the first 20 to reply were recruited and randomised according to a computer generated code: 10 patients received a tape (tape arm), and 10 patients did not (no tape arm). Allocation was kept in a sealed envelope. Ethical approval was obtained for the study.

The surgical consultation was conducted in accordance with GC's usual clinical practice, including a logical sequence of information provision covering key areas. GC (blind to patient allocation) turned two tape recorders on at the beginning of each consultation, leaving them running throughout. One copy was retained and later transcribed. Each patient was seen post-consultation by the outpatient nurse, given an information booklet, and informed they would be invited to pre-operative information sessions. The patient then met with JD, who opened the envelope and informed the patient as to whether they were in the tape arm, in which case they were given a recording to take home, or the no tape arm.

Approximately six weeks post-consultation, ML, a clinical psychologist, conducted semi-structured individual interviews with 10 patients who had received a tape, and nine who had not (one patient withdrew because of illness).

Interviews lasted 30–80 minutes, were audiotaped and transcribed. ML studied the transcripts and identified emerging themes. Examples of data that contradicted emerging themes were sought out, examined, and incorporated into the overall conceptual analysis and interpretation.⁵ Coding and interpretation was discussed with VB, who read all transcripts and validated the themes. ML undertook an initial content analysis of each surgical transcript.⁶

RESULTS

Surgical consultations lasted between 9–33 minutes. Fifteen patients were placed on a waiting list for cardiac bypass surgery, two patients for valve replacement, and one patient for both procedures. Intervention was contraindicated for one patient. Content analysis verified that GC had provided each patient with information within each identified key area.

The majority of patients (8/10) listened to their tape; seven found having the tape of positive benefit, while one “didn't feel it made a difference”. Of the nine patients without a tape, seven were disappointed. Thematic analysis identified four key areas of concern for patients regarding information experience. In each of these areas, access to a recording was found to be of actual or potential value (table 1). The qualitative approach highlighted individual differences in recall needs and in the use and meaning of the tape. Playing the recording was not a neutral undertaking. Two patients chose not to listen to their tape, and the anticipated impact of hearing the consultation may have played a part in their decision making—for example, one patient said he would “be embarrassed to hear my own voice”.

DISCUSSION

Our findings are in accord with studies of patients with cancer. The majority receiving a tape found it of value, while most without a tape felt they had missed out on an opportunity to improve their information experience.

An unexpected finding was the importance some patients attach to having an accurate record of their own contribution to the consultation. Some patients reported difficulties with understanding and/or recall of risk information. Communicating risk information is a key problem area. Doyal⁷ argues that for competency to consent “patients must be... able to understand, remember, deliberate about, and believe clinical information”. We found patients describing ways in which they had used, or would have liked the opportunity to use, their recording to assist them in these tasks.

Uptake to the study was lower than anticipated and investigation is required to determine whether this is a reflection of patient attitudes towards audiotaping. We are also not able to assess whether the process of audiotaping, or trial participation, altered patient behaviour within the consultation or impacted on subsequent reflections on consultation experience/audiotaping.

Table 1 Results of thematic analysis

Patient information concerns	Illustrative quotations from interview transcripts		Identified functions of audiotape
	Patients without access to tape	Patients with access to tape	
Difficulty taking in information or fear of missing information	"As somebody explains to you 'this is a life threatening procedure'...you start to go in your mind very fast, and you're not listening to what the guy's saying to you..." (Pt T)	"You're trying to take everything in...but there could be one thing, you know, that you've missed. So it was nice to have the tape..." (Pt L)	Fills gaps, enables patients to take in information as and when ready
Understanding information, including risk information	"Some of the things he said I didn't fully understand... He said something about 'you could have a heart attack or you could have a stroke'. Now I didn't quite know whether he meant if I didn't have the operation I could have a heart attack or stroke – or I could have a heart attack or stroke having the operation... He wasn't very clear." (Pt A)	"He explained the types of risks and fatalities he had, you know, percentages, and such things... Talking about it straight away through the interview, I was a bit up and down my understanding level, but when I got home and put the tape on I got more understanding from it, which made me a bit more comfortable..." (Pt P)	Enables patient to revisit and process information and clarifies whether further information required
Difficulty with recall of "one off" consultation	"I can't remember half of what he said. If I'd got a tape I'd be clearer in my mind" (Pt D) "That's the way I think it happened...he might not have said it that way at all. A tape would put your mind at rest" (Pt M)	"When we got home you'd be thinking, oh, what did he say about warfarin?... I can always put the tape on and listen again" (Pt L) "All I listened for, to see if it was exactly the same as it were put over" (Pt S)	Enables patient to "re-hear" consultation, provides an exact record of the two way dialogue that can be revisited over time
Difficulty with recall of two way dialogue	"Disappointed not to get a recording because after a couple of weeks you've forgotten everything you said and that he said" (Pt I)	"I listened to it just to know what I had said and what Mr (GC) had said to me. As I'm getting older I'm getting more forgetful" (Pt F)	
Communicating to others	"It's hard when you come home, 'What's he said?' and you can't remember..." (Pt Q)	"The tapes are very handy for me to let my wife know...what I might have said wasn't what really happened, so she now knows what really happened at the interview" (Pt R)	Exact record can be shared with family, friends and others

While the findings from this exploratory study cannot be generalised, they add the perspectives of a group of prospective heart surgery patients to the audiotape debate. The results are promising and suggest that audiotaping consultations may have a role in improving the quality of pre-operative information given to cardiac patients. Given the seriousness of the issues facing patients and their families, further comprehensive investigation into the effects of audiotape provision is necessary. Further research is required to ensure the provision of recordings has no adverse impact on any patient subgroup(s); to examine the potential contribution of audiotaping towards communicating risk information; to explore the attitude of surgeons towards audiotaping; and to assess the impact of the intervention on surgeon and patient behaviour.

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