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Title Page

Soliciting additional concerns in the primary care consultation and the utility of a brief communication intervention to aid solicitation: a qualitative study

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Abstract

Objective

To investigate the perspectives of general practitioners (GPs) on the practice of soliciting additional concerns (ACs) and the acceptability and utility of two brief interventions (prompts) designed to aid the solicitation.

Methods

Eighteen GPs participating in a feasibility randomised controlled trial were interviewed. Interviews were semi-structured and audio-recorded. Data were analysed using a Framework Approach.

Results

Participants perceived eliciting ACs as important for: reducing the need for multiple visits, identifying serious illness early, and increasing patient and GP satisfaction. GPs found the prompts easy to use and some continued their use after the study had ended to aid time management. Others noted similarities between the intervention and their usual practice. Nevertheless, soliciting ACs in every consultation was not unanimously supported.

Conclusion

The prompts were acceptable to GPs within a trial context, but there was disagreement as to whether ACs should be solicited routinely. Some GPs considered the intervention to aid their prioritisation efficiency within consultations.

Practice implications

Some GPs will find prompts which encourage ACs to be solicited early in the consultation enable them to better organise priorities and manage time-limited consultations more effectively.

1. Introduction

Primary care is generally patients' first point of call [1]. Demand for general practice in countries like the United Kingdom is increasing, with 40 million more consultations in 2014 than in 2008/09 [2]. Although patients typically attend GP appointments with multiple concerns [3-5], British GP consultations are time-limited; often scheduled to last for approximately 10 minutes [6]. In this time-restricted context, patients do not raise all of their concerns at the outset of their appointment, instead presenting their further concerns towards the consultation's close [4]. Where new concerns are raised late in the consultation, there may not be time to adequately address them.

Soliciting additional concerns (ACs) towards the beginning of the consultation has been recommended [7, 8]. Previous research, however, suggests such solicitations occur in only a minority of consultations [9], and where attempted, is usually towards the close of the consultation, once the presenting concern has been addressed [4, 10]. This may mean a number of patients leave with unvoiced ACs [10-12], although prevalence estimates range widely from 20-89% of consultations [10, 13].

Late-arising and unvoiced ACs can prevent GPs and patients prioritising important issues for discussion. This is particularly important since time restrictions may prevent the full management of multiple concerns [5]. Conversely, successfully soliciting ACs may facilitate early identification of serious problems, reduce patient anxiety, decrease the need for unnecessary intervention, and potentially increase patient satisfaction [14-16].

Linguistics research suggests the phrasing of AC solicitations may influence a patient's response [17-19]. When incorporated into a solicitation, certain words appear more likely to occasion particular

responses. Some words tend to occasion confirmation and others disconfirmation; these words are described as having positive or negative polarity, respectively. In a US study, Heritage et al. [20] tested the effect of using ‘some’, which has positive polarity, and ‘any’, which has negative polarity [21], on concern disclosure within primary care consultations for acute medical conditions. In one intervention arm GPs asked patients “*Is there anything else you want to address in the visit today?*”; in the other, GPs asked patients “*Is there something else you want to address in the visit today?*” [20. P1429]. In both arms, the GPs asked the question immediately after the patient had presented their initial concern(s).

Heritage et al. [20] found AC solicitations using ‘some’ reduced the number of patients leaving with unvoiced concerns by 78%. Although these results are promising, a similar study was needed to explore the utility of this communication intervention in a UK setting [20]; as consultation length and the types of issues discussed vary between countries and health care systems [6, 22], with some suggestion that psychosocial issues are more often solicited in fee-payer-provided systems in comparison to gate-keeper systems [22]. This study reports qualitative findings from a UK-based ‘Eliciting patient concerns’ (EPaC) study. This mixed-methods feasibility study was informed by the US study [20], but differed through inclusion of a third control arm and including patients attending for both acute and routine appointments. The qualitative study reported here explored GP perspectives on the practice of soliciting additional concerns (ACs) and the acceptability and utility of the brief communication interventions (prompts).

2. Methods

2.1 Study design and setting

Embedding qualitative research in trials is an established approach for understanding the intervention process and the scope for integrating interventions into routine practice [23]. Qualitative interviews provide access to GPs' views on their study involvement [24], the soliciting ACs within the GP consultation and the utility of the communication interventions. The study was undertaken from a subtle realist position [25]. It sought a truthful account of the topic whilst recognising that the complexity of human experience and perception, and the inextricable involvement of researcher interpretation, means only an approximation of truth is possible [26]. A pragmatic approach [27], which did not privilege any particular a priori theoretical frameworks was adopted.

2.2 Sampling and recruitment

To maximise opportunities to capture the range of views across GPs, a total sample (all 21 GPs participating in the feasibility study) was sought (Figure 1). GPs within Hampshire, Wiltshire, and Dorset were recruited via the Primary Care Research Network, South West. Interviews were conducted once GPs had completed the intervention component of the trial.

Figure 1: EPaC study design overview

2.3 Data collection

Data were collected August 2013-March 2014 via semi-structured interviews, which were audio-recorded and transcribed verbatim. An interview guide developed by the research team was used to maintain a degree of consistency between interviews (Appendix). Interviews were conducted face-to-face or by telephone, depending on GP preference. RS undertook all interviews except one (due to a conflict of interest), which was undertaken by an experienced qualitative researcher within the same department.

2.4 Data analysis

Data analysis began following the first eight interviews - which contained data from interviews with GPs from the three different trial arms - and ran in parallel to further data collection. Data were analysed using the Framework Approach [28] (Table 1) and managed using NVivo 10 software. The Framework Approach was adopted because:

- It is congruent with the subtle-realist, pragmatic approach underpinning the study [25, 29]
- It offered a systematic and readily auditable means of analysing data.

Table 1: Framework Approach process

Strategies to enhance rigour were considered in relation to Lincoln and Guba's [30] quality criteria; 1) credibility, 2) dependability, 3) transferability and 4) confirmability (Table 2).

Table 2: Approach to rigour in the study

During the analysis process, RS and GML discussed the developing framework and GML reviewed theme formation. Negative case analysis [31], was employed. This involved actively seeking views within data which diverged from those commonly expressed in order to refine the developing theory [31].

2.3 The participants

Of the 21 GPs invited, 18 agreed to participate in the interview study. Reasons for non-participation included being too busy and being unable to arrange an interview within working hours. GP demographics/ recording information are provided in table 3.

Table 3: GP demographics and recording information

3. Results

3.1 Data organisation

Data were organised into four themes (Table 4). Themes 1 and 2, which relate to perspectives on AC and intervention utility are reported here; themes 3 and 4 (trial processes/experience) will be reported elsewhere.

Table 4: Themes and sub-themes overview

3.2 Theme 1: Perspectives on eliciting ACs

GPs described their views on the soliciting ACs within consultations, following participation in the trial. Data were organised into three subthemes: 'the importance of ACs within consultations', 'approaches to eliciting ACs' and 'influences on the solicitation of ACs'.

3.2.1 *The importance of ACs within consultations*

At a conceptual level, GPs considered identifying ACs as an important element of the consultation. Three main reasons were proffered. Firstly, some considered seeking ACs maximised efficiency; GPs

reported knowing the patient's full agenda helped them to prioritise and plan consultations, while not identifying ACs was portrayed as reducing efficiency by risking the need for repeat visits.

"I feel if you don't explore what their other agenda there might be or explore their psychosocial aspects properly or really get into their ideas, concerns and expectations you just haven't done the job properly. [...] you almost end up making more work for the surgery in the long run because the patient likely will have to come back to see another doctor because things haven't been addressed" (GP 20, Control)

Second, soliciting patients' ACs was described as having both individual and interpersonal benefits. At an individual level, participants suggested patients are likely to feel more satisfied when GPs actively solicit and listen to their concerns. Soliciting concerns was therefore seen as a vehicle for cultivating a positive therapeutic relationship. Some noted that soliciting ACs was also linked to GP satisfaction.

"You've got to deal with your patients properly in order to give them the satisfaction and build the relationship with them. If you're superficial all the time, then you will find the consultation is dissatisfying and so will your patients, so they're less likely to be productive and you'll get less positive feeling about doing them". (GP03, ANY)

Thirdly, soliciting ACs was considered important for avoiding the clinical consequences of failing to identify concerns that could be indicative of serious conditions. This was also linked by some GPs with more efficient prioritising of patients' multiple concerns .

“the point that the doctor thinks is more important, that might actually be more serious than the patient can appreciate, like the remark on the door handle as they're leaving about a breast lump or something like that, which actually is far better brought up sooner in a consultation rather than later, because it's a thing that really needs to be dealt with” (GP21, ANY)

Despite the abovementioned benefits, some GPs voiced concern that the consistently soliciting ACs could encourage the routine expression of ‘trivial’ or self-limiting issues.

“I would have some concerns about using it [the intervention] all the time in terms of the long-term effect it might have on people's behaviour. So sometimes uncovering extra agendas are very helpful for the reasons I've said [time efficiency, being thorough and job satisfaction] but also I'm aware that some agendas are things that having found out you might want to or feel obliged to address, but actually that it makes little difference to the patient's main medical problems.” (GP06, ANY)

Notwithstanding some reservations, participants recognised that eliciting concerns was a valuable communicative practice for maximising consultation efficiency, reducing the likelihood of failing to identify serious medical conditions, increasing satisfaction, and enhancing the doctor-patient relationship.

3.2.2 Approaches to eliciting ACs

Participants reported that traditional training advised GPs to solicit for ACs towards the close of the consultation, once the initial presenting concern had been dealt with. GPs in the intervention arms of the trial, however, were instructed to solicit for ACs early in the consultation. Whilst discussing the differences of early or late solicitation, some GPs described how they had already evolved their practice before participating in the trial to ask patients about ACs earlier to minimise concerns being raised late in the consultation and to effectively prioritise their time. These GPs therefore described the trial intervention (in relation to the timing of solicitation) as being similar to their usual practice.

“what I found I didn't like was when I deal with a complaint, think it will just take ten minutes and find out that was a minor problem, actually there's a major problem that was mentioned in the last minute. So I was never happy with that, so I always ask at the start to find out what the problems are”. (GP07, SOME)

With regard to usual practice, GP accounts varied regarding how frequently, and where in the consultation, ACs were solicited. Some GPs reported soliciting ACs routinely, others estimated their solicitation attempts to occur in about half of their consultations and others still noted soliciting only when prompted by patient cues suggestive of other concerns. Examples given of such cues were: presenting with seemingly trivial issues, demonstrating signs of being nervous or upset, and lingering after the presenting complaint had been resolved.

3.2.3 Influences on the solicitation of ACs

GPs identified a range of barriers and facilitators to soliciting ACs. All participants described having to manage competing demands, and lack of time was highlighted as a major barrier to seeking ACs.

Some GPs expressed apprehension that soliciting ACs would result in longer consultations and that this inhibited them from actively seeking ACs. Working within the constraints of a 10-minute consultation prompted some to reflect that only so many problems could be addressed in one appointment. These beliefs were intertwined with awareness of other patients in the waiting room, and a desire to provide an equitable and timely service for all.

“I think that the GPs want to be listening, give the patient time, and open up the agenda and elicit those concerns, but they feel very pressured for time, and I think that time pressure means that we don't want to open up, in speech marks, a can of worms [...] and lead to being late and further under pressure, and not being able to give your best to the next patient that walks through the door” (GP21, SOME)

A need to protect their life outside of work and to avoid ‘taking work home’ were also described as potentially deterring some GPs from soliciting ACs. As noted earlier, however, recognition that ACs were often important issues and that early identification could ultimately increase the efficiency of the consultation were both seen as motivating factors.

Another influence on soliciting ACs was related to the emotional state of the GP. Normal fluctuation in a GP’s emotional state due to environmental and personal stressors was proposed as explaining why and how the frequency of solicitation might vary. GPs’ recognition of the importance of personal emotional state and soliciting ACs was connected to their desire to balance work and home life and avoid ‘burnout’ (where the GP risked emotional exhaustion and an apathetic attitude towards patients).

"I think it [soliciting additional concerns] depends, to some extent, on your mood at the time as well. I know this shouldn't come into it but it does inevitably and if you're feeling tired or anxious about something, as a GP, then you don't want to engage with something that you can't control very easily. It's the unpredictability of the hidden or additional concern." [GP03, ANY]

"getting their concerns out at the beginning you can then focus on what's important, and you can then try and use the time more effectively. But, yes, time does, and obviously how you're feeling on the day, what your last patient was like, all these factors are going to have an impact on how you consult." [GP01, CONTROL]

A key influence in soliciting ACs related to patient presentation and choice. A number of GPs noted that patient trust in the doctor and readiness to disclose were crucial to identifying the patient's complete agenda.

"It's a good thing to know your patient but obviously if their situation changes, they may have other issues that need addressed, but they may feel they're not ready to divulge them at, at a particular stage." (GP04, CONTROL)

"Sometimes it may be on the other side where you have a hunch and then you ask and they are like, 'What do you mean? There is nothing wrong', or 'I have nothing else, no thank you, doctor', so you have to gauge the patient as well [...]It might be that the patient actually then decides that they don't want to dwell into that with this particular

doctor, or they have changed their mind and they don't want to talk about it at all."

(GP16, SOME)

Building rapport with patients was considered important; personal list systems (where patients are allocated a specific doctor) were felt to aid the development of trust, thereby increasing the likelihood of successfully eliciting patient concerns. Although participants recognised the role soliciting ACs could play in increasing the efficiency of consultations, there are a range of apparent challenges for the routine use of this practice in every consultation.

3.3 Theme 2: Intervention utility

GPs discussed the practicality of using the intervention within consultations, their views on the impact of the 'prompt' on the consultation and its potential use in routine clinical practice.

3.3.1 Using the prompts

Overall, GPs evaluated the communication intervention as highly deliverable. Many noted that using the prompt was easy, and some suggested it was similar to their usual approach with patients. However, some GPs noted that initially, the wording and/or timing felt unnatural to them. They suggested that altering long-established routines and scripts could be difficult, especially with regard to changing the wording and timing of the question '*are there any other concerns?*' However, they reported that the deliverability of the intervention questions improved with use and repetition.

"I suppose especially the first few times, it was just making sure I was using the right form of words and introducing it at the right time, I suppose was just a bit difficult, but

yes I think that went pretty well. It was straightforward to do, especially once you were just familiar with that form of words really” (GP06, ANY)

Finally, it was noted by some GPs that the intervention seemed less necessary and more difficult to deploy in situations where a patient had entered the consultation with a very explicit agenda of discussing multiple concerns (such as a list, or a statement alluding to a number of issues) or when the patient’s concern was emotive.

“The only thing is [...] some patients just blurt out all their long things and then it seems sappy at the end of that to say, 'And is there anything else?' when they've already given you six things. [...] But apart from that I didn't have an issue with it at all.” [GP11, ANY]

“I think if someone comes in and they burst into tears in front of you and they say their world's falling apart, at that point whether you've got any other complaints, you're belittling their first one. [...] So I think that would be a time when I wouldn't necessarily do that”. [GP07, SOME]

In addition to the challenges for soliciting ACs identified in the previous section, analysis of this subtheme encompasses challenges specific to the routine use of a precise technique for soliciting ACs.

3.3.2 Perceived impact on the consultation

GPs' accounts portrayed varied perceptions of the impact of the intervention on the consultation. Some GPs reported no perceptible difference when deploying the prompt compared to their usual practice.

***Interviewer:** Did it [the intervention] make any difference to the consultation did you think?*

***GP11 [ANY]:** I wasn't acutely aware of anything but I think that depends on your consultation style anyway. I'm quite laid back with my patients. So I think if you had a doctor who was a bit, 'Yes, what do you want? Sit down' then it would make a difference.*

***Interviewer:** [...] Am I right in saying, did you say you didn't really feel it made a difference to the consultation?*

***GP07 [SOME]:** No, only because I normally do that. [...] It was very similar to what I already do so you know, you'd have to analyse it in great depth over a huge amount of patients to see if that wording was any different to what I normally do. I think that would be very different to perhaps how I used to practice when I was younger, when I was less experienced, when I didn't do that.*

Conversely, others did perceive a difference, and reported that asking the intervention question of 'any' or 'some' other concerns did seem to elicit ACs earlier in the consultation. Those who perceived a difference evaluated the intervention positively, irrespective of the wording they were asked to use. GPs reported being better able to plan their encounters with patients and clarify and

meet patient expectations. One GP described the intervention as giving him the confidence to proceed with the consultation safe in the knowledge that ACs would be unlikely to be raised later.

“Potentially it [the prompt] can come to the point more quickly and try to reduce time of the consultation. Also in terms of the patient perspective, it can cover more expectations for the patient so they expect something from you and rather than digging in something less important, you come to the point [...] and we satisfy their expectations more often. [GP05, SOME]

“I found it extremely useful because rather than waiting at the end to ask additional questions, patients were more forthcoming to install the problems at the beginning of the consultation. Now, this is giving me more time to decide which one to tackle first and I have been using the wording since and it's really, really helpful”. [GP08, ANY]

“I was quite impressed; [...] I think one patient I remember volunteered it at that early stage so I thought oh thank goodness I understood that because I might not have done. But also when they said no, there isn't anything else that gave me the confidence to put all my efforts into the problem that they'd given. Sometimes I think in general practice you just wonder whether there's something about to ambush you, so I kind of almost relax, okay, I've got the deal, this is it and I've got ten minutes to deal with this, ooh, this is quite a nice feeling”. [GP18, ANY]

Others, however, identified instances of negative responses from patients. These were largely described in relation to apparent patient ‘surprise’, which GPs attributed to being asked about ACs

so soon after stating their reason for consulting. Indeed, some GPs suggested that asking the prompt so early in the consultation was not always appropriate. Instances where early solicitation was identified as inopportune were as reported earlier i.e. before trust had been established between patient and GP and when patients presented with an emotional concern.

Interviews captured variation in terms of GPs' views about whether the wording used in the brief communication interventions ('any' or 'some' other concerns) was perceived to be important. Some GPs suggested the wording of the question could make a difference, whilst others considered the GP's general manner and approach to patients to be more influential than the particular wording of the soliciting question. One GP suggested that the intervention was too simplistic, requiring further prompts than the single intervention question.

3.3.3 Potential for use in routine practice

There was consensus that soliciting ACs was the ideal to which GPs should aspire. There was no consensus, however, regarding the utility of the study prompts, or whether soliciting ACs should be part of routine practice, where 'routine' was defined as 'for every consultation' (Table 5). One GP suggested that soliciting ACs was already routine practice for all GPs, but he still saw value in the intervention as a reminder to GPs (who were unanimously described as 'under pressure' and very busy). Some GPs suggested that the prompts could become routine, but others expressed concern regarding the necessity and desirability of soliciting ACs from every patient. The concerns included increasing consultation lengths and overly encouraging patients to attend with multiple, potentially self-limiting concerns in the future.

Table 5: Extracts from ANY and SOME participants illustrating the interventions' potential for routine use in primary care.

Of note, GP03 and GP21 explicitly identified the need for 'hard evidence' in support of the approach in order for it to be adopted in practice. By contrast, other GPs reported being encouraged to change their own practice by their experience of using the intervention and said that they were continuing to use the intervention beyond the project lifetime. These GPs all reported the timing element of the intervention to be useful, however there was no consensus regarding the importance of using the exact wording (Table 6).

Table 6: Extracts from ANY and SOME participants on the perceived importance of question wording on AC solicitation success.

Although soliciting ACs was strongly endorsed as ideal, there were a range of opinions about the uniform adoption of the intervention and the level of evidence required before GPs should incorporate the intervention into routine practice.

4. Discussion and conclusion

4.1 Discussion

This paper reports novel findings exploring GP perspectives of soliciting ACs and the utility of an intervention to reduce unvoiced patient concerns. A number of studies have surveyed doctors' views or explored solicitation practices observationally within GP-patient consultations [3, 4, 10, 15, 32, 33], but little research has explored doctors' experiences of, and perspectives on, soliciting ACs.

This study used semi-structured interviews to provide deeper insights into GP views on soliciting ACs and the utility of a brief communication intervention. GPs considered eliciting ACs to be extremely important to ensure the identification of serious illness, to maximise efficiency, and to foster a positive patient-doctor relationship. These suggested benefits mirror those raised in previously published research [5, 14-16]. However, GPs also expressed apprehension over soliciting ACs, not only with regard to opening 'Pandora's box' [20, 34] but also encouraging the expression of trivial (including self-limiting) concerns, thereby modifying future consultation behaviour. Whilst there is some evidence that patients may modify their behaviour in response to organisational practices [11], evidence is conflicting as to whether early solicitation increases the expression of ACs within primary care consultations, with studies both supporting [20] and refuting [8] this idea. Neither has existing research found soliciting ACs to significantly increase consultation length [8, 20].

Many factors were identified as having the potential to adversely influence GPs' willingness to search for ACs. Factors such as patient presentation (whether or not the patient exhibits cues suggestive of ACs) and choice (whether or not the patient wishes to disclose their ACs, and/or trusts the GP enough to do so) have been highlighted elsewhere as influencing disclosure [11, 15, 35]. However, the influence of the GP's own emotional state and GP 'burn-out', though acknowledged broadly within the medical literature [36, 37], has not been implicated in reluctance to solicit ACs. GPs in this study reported competing demands, particularly with regard to maintaining parity across time spent with individual patients. This reflects much of the literature about primary care consultations, in which lack of time (whether actual or perceived) is identified as a significant challenge for practitioners [5, 6].

GPs' accounts of 'usual' solicitation practices varied, and although a number reported soliciting towards the close of the consultation, in line with previous research [4, 10], there were some GPs

who described having modified their practice independent of the trial to solicit early within the consultation. For a number of the GPs who reported their usual solicitation as occurring later in the consultation, the intervention had prompted earlier solicitation and altered their practice beyond the study period. Perceived benefits attributed to early solicitation related to an increased ability to prioritise and manage time; this finding supports previous work [5] recommending early solicitation for these reasons. Not all GPs, however, felt early solicitation was always helpful. One GP questioned whether it might inhibit patients' expressions of concerns in cases that require a degree of rapport to be established first. There was general agreement that where a patient initially presented with emotive concerns, early solicitation for other problems might not be always appropriate. The importance of building rapport and trust between GP and patient are considered important for encouraging disclosure [38-40]. However, there is no evidence that early solicitation hinders disclosure [7, 20].

The GPs recruited to this study were from practices in four southern English counties and individual GP participants had a range of background demographics, thereby enhancing the transferability of these findings to other GPs in other areas. There are, however, some limitations to the study. Firstly, we were not able to obtain the perspectives of all GPs involved in the trial. Omitting perspectives in any study can influence the analysis, but the three GPs who declined to be interviewed were similar in terms of their demographic backgrounds to those included. Secondly, although the reported findings suggest that the early solicitation of patients' ACs may help some GPs to manage their consultations more effectively, this study was limited to a select group of GPs who were participating in a communication trial and therefore were likely to have some interest in communication skills. Further work is needed to explore the extent to which early solicitation of patient concerns happens in routine practice and to gain GP views on the utility of this practice in routine consultations.

4.2 Conclusion

GPs consider soliciting ACs to be central to their practice, yet face challenges when managing complex patients with multiple concerns in a time-constrained environment. The need to solicit ACs occurs alongside recognition of other considerations, such as providing patients with equitable care, GP emotional state and maintaining a reasonable work-life balance in order to avoid 'burnout'. These are important concerns which can deter GPs from soliciting ACs, and strategies which can support GPs to face these challenges are paramount. Early solicitation using prompts was acceptable to GPs. Prompts to solicit ACs early will be helpful to some GPs, enabling patient concerns to be identified and their prioritisation negotiated between doctor and patient at the outset of the consultation. Further research is needed to establish the impact of early solicitation on GP consultations, under what conditions early solicitation may not be helpful, and the extent to which establishing patient concerns at the beginning of the consultation aids time management. In addition, longitudinal research is needed to explore the impact of seeking ACs on future consultation behaviour.

4.3 Practice implications

The use of prompts to solicit ACs early within the consultation will enable some GPs to manage their time-limited consultations more satisfactorily.

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6. Conflict of Interests

None.

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Appendix

Summary of semi-structured interview guide questions

Introductory questions

- 1.1 Could you tell me, why did you choose to take part in the study?
- 1.2 Prior to the study what did you think about additional / unvoiced concerns if anything?
- 1.3 Do you routinely explore patients' additional concerns, once you have established their main reason for coming?
- 1.4 Can you tell me about what might deter GPs from eliciting additional concerns?

Questions on the intervention (Intervention arm GPs only)

- 2.1 Can you tell me, how did you find delivering the intervention?
- 2.2 What do you think about the intervention?
- 2.3 Do you think the intervention as it was piloted could become a routine practice?

Practical issues

- 3.1 In your practice I believe patients were recruited via X. What did you think to the recruitment process?
- 3.2 How did you find being video and audio recorded?
- 3.3 If the study were to run again, knowing what you know now, would you change anything (if yes, explore further)?
- 3.4 Is there something else you want to add or anything else you want to say?

Table 1: Framework Approach process

Framework stage	Stage procedure
Familiarisation	The primary analyst (RS) listened to interview recordings and repeatedly read the first eight interview transcripts, noting key ideas and recurrent themes and subthemes.
Framework development	A preliminary framework was drafted based on notes made in the familiarisation stage and the a priori aims. Data corresponding to each theme were then indexed.
Indexing	The framework was applied to subsequent transcripts. Where existing themes within the framework did not adequately encompass newly included transcripts, the framework was modified accordingly.
Charting	Indexed data were arranged into charts and summarised. Charts provided visual indications of indexing consistency. Where summary data were absent, original transcripts were revisited to confirm an absence of content.
Mapping	The charts were reviewed and the range, associations and explanations expressed across themes were synthesised and checked against original data.

Table 2: Approach to rigour in the study

Quality criteria	Description	Strategies employed to enhance rigour
1. Credibility	When findings are presented with enough description that the multiple views/experiences of study participants can be seen. Those who were studied should be able to recognize themselves in the findings.	<p>Field notes: consideration was given to field notes where GPs and other practice staff had shared their views of the study design, implementation and premise with RS, including negative views. These field notes informed the interviews, prompting discussion of issues that had been raised during the trial period.</p> <p>Thick description: Quotes are presented to evidence statements with enough information to contextualise the exert and allow the reader to judge the findings for themselves.</p> <p>Peer review: During the analysis process, RS and GML discussed the developing framework throughout the process and the wider team (which included GPs) provided peer review of 1) the interview transcripts, 2) the preliminary framework developed and 3) at the end of the process.</p>
2. Dependability	Variation within and between accounts are articulated. Any alterations to the research process are documented and made evident to the reader.	<p>Clear description of the analytic approach adopted was provided to enable to reader to understand the analysis undertaken.</p> <p>Negative cases analysis: was used in an attempt to capture variation within and between accounts.</p> <p>Tables: were used present variation and similarities visually.</p>
3. Transferability	The extent to which hypotheses or 'theory' generated by the qualitative work are transferable to other groups in the sample population or others.	Transferability of the findings is considered in the final section of the discussion (page).
4. Confirmability	That the conduct of the research and findings derived from this, appear reflective of the phenomenon, rather than the researcher's own personal values and theoretical leanings.	<p>Peer review (as noted above)</p> <p>Reflexivity: a reflexive approach was undertaken throughout. This was vital as RS was also the research fellow implementing the feasibility trial. It was agreed that another experienced interviewer within the department should conduct any interviews where RS' involvement might threaten the quality of data collected; this happened on one occasion.</p>

Table 3 GP demographics

Demographic	Number
Age (years)	
31-40	5
41-50	8
51-60	4
>60	0
Sex (M:F)	11:7
Trial allocation	
'Any' arm	6
'Some' arm	5
'Control' arm	7
	Range (Median)
Practice list size	6,200-17,000 (10,514)
Index of multiple deprivation (IMD) score	8.43-27.6 (14.8)
Years qualified as a Dr	12-29 (18)
Years qualified as a GP	2-23 (12.5)
Whole time equivalent	0.4-1 (0.8)
Interview duration (min/secs)	13:34-41:55 (27:37)

Table 4: Theme and subthemes overview

Theme	Theme description	Categories
1. Perspectives on eliciting ACs	Relates to how the GPs viewed the solicitation of ACs within consultations in their own usual practice and in general.	<ol style="list-style-type: none"> 1. The importance of ACs within consultations. 2. Approaches to eliciting ACs. 3. Influences on the solicitation of ACs.
2. Intervention utility	Describes the views of GPs randomised into one of the intervention arms, in relation to their experiences of deploying the intervention within the context of the study and its potential for routine use.	<ol style="list-style-type: none"> 1. Using the prompts 2. Perceived impact on the consultation. 3. Potential for use in routine practice.
3. Evaluations of the recruitment process	This theme presents data relating to GP experiences of recruitment during the study; both in terms of their own recruitment to the study as GP participants and the recruitment of patients.	<ol style="list-style-type: none"> 1. Satisfaction with recruitment 2. Views on study eligibility criteria and recruitment strategies. 3. Influencing factors on recruitment 4. Suggestions for improving recruitment.
4. Experiences of recording consultations	Relates to GP experiences of recording their consultations and includes overall evaluations of comfort with being recorded, technical aspects and recommendations for improving the experience.	<ol style="list-style-type: none"> 1. Experience of recording consultations. 2. Perceived influence of recording on consultations. 3. Suggestions for improving the recording experience.

Table 5: Extracts from ANY and SOME participants illustrating the interventions' potential for routine use in primary care.

Position on whether the intervention could be adopted in primary care as part of routine practice	ANY-group exemplars	SOME-group exemplars
Supportive	<p><i>“Yes, I’ll put it the other way round and say it is part of routine practice. And where it isn’t part of routine practice it should be really. [...] Unfortunately I think as GPs we tend to lose our initial skills of consultation under the pressure of work. And we may forget that particular approach and phrase. So it’s worthwhile bringing it up again to remind people if they don’t use it.” [GP13]</i></p>	<p><i>“Yeah, I think it could be. I think it definitely could be. I think if you’re going to adopt it from someone who doesn’t do it already then yes. I think asking someone who kind of does that sort of thing to change, it’s always going to be less easy than someone who doesn’t - yes I absolutely agree. I think it’s probably part of general practice” [GP07]</i></p>
Against or uncertain	<p><i>“I think it is quite difficult to have the discipline to do that always and I would also have some concerns that asking that routinely could encourage patients who know me well to bring lots of things to our consultation. So I think in general practice when we have a long-term relationship with patients, especially with personal systems where you end up seeing your own patients, the same patients, then I think you almost set up the way that you operate and train patients to behave in a certain way” [GP06]</i></p>	<p><i>“I think it should be but it is obviously a practical danger, as we discussed. [...] Depending on the workload I would like to be obviously more satisfactory for our patients and spend more time, but how practical? I would like to extend my appointments to 20 minutes, if I could, to give more opportunity but it’s not going to happen” [GP05]</i></p>

Table 6: Extracts from ANY and SOME participants on the perceived importance of question wording on AC solicitation success.

Perceived importance of prompt phrasing	ANY-group exemplars	SOME-group exemplars
<p>Not important</p>	<p><i>“It [the prompt] seemed to be fairly non-judgemental as well so people didn't seem any way taken aback or phased by asking it in that way. So, especially early on if you're asking, 'Is there anything else?' and you're a bit rushed maybe that might be extending a message that, 'Don't really raise anything unless you need to,' whereas, 'Are there any other issues you'd like to discuss today?' is much more given to any range of things that someone might want to talk about.”</i> [GP06]</p>	<p><i>“In the study I think the words were, something like, in addition to the problem, 'Do you have some other problems that we could talk about today?' [...] Whereas normally I'll say for example, 'Okay, so you've come in with a knee problem. We'll deal with that, no problem, we can deal with that in a second. Before we deal with the knee is there anything else you want to talk about? [...] I'm not convinced it [the intervention] had any benefits over what I already do but then I wouldn't necessarily feel that because I'm more comfortable with what I do. It was very similar. So, I think if you took me - if you were giving that phrase to a doctor who didn't do that they might see significant benefits”.</i> [GP07]</p>
<p>Important</p>	<p><i>“I don't think that makes much difference, in my experience, okay? I really don't know. You can phrase it whatever way you like. The crucial thing is to ask at the beginning, 'Are there any other - or anything else to discuss?' I really don't think that specific wording makes any difference whatsoever.”</i> [GP18, ANY]</p>	<p><i>“I think it sounds a bit softer, rather than the 'any' may be a bit dismissive. [...] I think 'some' just kind of opens up a gate while 'any' just sounds a bit like you are stocking up problems in my opinion, which was actually something I've never thought about, but I did after the consultation and after the study was over I tried myself to play with these two words to see if there was any difference really in my own patients that I know, and I actually did find there was a difference, definitely.”</i> [GP16]</p>

Figure 1: EPaC study design overview

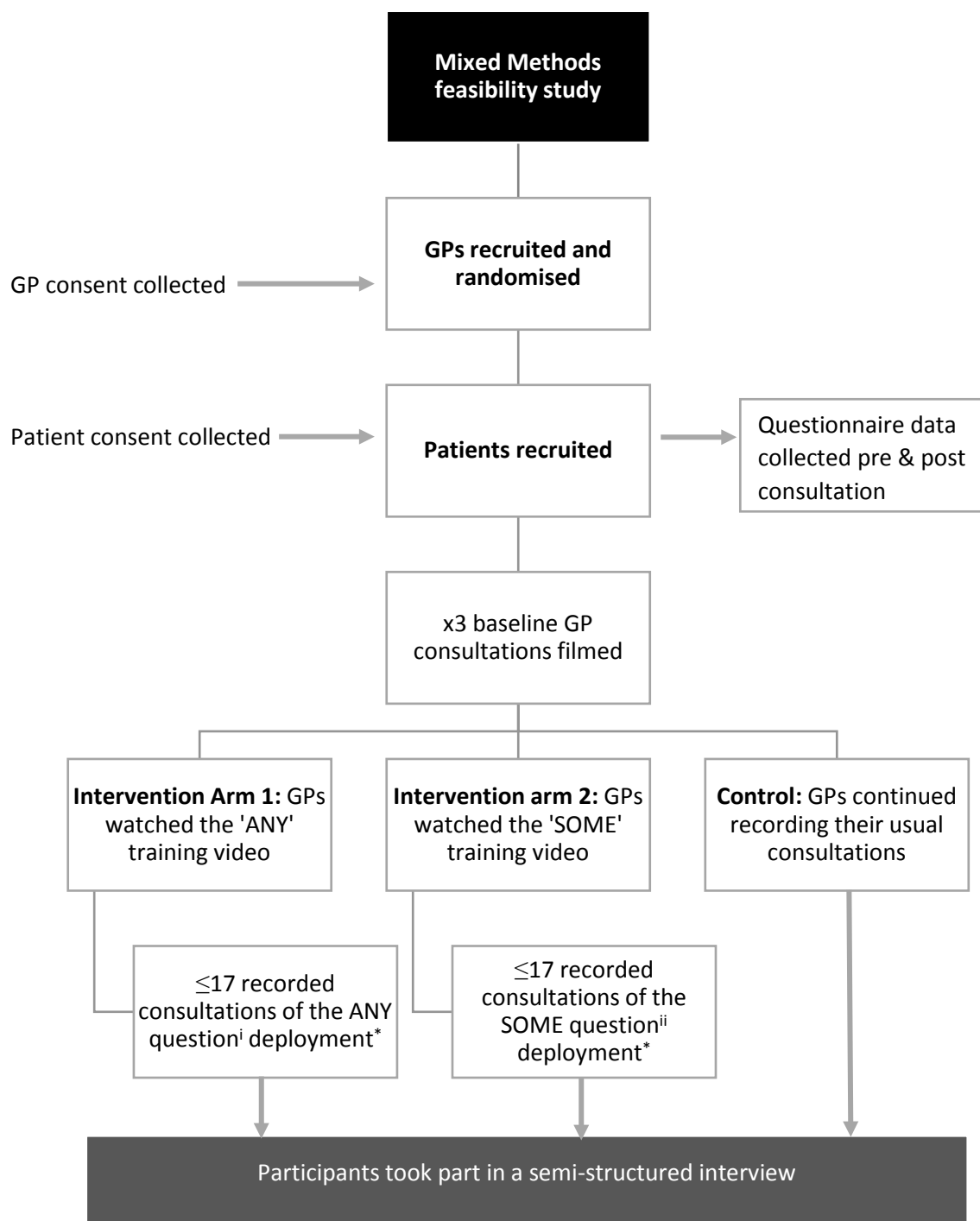


Figure key: ⁱ “are there any other issues you’d like to discuss today?” ⁱⁱ “are there some other issues you’d like to discuss today?” * Deployment of the key question in both intervention arms immediately followed the patient’s initial presentation of their concern(s).