

Sharing decisions in consultations involving anti-psychotic medication: A qualitative study of psychiatrists' experiences

Clive Seale^{a,*}, Robert Chaplin^b, Paul Lelliott^b, Alan Quirk^b

^a*School of Social Sciences and Law, Brunel University, Uxbridge, Middlesex UB8 3PH, UK*

^b*Royal College of Psychiatrists' Research Unit, UK*

Available online 15 December 2005

Abstract

In psychiatry, and in treating people with a diagnosis of schizophrenia in particular, there are obstacles to achieving concordant, shared decision making and in building a co-operative therapeutic alliance where mutual honesty is the norm. Studies of people with a diagnosis of schizophrenia have revealed critical views of medical authority, particularly over the issue of enforced compliance with antipsychotic medication. Psychiatrists are known to place particular value on such medication. This qualitative study reports the views of 21 general adult psychiatrists working in UK about their experiences of consultations involving discussion of antipsychotic medication. Interviewees reported a general commitment to achieving concordant relationships with patients and described a number of strategies they used to promote this. In this respect, their self-perception differs from the picture of authoritarian practice painted by critics of psychiatry, and by some studies reporting patients' views. Interviewees also described obstacles to achieving concordance, including adverse judgements of patients' competence and honesty about their medication use. Explaining the adverse effects of medication was perceived to discourage some patients from accepting this treatment. Moments of strategic dishonesty were reported. Psychiatrists perceived that trust could be damaged by episodes of coercion, or by patients' perception of coercive powers. We conclude that a self-perception of patient-centredness may not preclude psychiatrists from fulfilling a social control function.

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Keywords: Psychiatry; Antipsychotic medication; Schizophrenia; Psychosis; Decision making; Concordance; UK

Introduction

The general rise of patient-centred medicine in Western health care systems (Armstrong, 1984; Arney & Bergen, 1984) has been associated with profound shifts in thinking about the appropriate

way in which to conduct health care relationships. Because thinking in terms of patient compliance or non-adherence has been criticised, on the grounds that this involves unduly blaming patients whose own expertise and rationality goes unrecognised, many therefore now advocate concordance as a model that is more in tune with current views (Bissell, May, & Noyce, 2004). Concordance involves mutual respect and understanding in pursuit of an ideal therapeutic alliance (Working Party, 1997). Decisions about treatment are then shared by all parties in the relationship, including health care

*Corresponding author.

E-mail addresses: clive.seale@brunel.ac.uk (C. Seale),
rchaplin@cru.repsych.ac.uk (R. Chaplin),
plelliott@cru.repsych.ac.uk (P. Lelliott),
aquirk@cru.repsych.ac.uk (A. Quirk).

providers, patients and any third parties such as relatives (Charles, Gafni, & Whelan, 1997, 1999). This approach has been a popular professional ideal in general practice (although in the UK organisational changes may have introduced new restrictions on doctors' capacity to practice in this way in recent years (Charles-Jones, Latimer, & May, 2003)). It entails an implicit view of 'non-compliance' as a potentially reasonable response to breakdowns of concordance, a view to which medical anthropologists and sociologists studying patients' experiences of treatments (including medications) have made important contributions (Britten, 1994; Conrad, 1985).

While the enthusiasm for shared decision making is widespread, it would be incorrect to claim that its only rival is outmoded paternalism, or that concordance is straightforward to apply in all health care relationships. Charles, Gafni, and Whelan (1999) in arguing this note the potential disjuncture between ideal models of communication and the actual contingencies of healthcare situations, showing that treatment decision making is often dynamic and complex, taking place over time and not always restricted to the physician–patient dyad. Significantly, Szasz and Hollender (1956) in their early, classic outline of 'mutual participation' as a potential framework for doctor–patient relationships noted that this sometimes could be inappropriate, for example where a patient was unconscious, a very young child, or experiencing an immediately life threatening process. Thus clinicians' judgements of patients' competence to engage in shared decision making may be an important factor. In psychiatry such judgements are commonly summarised by referring to the degree of 'insight' that a patient has into his or her condition. Ethicists commonly argue that a paternalistic mode of decision making may be justified where insight is impaired, and that this applies particularly to the care of those diagnosed with schizophrenia (Szmukler, 1999). More broadly, in psychiatry the contest between paternalist and libertarian views is complicated by considerations of the adverse effects of illness on others.

Psychiatry, social control and shared decision making

Thus the capacity of psychiatrists to engage in concordant, shared approaches to treatment decision making with patients, particular if they are regarded as suffering from psychosis, may be

constrained where they perceive the patient to lack competence (impaired capacity to make rational decisions). Nevertheless considerable evidence exists to show that a good therapeutic alliance is associated with better outcomes for people with serious mental illness (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; McCabe & Priebe, 2004) and psychiatrists, like other medical staff, are part of a generalised health care culture where democratic professional–client relations are seen as desirable. Thus, advice exists in the psychiatric literature on how to build a shared alliance with patients diagnosed as having schizophrenia (Bhugra & Holsgrove, 2005; Piatkowska & Farnill, 1992), advocating respectful exploration of patients' feelings about their illness and treatment, and negotiation of treatment interventions. While mentioning that patient competence is a particular issue in consultations involving antipsychotic medication, these authors do not however provide much guidance on how to manage the implications of impaired rationality for participation in shared decision making.

Evidence from qualitative studies of patients' raises doubts about the commitment of psychiatrists who treat people diagnosed with schizophrenia to a patient-centred practice involving shared decision making. Thus Day and Bentall (1996), advocating psychological treatments, refer to 'the reluctance of some clinicians to take seriously the patients' perspective when planning treatment interventions' (p. 247) and describe a 'lack of respect for patients' opinions' (p. 248). Pilgrim (1990) argues for a 'democratisation of mental health services to break down medical dominance and to make decisions about patients a matter of negotiation with them, not about them' (p. 224). Rogers et al. (1998) in a study of patients' experiences of antipsychotic medication claim that 'social control' and 'coercive professional action' undermine the capacity of patients to be self-reliant, where a more 'voluntaristic rather than coercive patient/professional relationship' would be appropriate (p. 1321). In this light a study by Packer, Prendergast, Wasylenski, Toner and Ali (1994) finding that 91% of American psychiatric trainees feel that people diagnosed with schizophrenia cannot develop a therapeutic alliance is disturbing, suggesting an inappropriate readiness to reach a judgement of incompetence.

Studies of psychiatrists' practical methods for building therapeutic alliances with patients are in fact rare (Awad, 2000; Cruz & Pincus, 2002) and we

have found no studies of how working psychiatrists think about the effects of coercive episodes on their relationships with patients. Clearly, with an illness condition that is perceived to impair rationality there may be special considerations in seeking to apply a communication model that assumes rationality in all parties to the encounter. At the same time, it is clear that in most Western countries psychiatry has long been implicated in measures that involve social control (Ramon, 1985), supported by legal frameworks that confer considerable powers of coercion. In the UK for example, new mental health laws are now (2005) being passed, drawn up in response to a renewal of concerns about the danger posed by individuals with mental disorder, giving increased powers to psychiatrists to compel people living outside hospitals to comply with treatments. Understanding is needed of the ways psychiatrists perceive their relationships with patients in the light of these dilemmas and pressures, which are perhaps at their most extreme where antipsychotic medication is a focus.

Medication, adverse effects and 'non-compliance'

Despite advances in psychological therapies, medication remains the mainstay of treatment for people with severe mental illness. Psychiatrists place higher value on drug treatments for people they perceive to be experiencing psychosis than do other mental health care professionals (Cape & Antebi, 1994; Jorm, Korten, Jacomb, Rodgers, & Pollitt, 1997; Patel, 2004). Polypharmacy, and inappropriately high doses of antipsychotic medication are a recognised problem in this field (Lelliott et al., 2002). One cause for this in psychiatry (Taylor, Mir, Mace, & Whiskey, 2002) as well as some other fields of medicine where 'irrational prescribing' has been detected (Henriksen & Hansen, 2004; Kumar, Little, & Britten, 2003) is the anxiety and stress that results from bearing 'last resort' responsibility for patients in distress. Yet antipsychotic medications have a range of adverse effects.

Discrepancies have been found between psychiatrists and patients in estimating the degree to which antipsychotic medication has adverse effects (Day, Kinderman, & Bentall, 1998; Rettenbacher, Burns, Kemmler, & Fleischhacker, 2004), and in delivery of information about these (National Schizophrenia Fellowship, 2000; Smith & Henderson, 2000). At the same time, difficulties in explaining the full profile of

a medication's adverse effects are not exclusive to psychiatry. A study of doctors in 10 different specialities outside psychiatry may explain why psychiatrists find this difficult: McGrath (1999) found that doctors were concerned about the impact of such information on patients' motivation to take medications. Additionally, doctors regarded it as impractical to give information about every possible adverse effect.

The many studies that document 'non-compliance' by patients with antipsychotic drug regimes have led to an equally voluminous literature on the causes of this. Some qualitative studies of patients' perspectives on medications (Conrad, 1985; Rogers et al, 1998) depict non-compliance as a rational and positive attempt at self-management of illness. Where investigators are committed to gaining the kind of phenomenological understanding of respondents' perspectives common in some forms of qualitative research, the depiction of research subjects as essentially reasonable and largely self-directing is somewhat inevitable, since this is how most people like to present themselves. Nevertheless, a review of qualitative studies of the experience of using medications (Pound et al., 2005) finds some evidence for approaches that many would consider have an inadequate rationale, such as only taking some medications (eg: antibiotics or antiretrovirals) when symptoms are experienced. More medically oriented studies, often employing quantitative methods, are less committed to exploring patients' own reasoning, and list factors like substance abuse, disturbance of cognitive functioning during episodes of increased illness severity, living alone or in poor housing, and being young and male, as leading to poor compliance (Awad, 2004; Kampman & Lehtinen, 1999; Lacro, Dunn, Dolder, Leckband, & Jeste, 2002; Nose, Barbui, & Tansella, 2003; Young, Reuben, Hillbrand, & Daneri, 1999).

There is also a small literature describing and evaluating ways of encouraging compliance where quite elaborate interventions have been reported and evaluated, ranging from 'psycho-education' programmes, to behavioural modification interventions and motivational interviewing techniques (Awad, 2004; Dolder, Lacro, Leckband & Jeste, 2003; Marder, 2003; Young et al, 1999). Several studies, too, show that psychiatrists often underestimate the extent of their patients' non-compliance with medications (Babiker, 1986; Marder, 2003).

Studies of prescribing in other fields of medicine (Butler, Rollnick, Pill, Maggs-Rapport, & Stott, 1998; Kumar, Little, & Britten, 2003; Lutfey, 2005) have demonstrated the value of gathering the views of experienced practitioners, but we have been unable to locate qualitative studies of working psychiatrists' perspectives on non-compliance and other issues concerning antipsychotic medication. For example, psychiatrists' methods for finding out about, explaining and addressing patients' behaviour with their medications are largely unknown. The degree to which psychiatrists believe they negotiate decisions with patients about medications, and their perceptions of their success in building therapeutic alliances with patients is undocumented. We therefore report in this paper a qualitative study of psychiatrists' perspectives on consultations involving anti-psychotic medication, assessing the extent to which shared decision making is reported in everyday working practice and describing psychiatrists' reported methods for creating a therapeutic alliance that includes negotiation of medication use and consideration of the impact of coercion. We believe this study is the first qualitative report of doctors' perceptions of their role in consultations involving antipsychotic medication.

Methods

Qualitative interviews of approximately 30–40 min were held with 21/32 consultant psychiatrists practicing in two mental health care trusts in England. Characteristics of the interviewed sample are given in Table 1. We approached all consultant psychiatrists in the two trusts whom we understood to be responsible for providing community psychiatric services to adults. The 11 who were not interviewed either did not volunteer on receiving a general invitation to participate (5 males and 1

female in Area 1), refused when asked directly (4 males in Area 2) or indicated that their work did not include outpatient appointments (1 male in Area 2).

We did not inquire about ethnicity, but recorded interviewer's impressions of this. All of the interviewees were white. Three indicated that they were nationals of other countries. Three were originally from Eire and one of these indicated having trained there. Otherwise, interviewees appeared to be UK nationals, presumed by us to have trained in the UK.

The interview was loosely structured around key topics. Although the focus was on outpatient consultations involving discussion of antipsychotic medication, interviewees occasionally deviated from a strict focus on this where giving examples of particular doctor–patient communications. The interviewer (CS) was free to word questions as he wished, and to follow up interesting topics with further supplementary questions. All interviews were audio taped and transcribed in full.

Interview transcripts were indexed with a coding scheme that allocated passages to key themes identified in team discussions. Codes were also developed by two of us independently (CS and RC) and in team discussions we reconciled or merged these coding categories. NVIVO qualitative data analysis software was used to code and retrieve segments of texts. Coding involved, for example, marking all segments of text where respondents spoke about ways of finding out about how their patients' used their medications, or all segments where psychiatrists said how they explained the 'side effects' of medication. Once this text was retrieved, it was further subcategorised into, for example, different ways of finding out, or of explaining. This relatively straightforward approach to thematic qualitative analysis is described in numerous textbooks (for example, Seale (2004, pp.313–321)).

In qualitative research, Lofland (1971) has argued, the aim is to find out the kind of things that happen, rather than precisely estimate their prevalence, which would require representative sampling and standardised interviewing. We feel that this encapsulates the approach of our study, though there is room for debate as to whether this simple description can apply to all forms of qualitative research. Nevertheless we provide counts of how many doctors in the sample exhibited the themes reported. This is aimed at assisting readers in gaining a rough sense of prevalence across the data set. Statistical generalisation to the population

Table 1
Age, gender and experience of interviewees

	Area 1	Area 2	Total
Age ^a	44 (33–59)	48 (38–52)	46 (33–59)
Years as a psychiatrist ^a	17 (7–33)	20 (9–26)	19 (7–33)
Years as a consultant ^a	10 (4–24)	11 (2–16)	10 (2–24)
Male	12	5	17
Female	1	3	4
Total (<i>n</i> =)	13	8	21

^aMean (Range)

of UK psychiatrists is not intended. Systematic coding and counting means that we could search for instances that contradicted an emerging generalisation. For example, we report below that most psychiatrists preferred a patient-centred approach; one doctor, though, made a comment indicating a different view. We have paid particular attention to identifying such ‘deviant’ cases. These various principles of qualitative research and analysis are summarised in Seale (1999) where full references are given to the works where they are discussed.

Results

Background to consultations

Commitment to patient centred practice

When we asked doctors how they thought their approach to these consultations compared with that of other psychiatrists it became clear that there was considerable uncertainty about this, reflected in various qualifiers (for example: ‘perhaps I might have a different approach to...’ or ‘I suspect that...’). Eight commented that they rarely saw other psychiatrists in action:

It is very very difficult to compare one’s own style with other people because being a consultant psychiatrist is a fairly isolated practice with respect to other consultants. (Interview 1)

Interviewees were asked about the way their management of these consultations had changed over time. The most common perception (16/21) was that there had been a trend towards more patient-centred practice, in which a combination of features indicated an attempt to generate a more co-operative relationship than in the past. These included use of language that patients could understand, negotiation of decisions and provision of information about alternative treatments. The growth of patient and consumer groups was mentioned by some as being an influence on this.

I’ve learned how to negotiate with individuals about their medication. Also, I think our practice has changed—well I think our practice has changed. We are a lot more open to discussion and debate, information and choice, which is how it should be really. [It is] partly because of the whole changing focus of mental health, user groups, community based etcetera. (Interview 3)

It was clear, too, that the work involved learning to deal with stress. The sources of this were time pressures, worry about whether correct decisions had been made, anxiety about a deteriorating clinical situation, feeling uncomfortable or fearful if patients were hostile or potentially dangerous, and managing feelings of impatience or annoyance relating to particular patients. Thus, while stress and time pressures created a difficult working environment in which there were few opportunities to observe other consultant psychiatrists, respondents described an increasingly patient-centred practice.

A central dilemma: medication and adverse effects

With the exception of one doctor who indicated ‘I don’t think [giving medication is] the most important thing I do when I interact with patients... I think I don’t value [it] as much as I used to’ (Interview 2), the most common view was that medication was an important, and probably the most important, aspect of treatment for people diagnosed with schizophrenia (14 doctors). Seven qualified this, saying that medication had an important part to play along with non-drug treatments, being the factor that stabilised patients sufficiently for other interventions to be possible.

I think it’s a mainstay of treatment—what I mean by that is that other forms of treatment are effective but are considerably less effective if the drug treatment isn’t being given whereas the drug treatment doesn’t depend on the others to have its effect in its area. (Interview 13)

Four doctors, though, indicated that medication was only valuable if used judiciously. This view was associated with concern about inappropriate diagnosis and consequent overuse of medication:

I think psychiatrists don’t get enough credit for this. If you did a tally you’d find that many psychiatrists stop almost as much medication as they start, because people come to us on cocktails that primary care physicians have prescribed and our job is as much to protect people from medication as it is to prescribe it (Interview 2)

Nine doctors mentioned particular concern about adverse effects and it was clear that this conflicted with the desire to promote medications to patients as the mainstay of treatment.

Certainly side effects is a major issue, and really shouldn't be underestimated. A lot of the side effects of the tablets we give, particularly the older tablets are very unpleasant, but even with the newer ones, for example the potential for weight gain is a huge issue with many of the newer [drugs]. Really shouldn't be underestimated at all. (Interview 9)

Fifteen mentioned aspects of communication about adverse effects that were difficult and seven expressed concern about the negative impact of information about these effects on patients' motivation to take medications. Additionally, eight doctors mentioned difficulty in providing comprehensive or precise information about adverse effects, either because they found it hard to know these themselves or because it was impractical to discuss every single one, including those that might be extremely rare, in the time available. That this was a problem was indicated by the fact that several linked this anxiety to the potential for later complaint or litigation from patients affected by harmful effects they had not been warned about.

I am generally fearful that I don't give people enough information. And we live in a litigious world, and I don't know any doctor who is not worried about it. It is absolutely impossible to give them every bit of information. (Interview 21)

Anxiety about this could be considerable when there was pressure to make people well:

I'm coming under quite a lot of pressure from the staff in that they're saying well Clozapine worked before Dr (*name*) why don't you use it again. And sometimes there's pressure from the nursing staff who sometimes don't understand the ins and outs of the side effects and whereas one tries to say it's the one in three people who become diabetic, the problem is they aren't doing the prescribing so they don't have the responsibility for that, they just want the patient better. So I think often its not just dealing with family things its often dealing with colleagues as well which can be quite difficult. (Interview 14)

A central dilemma, then, lies in the fact that on the one hand, doctors were largely convinced about the value of antipsychotic medications, but on the other hand, were worried about the consequences of fully explaining adverse responses. Some appeared to solve this by being economical with the truth.

Conduct of consultations

Building a therapeutic alliance

A preference for a co-operative relationship involving shared decision making, choices that reflected patient's wishes, negotiated agreements and a sense of partnership, was described by 14 of the psychiatrists:

I genuinely see us as in it together, if you like, that it's a partnership and it's not going to work if I am somehow in a position of superiority and they're in a subordinate subject position. I think it just won't work. (Interview 19)

A number of ways of achieving this were described, including listening to people's views about their situation, their illness and their medications (9 doctors), showing empathy, understanding, warmth, encouragement, respect or closeness (8 doctors) and using language carefully and tactfully, often using non-technical words and explanations that a patient could understand, or reflected the patient's way of seeing things (7 doctors). An example of the latter is

Pretty often in this kind of situation you have, let's say a young man who's experiencing some auditory hallucinations that are very derogatory and he's experiencing them as very real, and we would say 'are there people hassling you?' and it's that kind of term that I would use. (Interview 10)

The benefits of knowing someone over a long period of time were described by six doctors and three mentioned the need to give people time to process and respond to information before reaching decisions. It was clear, too, that the job involved considerable self-control and skill in the management of emotions. Thus, five doctors indicated that it was important to be able to express a human rather than a purely professional response. Another five spoke about developing skills in overcoming hostility, suspicion or conflict; four spoke of the need to be able to tolerate disagreement and another four of the need to avoid appearing rushed. Two described the importance of occasional injections of humour into the relationship and three about the need for a careful approach to raising sensitive issues, such as adverse effects affecting sexual function.

At the same time, a somewhat more manipulative aspect of the relationship was portrayed by some. Three described striking bargains with patients:

He decided that he wanted to come off medication, and I discussed it with him and he was continuing to use cannabis, and he was eventually insistent that he was going to stop it and I said I would allow it. As a *quid pro quo* perhaps he would agree to stop using cannabis. (Interview 11)

Three more said that it was important to give people the impression of a personal service. For one, this involved a little trick:

I do realise that it's a deception, but it's a way of making the patient think that I have a personal recollection of their personal situation—I'll jot down the names of their children or whatever [in the notes] so that I'm able to at least have a person think that I know something about their personal life. (Interview 2)

An exception to the general rule of commitment to democratic models of decision making was a doctor who said that his style was in general a coercive one, but that he was good at hiding this from patients:

I think I don't probably come across as particularly coercive, like other doctors, but I think I probably am, in much more subtle ways. I might be very good at being 'oh he seems a really nice chap, and there's no pressure on at all' but actually I'm quite biased if they need antipsychotics, it's probably to try and persuade them to take them, even if they won't be able to tell that. (Interview 8)

Psychiatry is an occupation involving personal service and there are evident similarities of several of these strategies with the emotional labour done in other personal service occupations, including both those where the service is desired (e.g. flight attendants) and not desired (e.g. debt collectors), as described by Hochschild (1983). Additionally, points at the mild end of the 'spectrum of coercion' described by Szmukler and Applebaum (2001) are described in these data, including persuasion, bargaining and a degree of deception.

Honesty and dishonesty

Seven of the doctors made comments about the value of honesty in relationships with patients. This

involved being as honest as possible about risks, particularly with regard to adverse effects, developing a reputation for being 'straight' with patients and for facing up to difficult issues such as the limitations of one's own knowledge. Although one mentioned that this was an ethical way to behave anyway (interview 19), all mentioned that there were potential benefits to this approach in building up trust.

I don't feel that I have all the answers. I feel that's very liberating (laughs). If I don't know something, I just tell the patient, 'I'm sorry I don't know that' or I feel happy to say, 'I'm not very good at that.' (Interview 13)

At the same time, the requirement to be honest was subject to limitations. Nine of the doctors reported degrees of deception in their approach to patients. This could range from not telling patients certain things, to saying things that were not true. All of these involved the feeling that the deception was in the best interests of patients. Explanation of adverse effects of drugs, or naming the diagnosis, presented particular difficulties, leading to delays in the disclosure of such information.

If you emphasise too much the side effects sometimes you feel that you are increasing the probability of the person saying 'no I don't want to take this medication.' (Interview 12)

The following example shows that a degree of dishonesty was sometimes considered necessary in order to preserve or help create a relationship.

[A man of] about thirty eight who had schizophrenia but was convinced he did not have a mental health problem of any type and really didn't want to be seen... he really didn't see the point in seeing anybody, so I called at the house without warning in advance, or else he might have left...apologised and said 'it's all part of system follow up' trying to locate the blame in some bureaucratic system, and said 'I really apologise, now I'm here, can we talk these things through'. (Interview 6)

Becoming directive or coercive

At times, within the context of a generally cooperative relationship, it was judged necessary to be firm with patients, or to confront them with difficult issues that doctors felt were being avoided:

I felt that because she didn't have a particular suggestion [and was particularly unwell] that that was the cue for me to be as it were more paternalistic really and say well this is what I think we should do from your past experience from my experience, let's give it a try. (Interview 1)

Judging when to adopt a directive approach often depended on whether a patient was judged to have 'insight', be 'very psychotic', relapsing or likely to be a danger to themselves or others:

I like to think that most of the time I'm collaborative but that I can recognise when I need to be more authoritative—authoritarian if you like...I will be directive if somebody is too unwell to make a choice. In community or the outpatient setting it will be less so but there will still be occasions when I have to do that, so being able to recognise when. But I actually think I am collaborative and involve patients. (Interview 3)

Coercive methods were perceived as reflecting a failure to build an alliance and as sometimes damaging future prospects for this so that the decision to adopt a coercive approach was a matter of concern, and doctors sometimes wondered whether they had got this right, found themselves trying to resist their own desire to impose solutions on patients, or reversing earlier coercive measures in order to improve the chances of later co-operation. Patients were regarded as having fluctuations in the severity of their illness and their capacity to participate in decisions. This made it possible sometimes to discuss with them beforehand when coercion might be necessary, or how it might be avoided.

If it gets to the stage when you're going to have to force them I'd rather be straight about that as well. When you come and say 'I'm going to have to section you now', and we did talk about that [as] a part of the warning about the tablets, 'look, you know what happened last time, that's a possibility'... I think she knows I'm straight... and she's agreed that if she does relapse she'll come and see me and we'll admit her voluntarily. We set up all these different things, I think that's all part of the relationship, that she now is happy to take the tablets. It's quite a complicated build up in trust I think. (Interview 8)

Alternatively, once patients were considered to have regained competence, doctors might try to

reverse the damage done to the therapeutic alliance by a coercive episode, as in the case of a man obliged by his doctor to accept depot injections:

He's on a depot injection now and he's got a lot of objections to it [...] and in fact I'm not going to carry on with it ... he has decided against this medication... he's now well enough to make a reasonable argument about it all... and I think in the longer run it's really the only way. (Interview 17)

These psychiatrists, then, largely seek to implement a concordant, patient-centred practice and are able to describe a number of practical ways in which they try to achieve this, many of which involve elements of emotional labour. At the same time, they show themselves to be willing to use dishonesty and coercion where they judge this to be in the best interests of their patients. There appears to be an acute awareness of the effects of coercion on their relationships with patients and ways are described of preventing, minimising and if necessary repairing damage to the relationship.

Non-compliance

Four doctors mentioned spontaneously that non-compliance with medication was an issue in their practice, one of these finding it to be particularly frustrating:

Normally we spend a long time getting somebody stable on a particular medication and... they call up for an urgent appointment and when they come it is very very clear that the carer or relative has said 'you're fine now, stop medication'... We work extremely hard with some very complex people with polypharmacy which is difficult to work with, finally get them well, and it all happens again. And again and again. (Interview 19)

Seven doctors indicated that knowing whether patients were taking their medications as recommended was an area of difficulty where uncertainty about the true situation was inevitable:

I've no idea, and nobody has any idea, about whether there is a match between a psychiatrist's belief about what a patient is taking and what they are actually taking. (Interview 2)

A variety of explanations for non-compliance were offered, the most common being concern

about 'side effects' (13 doctors). Eleven indicated that it was also caused by patients not recognising the need for medication, not believing or accepting they were ill, or lacking 'insight'. A further ten mentioned forgetfulness, disorganisation and lack of structure (influenced by ill health) and eight indicated that non-compliance often occurs if a patient feels they are better. An example that combines a number of these with other less frequent explanations, is shown below:

The chief reasons would include forgetfulness, so non intentional not taking it including due to being distracted by their ill health. Another one might be feeling that there isn't a health problem that requires medicine, and that not being explained to them, or is explained and not accepted by them. Another may be family culture or relatives, they say 'pull yourself together' or it's a sign of weakness if you take medicines. Another might be fear of side effects, or actual side effects, which may come on much earlier than the beneficial effects of course. Another may be the conviction medicines won't work. Another may be dislike of western capitalists and drug companies and a preference to go for homeopathic or other alternative remedies. Those are just a few that come to mind. (Interview 6)

When asked how they found out about what patients were doing with their medication, the most commonly mentioned approach was to ask patients (19 doctors), as in 'You rely on self report' (Interview 11) or 'In the vast majority of cases I have to rely on their account' (Interview 15). Several distinct approaches were described to eliciting information from patients. The most common (11 doctors) was to indicate that non-compliance was normal, and that reporting it would not be followed by disapproval. Six mentioned the value of having a trusting and co-operative relationship in which honesty feels right, and one described appealing to the wisdom of knowing true intake if future dosage was to be planned rationally.

However, other self-reporting methods were less reliant on trust and appeals to reason. Seven doctors described testing a patient's knowledge of what they were supposed to be taking against medical records, or monitoring whether the patient seemed confused about what they were expected to be doing. Two said that they asked patients to bring their medications to the consultation so that they could be counted and four said that they sometimes re-

quested considerable concrete detail of medicine-taking routines, such that it would be hard to invent:

Ask them in practice what time they take the medication, midday, tea time, night time, what the routines are, and you can go into quite a lot of detail about the way they take the medication, which gives you a sense actually of whether they are taking it or not, and whether they ever forget it. (Interview 11)

Additionally, measures that did not rely on self-report were used, with nine saying that they relied on reports from other members of the mental health care team such as general practitioners and seven indicating they relied on co-operative relatives or carers. Monitoring biological indicators such as blood serum levels (3 doctors), or whether expected adverse effects were reported (3 doctors), or whether there was a relapse (2 doctors) were also mentioned.

It is clear, then, that medication poses particular problems of information exchange and control. On the one hand, as we have seen, psychiatrists experience some pressure not to disclose fully all potential adverse effects, partly because they feel this may impair patients' commitment to taking medications. On the other hand, it appears that they often feel uncertain about whether patients are taking prescribed medications, suspect that adverse effects are a major reason for such non-compliance, and feel that patients' cannot always be trusted to tell them the truth about this. A genuinely concordant therapeutic alliance would remove these problems over information exchange, and quite varied steps are taken to try to promote this, but there often remain doubts about patients' true level of commitment to an honest participation in an alliance.

Discussion

These psychiatrists manage the evident time pressures and stresses of the job while rarely seeing how their consultant colleagues practice. This study therefore provides a rare opportunity to learn about this. These doctors believe that a more patient-centred practice is evident now than has been the case in the early years of their careers and they show a strong preference for a co-operative therapeutic alliance with patients, describing considerable variety in the ways in which they seek to achieve this. Thus, they have responded to tendencies towards

the promotion of the concordance ideal in the wider culture of medicine. But obstacles particular to psychiatric practice are perceived to stand in the way. Chief amongst these is the issue of patient competence, the judgement of which is clearly in the hands of the psychiatrist. This results in interactions that are fundamentally asymmetrical since a shared approach to decision making is abandoned if patients are seen as too ill to make decisions that are in their own or others' best interests. In these circumstances, strategies to preserve the possibility of a future co-operative alliance are attempted, but psychiatrists appear to recognise that coercion, or the potential for coercion, militates against honesty in the therapeutic relationship.

Psychiatrists also face a dilemma between the conviction that medications are a mainstay of treatment for psychotic illness, and concerns about the impact that full knowledge of unwanted effects might have on patients' motivation to participate in treatment. For some, this conflicts with the obligation to share information fully with patients, even though some evidence exists showing compliance is not affected by providing such information (Chaplin & Kent, 1998). Non-compliance with medications is regarded as a problem by some, and a variety of methods for discovering this were described, some of these depending on self-report by patients, others relying less on the honesty of self reports. Doctors' explanations for non-compliance reflect a continuing assessment of the degree to which patients can be considered competent decision-makers, and the extent to which they can rely on having established an adequate alliance.

Critics of medical dominance in mental health care services (for example, Day & Bentall, 1996; Pilgrim, 1990; Rogers et al, 1998) have described psychiatrists as agents of social control, suggesting that a paternalistic style of communication, rather than a patient centred style, enacts this. We argue, by contrast, that a social control function does not depend on a particular style of interaction. These doctors display considerable commitment to democratic modes of decision making and appear to have a number of practical strategies available to promote this. In describing these skills they are, in fact, similar to doctors in other areas of medical practice, such as diabetes (Lutfey, 2005) or general practice (Butler et al., 1998), so that at least in their self-image they are succeeding in locating themselves within a general medical culture which values patient-centred practice. In this respect these doc-

tors stand in contrast to earlier generations of psychiatrists, who worked in an environment where authoritarian relations were more acceptably embraced (Ramon, 1985), as did most other doctors. How can it be, then, that studies of patients and this study of psychiatrists produce such contrasting accounts?

One explanation might be that these psychiatrists are an unrepresentative sample. We recognise that this qualitative study in just two areas of UK and of consultants only, may suffer from this problem. Studies of other groups of psychiatrists might reveal a different picture. We urge that further qualitative studies of psychiatrists' views are carried out to assess this objection. Attempting to focus interviews on outpatient consultations only (in practice something which proved rather difficult as respondents often brought up examples from other areas of their practice) may also have produced an unrepresentative view of psychiatric practice. Outpatient attendees may be more stable patients living in the community. Such patients may be more likely to be judged competent than inpatients, or than people encountered in their own homes at times of crisis. These considerations, though, could also be used to argue that the dilemmas discussed in this paper are likely to be more pronounced in other psychiatric care settings.

Another explanation is that our respondents have given a false impression of their actual practice, presenting a more liberal image to a research interviewer than they do to patients. Studies involving direct observation of practice have a certain advantages over self reports since these can show in greater detail the strategies adopted in interactions with clients (Rutter & Cox, 1981). They can also show areas of practice of which psychiatrists may be unaware, or which they do not like to discuss (McCabe, Heath, Burns, & Priebe, 2002). It is possible that self-reports of patient-centred practice would be contradicted by direct observation. Against this, it is clear that a wide variety of patient-centred practices are known to the psychiatrists interviewed for this study, many of which were described in detail while recollecting particular patients, so that it is implausible that these are not at various points integrated into actual practice. Later reports from this study will present the results of audio-taped consultations involving these same doctors, in which comparisons will be made between interview and observational data. A considerable methodological literature comparing the advantages

of observation and interviews exists (Becker & Geer, 1957). We believe that interviews offer the advantage of discovering the intentions of participants in interactions, and in showing the longer-term context in which doctor–patient relationships develop.

Alternatively, we might conclude that patients' and psychiatrists' views differ for understandable reasons. Inhabiting parallel worlds, each party to the relationship perceives a different reality. We believe our study contains some evidence to support this view, since our interviewees were able to convey their frequent doubts about whether they really knew what went on in their patients' minds and lives. The variety of strategies reported to overcome dishonesty in patients' reporting of medication use, the self-reports of moments of deception on psychiatrists' part, and the fact that the psychiatric encounter is fundamentally asymmetrical in terms of powers of coercion, all support this view. Pilgrim & Rogers (2005) have claimed that psychiatrists' legal powers of coercion undermine initiatives designed to promote trust in psychiatric solutions. Anecdotal evidence from users of mental health care services (Chamberlin, 2005) suggests that for strategic reasons they may present to their doctors a false image of compliance. This would explain how psychiatrists manage to maintain a self-image as being committed to democratic decision making as an ideal, while being experienced by a proportion of patients as implementing a non-democratic treatment regime.

The present study would be usefully extended by an investigation of the conditions that place psychiatrists in the position of relying to such a large extent on medications to control the symptoms of people felt to be suffering from psychosis, an underlying factor causing such a focus on adverse effects and non-compliance. Ultimately the parameters within which psychiatrists work, and which obliges them to rely to such an extent on medications rather than alternative methods that may have promise, are set by resource limitations, structural and organisational factors.

The interviews undertaken for this study were with psychiatrists with considerable experience, several of whom indicated that time in the job had led to a more tolerant, less anxiety-driven approach to patients. One interviewee stated explicitly that he did not believe his junior colleagues were yet able to adopt the more patient-centred approach that he had built into his practice. It seems likely that anxieties over this reduce with experience and that,

as they find out how to work with patients, psychiatrists learn an increased tolerance for patients who disagree with them. Given this, a study of the perceptions and practices of psychiatrists with less experience, for example trainee, staff grade or locum consultants, would be revealing.

Acknowledgements

We are grateful to Rose McCabe for helpful comments on an earlier draft of this manuscript.

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