

A qualitative study into the impact of changes to the primary healthcare system in the UK on marginalised groups.

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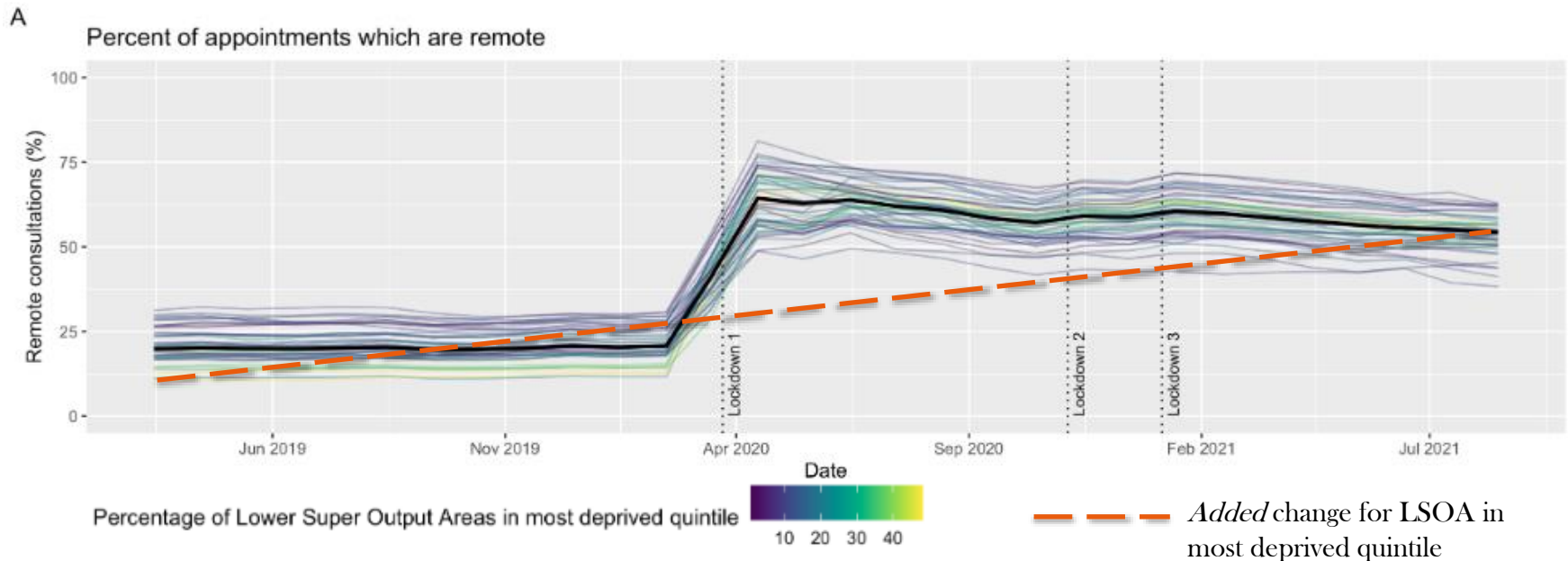
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*“On the phone I can’t do that, I can’t show them on the phone, so it’s what I say...and I’m not saying a lot”*

# Background



Source: The Lancet, Digital Health

# Marginalisation

- ❖ Overlapping
- ❖ Compounding
- ❖ Intersectional
- ❖ Process not identity
- ❖ Unreached, not hard-to-reach



Image of foodbank queue- stock image for anonymity reasons

## Context

- ❖ Living context of COVID-19 and policy changes
- ❖ A period of flux and normalisation

## Data Collection

- ❖ November 2021 – May 2022
- ❖ Marginalised groups selected through service use
  - ❖ Foodbank; Drop-in centre for immigrants, refugees and asylum seekers; Community hub
  - ❖ 15 interviews, and observation 84 hours
- ❖ GPs – 5 interviews
- ❖ Digital Health Hub staff – 4 interviews
- ❖ Service staff – 3 interviews (one per site)

# Example participants

Female, White British, mid-40s, foodbank user, recently lost access to her mobile phone, previously unreliable access to phone credit, one child at home, clinical depression, recently took herself off her medication, user of healthcare services for mental health concerns regularly and other issues sporadically

Male, Black British, 60s, Community hub user, experiencing homelessness at time of interview, no access to a mobile phone, congenital disorder leading to partial paralysis, heart condition, very low user of healthcare services

Male, Bangladeshi immigrant (20 years), 40s, drop-in centre chronic stomach issues and joint pain, high user health care services

Female, Eritrean Refugee (1 year), 30s, drop-in centre, mental health concerns, young child needs, reluctant user healthcare services

# Results: Language

Speaking over the phone can make language barriers larger

“Participant: I think by phone very difficult to tell my problem because I not speak English well I don’t know my problem by English how can I say, so a little bit difficult for me

Interviewer: And when its face-to-face?

Participant: When its face-to-face I can say her by *\*gestures by pointing\**

Interviewer: You can point at your body?

Participant: I have problem this *\*points to body\** and that *\*points to body\** but by phone I can’t explain what I have a problem I think a little bit difficult.” [10]

This creates articulation work for patients which may be outside of their language capacities

# Results: Visual communication

Patients lose the ability to visually communicate symptoms

“Urrmm I’m not...when its face-to-face explaining certain things I don’t have to do a lot of talking I just show them you know so they get the full scenario then you know on the phone I can’t do that I can’t show them on the phone so it’s what I say and I’m not saying a lot I won’t be saying a lot to them to know exactly what I’m going through.” [12]

This can make it challenging for them to communicate their needs. Patients are tasked with noticing and monitoring their bodies before articulating their needs.



# Results: Communication

Health literacy is needed to articulate symptoms

“When they want a reply that’s what I’m thinking I haven’t got enough time to say what I can say and if it’s not enough I lose out and that’s it and that’s what I’ve been doing, losing out so many... I don’t know how to explain it that’s what I mean yeah”  
[12]

Low health literacy limits patients’ capacity to communicate remotely with their doctor.

However, patients' accounts aren't always seen as credible

“I've tried to talk to them over the phone about my back and they're going 'alright you've got a sore back it's on your records'. I go 'this is not sciatica it's different' and they just wouldn't listen until I went down there and, actually they actually felt where it hurt like yeah, the Dr actually felt all the way along thinking its gonna hurt here because its sciatica, and it didn't, it hurt middle of my spine up my back, whereas sciatica is like here round there and down your legs and stuff electric”  
[9]

Patients are being tasked with noticing and articulation work but may not always be seen as credible 'reporters'

# Results: Mental Health

A loss of non-verbal and visual cues can be particularly challenging for mental health needs and safeguarding

“You could see me you would know...she’s not she’s probably struggling or whatever, she needs to talk, whatever is going on she needs to say it out loud and you would know because I feel like when I’m having an episode my speech is faster a lot faster, I think my eyes are...can look quite angry I think my face looks quite tense, even just simple things hair clothes how I conduct myself you could make a great urm diagnosis [...] if you saw me physically.”

[2]

The loss of important safeguarding information during remote consults may contribute to safeguarding risks

# Results: Listening

Patients don't have confirmation of listening: Non-verbal cues which indicate shared attention are lost

“Because you can tell like when, someone's listening to you, you can sort of tell that they're listening and then they respond to whatever, on the phone you don't really get that and you can't tell if someone's listening.” [9]

This may reduce levels of disclosure as it limits relationship building

- ❖ GPs become more attuned to verbal communication: pauses, tone of voice, etc.
- ❖ GPs use various techniques to manage diagnoses and safeguarding: Asking more explicit questions, investigation ‘inflation’, converting to f2f
- ❖ These techniques are framed as risk mitigation strategies

- ❖ Articulation work
- ❖ Noticing and monitoring work
- ❖ Responsibilisation
- ❖ Patient capacity and SES: Language, networks, health literacy, communication skills, symptom awareness (multi-morbidity)
- ❖ Risks of less disclosure
- ❖ Risks of lower information quality

What we already knew

What this study contributes

What this means

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